

Coproduction in High and Medium Security Mental Health Settings

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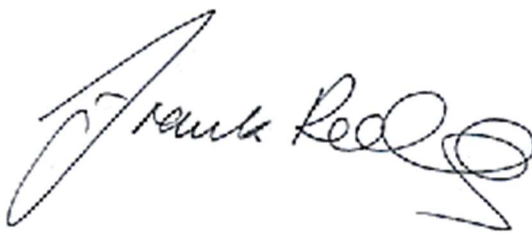
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Signed 

(Francis Thomas Reilly)

Date: 8th August 2025

DEDICATION

To my wife Yvonne. You have always been there helping me to be the best that I can be. Without you this journey would never have started and would certainly not have been completed. Your love and encouragement sustained me when I was ready to give it all up. I am grateful that I listened to you.

To my family who have endured my research journey as much as I did. I love you deeply with all my heart. Now you know that anything is possible if you persist. Just get there quicker than I did.

To my mother Kathleen. Your joy when I passed Higher maths, never ever to use it in anger again, kept me going when the going was tough. I know wherever you are, you are as proud as punch.

To Frank Snr and Anne who encouraged me to keep going over all these years. Anne and I will be thinking of you when I finally don that hood.

To Mark whose work in Ashworth inspired me and whose support helped me keep going when events conspired against me. The fact of the matter is, I miss you every day.

And finally, to my ECMH family: Virve, Liisa, Lauri, Chris, Heikki, Brenda and the Markii; thank you for everything you have shared with me that has made this long journey one that I could finish.

Epitaph

Here lies Rev Donald McPhee

BA, MA, and BSc,

LRAM, and PhD.

A man of letters to the nth degree-

Whose thirst for knowledge was unabated-

A cultured man and educated.

At the age of seventy-three,

He entered the Open University

And there was found beneath the trees,

Death had taken him by degrees.

(David Campbell c1985)

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Many years ago, when I was struggling to prepare for an interview, I had a conversation with my old friend Ailsa who suggested I speak with her friend, Gillian. That conversation led to another with Andy, and then a small project on coproduction, writing some articles, then writing a chapter in a book. Before I knew it, I was Director of the Scottish Recovery Network, an Honorary Research Fellow, and a PhD candidate. Four people made that happen and without you this dissertation would have never happened.

Thank you: Dr Ailsa Stewart, Dr Gillian MacIntyre, Prof. Andy Kendrick, and the person who encouraged me to convert from MPhil to PhD, Prof Beth Weaver.

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This is all your fault!

Annie, we did it!

ABSTRACT

This study aimed to understand how rules-based environments in secure mental health care across Scotland and Ireland affect forms of coproduction and how staff conceptualise this process. The research was required because existing coproduction studies have predominantly focused on community settings, leaving a critical knowledge gap about collaborative partnerships within secure care environments where safety and security concerns limit traditional approaches.

Using thematic analysis of 28 interviews and three focus groups with 33 staff across high, medium, and low-security facilities, the research reveals that coproduction exists along a developmental continuum from compliance through cooperation to authentic coproduction, characterised by trust, reciprocity, and autonomy. The study demonstrates how environmental conditions, staff orientation, cognitive biases, and institutional cultures significantly influence coproduction potential, with off-ward spaces affording greater relational engagement opportunities than high-stimulus ward environments.

By applying game theory to staff-patient interactions, the research illuminates how repeated interactions foster cooperation despite power imbalances, creating Nash equilibria where maintaining peace benefits both parties. The findings suggest that seemingly inconsequential daily interactions represent legitimate expressions of coproduction overlooked by previous definitions, expanding classical conceptualisations beyond service design to include relational processes that contribute to shared outcomes.

The study offers practical recommendations including rotating staff between ward and off-ward positions, addressing team dynamics that reinforce custodial cultures, and implementing dynamic risk assessments that meaningfully involve patients. Whilst acknowledging limitations, particularly the absence of patient perspectives, this research provides nuanced understanding of how coproduction manifests within security constraints, offering insights for theory, research, and practice development in secure care environments and broader coproduction applications.

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LIST OF ACRONYMS

UEC	University Ethics Committee
TSHREC	The State Hospital Research Ethics Committee
WREC	The Forensic Network West Research Ethics Committee
DHREC	Dundrum Hospital Hospital Research Ethics Committee
HCA	Healthcare Assistant
NA	Nursing Assistant
NM	Nurse Manager
NHS	National Health Service
CM	Clinical Manager
NC	Nurse Consultant
TMVA	Therapeutic Management of Violence and Aggression
PMVA	Prevention and Management of Violence and Aggression
HSE	Health Service Executive (Ireland)
CMH	Central Mental Hospital (Dundrum)

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Chapter1. Introduction

1.1 Chapter Overview

This chapter introduces the thesis and outlines the problem that will be explored by the research. Firstly, this chapter outlines the context of the research. Specifically, what forensic mental health refers to in Scotland and Ireland. It then offers a description of the forensic secure care estate in Scotland and Ireland, and the impact that constraints and public protection considerations at different levels of security place on the development of relationships and coproduction. This is followed by an outline of the key concepts that will be explored: mental health and the predominant medical model in forensic mental health; interpersonal dynamics, environmental conditions and the concept of relational security; and finally, coproduction in secure conditions. The last section of this chapter gives a rationale for the research, alongside a discussion of the research questions. An outline of the rest of the thesis is also provided.

1.2 Secure Care context and coproduction

This research explores how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction. The context of secure forensic mental health services is central to understanding the opportunities and constraints for coproduction in these unique environments. The Scottish Government defines forensic mental health care as services which:

‘... specialise in the assessment, treatment and risk management of people with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings. Some other people are managed by forensic mental health services because they are deemed to be at a high risk of harming others or, rarely, themselves under civil legislation.’ (Scottish Government 2025: no page)

Unlike general mental health settings, forensic facilities operate under complex dual mandates: to provide therapeutic care while simultaneously maintaining security for public protection (Crichton et al., 2004). This contextual reality shapes the way that staff approach patient involvement, creating distinct conditions for strategic interactions (Ireland et al., 2019). By examining the nature of security, the influence of institutional histories, and the nature of the experience of transitions across levels of security and constraint in the study sites, we can better understand how different environments enable or constrain the development of coproduction. Without this context, any analysis of coproduction in forensic settings would risk overlooking the impact that institutional constraints have on the opportunities for genuine coproduction between staff and patients.

Of particular interest is the intersection of the core elements of coproduction as identified by Elinor Ostrom: trust, reciprocity, and autonomy (Ostrom et al., 2012), collaborative practice and the therapeutic alliance within highly controlled environments, specifically forensic secure care contexts. In these settings, individuals' movements, interactions, and personal choices are tightly regulated based on the risk to themselves and others, symptom management plans, or rehabilitation objectives (Crichton et al., 2004). In addition there is a dynamic interaction between the perceived risk and collaboration in the creation of relational

security, i.e. security that is reliant on the quality of the conditional relationship between staff and patients (Royal College of Psychiatrists Centre for Quality Improvement, 2023). The study also examines the mechanisms that facilitate meaningful coproduction when personal agency is limited by secure conditions, and the strategies to empower individuals to contribute to decisions affecting their lives, even in highly controlled environments. By exploring these complex interactions, the aim of this study is to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction.

To begin with, there appear to be psychological and physical impediments to coproduction in secure care. For example, forensic mental health secure care is stigmatised by the general public (Tremplin & Beazley, 2024; Walkden & Turner, 2024), with patient access to external social networks or community resources either absent or highly controlled. Secure care facilities are also low or qualified trust environments, with prominent physical security measures such as high fences and locked doors working in unison with procedures designed to safely manage movement and interactions between patients and staff (The Forensic Network (Scotland), 2006). These impediments appear to constrain opportunities for coproduction. In the next section I explore the environments where these impediments exist.

The forensic secure care estate in Scotland, i.e. the clinics, hospitals and grounds where patients are held securely for treatment, underwent a transformation in the early 2000's with the creation of the Forensic Network (NHS Scotland, 2025a). The

network is a Managed Clinical Network¹ (NHS Scotland, 2025b) which was established in 2003 to coordinate social work, social care and health teams supporting mentally disordered offenders across Scotland (NHS Scotland, 2025a). In 2006 the network published a framework for the progressive treatment of people with a serious mental illness and significant risks to themselves and others within the hierarchy of secure care facilities (The Forensic Network (Scotland), 2006, 2010). For example, patients who are admitted to the only high secure facility in Scotland, designated The State Hospital in this study², are determined to pose a grave and imminent danger to others if at large (NHS Scotland 2025a no page). Patients admitted to the next level, medium secure facilities, still present a serious risk to others, but the danger has been determined to be comparatively less imminent. Patients in lower levels of security, such as Medium Secure 2 in this study, are deemed to present a lower risk to others (The Forensic Network (Scotland), 2006). The progression from high to low security is marked by reductions in the prominent physical security infrastructure, increasing freedom of movement and access to the world beyond the facility. In low security, for example, the physical barriers that do exist are intended to impede rather than prevent escape. As patients progress from high to low security the emphasis on physical security reduces as reliance on relationships to manage security (relational security: described below), activities to address boredom and connections to family, friends and the world outside the facility increase (Mezey et al., 2015)

¹ Managed Clinical / Care Networks (MCNs) are multidisciplinary groups that support a systematic approach to service redesign, integration and improvement. ([Managed Clinical Networks \(MCN\) – Hi-Net Grampian](#))

² see 4.2.2 for the justification for selective anonymisation of sites

This structure allows for direct admission at each layer of security dependent on the risk that a patient has been assessed as presenting. It also allows progression for patients as their conditions improve, to step down from high to medium to low security, and ultimately to discharge and freedom.

In the other national context for this study, the Irish secure estate, patients who are assessed as posing a grave and imminent danger to others are detained and treated within the prison system. The next tier at the Dundrum Hospital site - described as high secure in the Irish system - provides treatment and containment for patients whose profile would be similar to that for *settled* patients in The State Hospital who were preparing for a step down to medium security. In this context 'settled' means that patients are broadly compliant with their treatment but still present a danger to others. The Dundrum Hospital facility also combines a medium and low security service which provides detention and treatment for both men and women (Timmons, 2010).

In the next sections I provide further context regarding the forensic mental health population and staffing in Scotland. Unfortunately, comparisons with the Irish forensic system are incomplete as Ireland does not yet provide the same level of detail outlined in the Scottish forensic census described below.

1.3 Forensic Mental Health in Scotland and Ireland

This study investigates coproduction in secure forensic mental health care across Scotland and Ireland. It is therefore important to situate the study by illustrating what is known about the populations being supported by forensic mental health services in

each nation, and specifically the people being supported in secure conditions in both countries.

The 2022 Scottish Government census of forensic mental health care reported that 450 patients were being managed by forensic services, which includes care being provided by teams in the community (Scottish Government, 2024). Secure care patients were receiving treatment in the regional medium and low forensic secure units provided by NHS Greater Glasgow and Clyde, NHS Lothian, NHS Tayside and NHS Fife. The regional facilities also receive referrals from the ten remaining territorial NHS Boards. The highest level of secure care for men in Scotland and Northern Ireland is provided by The State Hospital's NHS Board across 140 beds. There are no high secure facilities for women in Scotland. Women who are assessed as requiring that level of care are referred to the high secure Rampton Hospital in Nottinghamshire or are managed within the medium secure estate. The medium secure estate consists of three NHS facilities. There are also private providers of medium and low secure services, but a comprehensive list of those facilities is not publicly available. One private medium to low secure unit is included in this study (The Scottish Parliament Information Centre (SPICe), 2023).

93% of referrals to forensic secure care were people of working age (4% were over 65), and 96% were male. 30% were being treated in low secure facilities, 28% in medium secure and 25% in high security. 3% were being treated in a general psychiatric ward. On average forensic patients were admitted for 2 years and 9 months, significantly higher than that for non-forensic in-patients (3 months). The most common diagnosis for forensic patients is schizophrenia (60%), with 25% also having a comorbidity for personality disorder (Scottish Government, 2024).

In Ireland the National Forensic Mental Health Service (NFMS) is based in Portrane, having transferred from the original Dundrum Hospital facility described in this study. The Portrane mixed sex facility provides care for 170 patients, 30 more than are supported in Scotland's State Hospital. This is an increase from the only secure facility previously available, 102 beds at Dundrum Hospital (Finnerty S, 2021). In common with The State Hospital, the Dundrum Hospital facility reported that the majority of their patients had a diagnosis of schizophrenia (Richter et al., 2018). However, the Irish model of care treats patients who present a grave and imminent risk to others, the highest level in the Scottish system, in prison rather than hospital. Dundrum Hospital, and now the NFMS Portrane, supports patients who would be comparative to patients considered to be settled and preparing for step down to medium security in The State Hospital, and patients that would be treated in medium secure units in Scotland. Low secure patients are treated in the community (HSE, 2025). Unfortunately, the forensic care census in Scotland is not replicated in Ireland. The most recent cross sectional and longitudinal study of the Irish Prison population suggests that 3.6% were experiencing psychosis, 4.3% were experiencing *affective disorders* such as depression and anxiety (Finnerty S, 2021). The Irish Prison Service reported on the 2nd December 2024 that there were 5,836 people in its facilities. Analysis of the data available at the time of writing suggests that an estimated 210 incarcerated people were living with and being treated for the symptoms of schizophrenia but without the designation of 'forensic patient'.

The most recent data from Ireland indicates that there were 15939 admissions to adult psychiatric hospitals in 2023 (Daly A, 2024). Of that number 46 were admitted to adult forensic psychiatry (op. cit). Unfortunately, there is no demographic data

publicly available specific to the forensic population comparable to the Scottish census.

1.4 Forensic Mental Health Workforce in Scotland and Ireland

Forensic mental health care in secure facilities in Scotland is provided by health and social care teams which will include psychiatrists, nurses, nursing assistants, occupational therapists and social workers. Care and support are provided by mental health nurses and health care (HCA) or nursing assistants (NA) in the first instance. A health care or nursing assistant does not require to hold a formal qualification, but most will hold an SVQ level 1 or 2 in health care and will be supervised by a qualified nurse (NHS Scotland, 2025c). Nurses in forensic care will be a registered mental health practitioner holding a degree (NHS Scotland, 2025d). Figures on the current workforce were not available at the time of writing, but the Forensic Network (Scotland) published a workforce plan in 2005 which indicated there were 284 nurses working in high secure (The State Hospital), 121 in medium security and 323 in low security settings (The Forensic Network, 2005).

Approximately 10,987 Social Workers were employed across Scotland in 2022, which was the most recent report available (Scottish Government, 2022). Social workers were predominantly employed by local authorities (n=6235) with the remainder working as independents or in third sector children and families charities (op.cit). Social workers work in specific adults teams which will include mental health services (n=2036), children and families teams (n=2861), and justice (n=978). A small number provide generic social work (n=360) (op.cit.).

The social care regulator in Scotland, the Scottish Social Services Council (SSSC), also surveys social workers who are qualified to work as Mental Health Officers (MHO) annually, with the most recent survey in 2023 indicating 729 active posts at that point. Only a very small minority of those MHO's are dedicated to providing social work services to High Secure settings (n=7) (South Lanarkshire Council, 2025).

Accurate figures for the other specialities in secure forensic care are not currently available. For example, there is a case study for occupational therapists that suggests that across the UK there are between 550 to 650 practitioners supporting work in secure units, but no figure for Scotland alone (Morris, 2021)

There is a similar dearth of sources that accurately report the forensic mental health workforce composition in Ireland.

In the sections 1.5 to 1.8 I will outline the key concepts referred to throughout the thesis. In sections 1.9 to 1.11 I outline the policy context and the personal and research rationale. I conclude this chapter by describing the research questions and presenting an outline for the thesis.

1.5 Mental Health

This section will outline the medical framework which applies within forensic secure locations. It is also the framework within which mental ill health is diagnosed, treated and understood in health environments.

Mental health is rarely well described by a single definition (Wren-Lewis & Alexandrova, 2021). For that reason, unless a source specifically uses them, I will not use the medical terms '*mental disorder*' or '*mental illness*'. I will instead refer to

the more neutral 'mental health' and 'mental ill health' throughout the thesis. I will also use 'forensic mental health' to describe the environment and population being supported by the staff in this study, from high to low security environments (Arboleda-Flórez, 2006). The term also describes a range of reasons and risks that led to a patient's admission to each of the units studied. I have chosen not to describe the offences that led to admission because they are symptomatic of the primary mental health diagnosis. That primary diagnosis is a medical description of a psychological and physiological disruption which resulted in harm or risk of harm to the patient themselves, harm or a significant risk of harm to other people or a conviction for an offence when the patient's thinking and perception of the world was affected by their mental ill health (Stein et al., 2010).

1.6 Medical understanding of Mental Health

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM V) published in 2013, is the most recently published guide to mental health diagnosis and treatment used by psychiatric services across the world (American Psychiatric Association, 2022). At 991 pages long it is the definitive resource for psychiatry. The first edition, in contrast, was 32 pages long (American Psychiatric Association, 1952). This increase in the medical categorisation of '*mental disorders*' reflects an expansion in the number of pharmacological and physical interventions that are available to psychiatrists in the treatment of psychiatric *disease*, although this expansion has been criticised as having scant evidence (Bentall, 2004).

Psychiatrists are initially trained as physical health physicians who later specialise in mental health (Rogers & Pilgrim, 2001; The Royal College of Psychiatry, 2025). They

are therefore trained to identify and treat the physical manifestations of what the DSM V describes as *mental disorder*, which is to say the physical symptoms of *unusual* thinking patterns and perceptions of reality. Boorse argued in 1975 that these are value judgements vis-à-vis the societal understanding of what is and is not 'normal' (Boorse 1975:53). Fulford (2001) by way of rebuttal acknowledged that psychiatric practice is value laden, but argued that theory, and by extension diagnostic tools such as the DSM V, are value free. However this suggests that psychiatry can exist in two worlds: one of value free science and value laden judgement where the theoretical psychological, biological, chemical and genetic proxy causes of ill health can be treated while the unobservable actual cause remains untreated (Spitzer & Wilson, 1975). A further paradox in psychiatry remains unresolved: that many physical and pharmacological treatments for mental health appear to work for some but not for others, albeit with unwanted side effects (Morrison et al., 2016; Morrison et al., 2015). The final paradox is contained in the manual itself: that distress is a normal reaction to negative stimuli, but distress that extends beyond what is culturally normative is not:

'An expectable or culturally approved response to a common stressor or loss such as the death of a loved one is not a mental disorder' (DSM-V, 2013:20).

This suggests that what can be considered to be a 'disorder' is not exclusively based on neutral observable facts but is heavily influenced by societal, cultural and personal subjective realities at the time the diagnosis is made. This an important consideration when psychiatric diagnosis and treatment are presented as the result of scientific reasoning and a representation of objective truth. This is a potential influence to consider when exploring forensic mental health where a crime and a medical diagnosis are intimately connected, and where societal attitudes and

expectations may influence both diagnosis, treatment, and potentially the interaction between staff and patients. This framework also does not consider the lived experience³ of the diagnosed person, which may be crucial information for professionals implementing coproduction.

In contrast to the medical model's focus on individual pathology and biological determinants, the social model of health emphasises the role of social, economic, political and environmental factors in determining health and wellbeing (Dahlgren & Whitehead, 1991). This model recognises that factors such as poverty, housing conditions, education, employment, social support networks, and experiences of discrimination significantly influence mental health outcomes (Marmot et al., 2012). Within mental health services, the social model acknowledges that psychological distress often arises from social circumstances rather than individual deficits, challenging the primacy of psychiatric diagnosis and pharmaceutical intervention alone (Tew et al., 2012). This perspective has particular relevance in forensic settings, where patients frequently present with histories of social adversity, trauma, and marginalisation that may be more significant determinants of their mental health than their diagnostic categories (Sirdifield & Brooker, 2020). The social model advocates interventions that address broader social determinants of health, emphasising community-based support, peer involvement, and the creation of environments that promote social inclusion rather than institutional dependence (Allen et al., 2014).

The mental health recovery movement, similarly, argues that people living with mental ill health can live the lives they choose with social or peer support and talking

³ The practical experience of living with a condition, experiencing treatment and the personal determination of what works for them in managing a condition

therapies (Lee et al., 2021) instead of, or with, pharmacology (Davidson et al., 2009). The movement is in opposition to the dominance of medical knowledge in mental health as the only description of reality (Burstow, 2017) and belies the powers entrusted to psychiatric medicine on the liberties of people living with mental ill health.

These are the complex realities that psychiatric nurses as the majority of participants in this study were managing during the course of this investigation. They were negotiating the real-life presentations of patients, navigating their way through that experienced reality, whilst also paying attention to the signals of heightened threat, and the clinical guidance of their psychiatrist. This is why it was important that this study shone a light on the actual daily experience of coproduction of staff in forensic secure care.

Given these competing paradigms and inherent contradictions within psychiatric practice, the focus on coproduction becomes not merely desirable but essential in forensic mental health settings. Coproduction offers a potential bridge between the medical model's emphasis on professional expertise and the social model's recognition of the broader determinants of health, whilst honouring the recovery movement's focus on personal agency and lived experience. In forensic environments where power imbalances are particularly acute, and individual liberty is severely constrained, coproduction may provide a mechanism for acknowledging the expertise that patients bring to their own care whilst working within the constraints of security. By examining how coproduction manifests in these challenging contexts, this study addresses whether coproduction is possible within systems designed primarily for containment and control, and whether it can contribute to therapeutic

outcomes that extend beyond symptom management to support recovery and rehabilitation.

1.7 Peace and Security

This study focuses on peace and security as fundamental concepts, exploring the conditions that enable their maximisation. It is from this foundation that access to other desirable elements, such as greater liberties and access to off ward environments, becomes possible because:

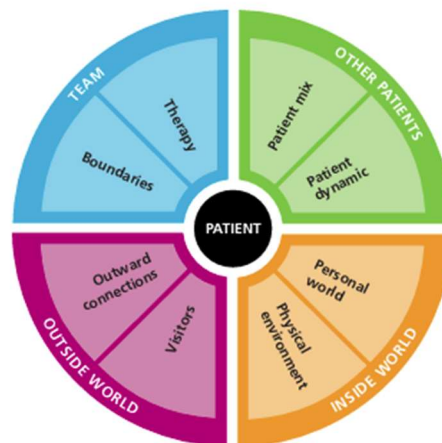
‘Patients and staff can’t participate positively or purposefully in the activities of the service unless they feel safe first’ (Royal College of Psychiatrists Centre for Quality Improvement, 2023:4)

This is also described as therapeutic security (Collins & Davies, 2005; Crichton, 2009) which relies on the development of *‘knowledge and trust between residents and staff’* (De Pau et al 2021:291). In both the UK and Ireland such spaces are created through the interaction of three types of security in forensic facilities. Firstly, the physical security of locked doors and high fences, often also a feature in lower security. Secondly, the procedural security, policies and protocols, that ensure that, for example, patients are periodically searched or are only admitted to the locations they are authorised to be in. And finally relational security, described as

‘...the knowledge and understanding we have of the patient, of ourselves, and of the environment, and the translation of that information in to appropriate responses and care’ (Royal College of Psychiatrist Centre for Quality Improvement 2023:5).

The latter describes a complex interaction between creating safe and professional relationships between staff and patients, the interactions between the patient and other team members, the interactions the patient has with other patients and the interactions and relationships that staff have with one another (Royal College of Psychiatrists Centre for Quality Improvement, 2023; Tighe & Gudjonsson, 2012). Relational security also takes into account the connection that patients have with the outside world through family, friends and visitors and their interactions with their inside world (Wilson et al., 2023). That is, how they process their interactions as well as the environmental influences on that processing. In contrast to the other aspects of security, many of the factors being managed in relational security are accessed by engaging with the patient and reflecting on the interactions that a worker has with them and other members of the team (De Pau et al., 2021). The Department of Health (DoH) and Royal College of Psychiatrists (RCPsych) booklet, *See, Think, Act: Your Guide to Relational Security* (Royal College of Psychiatrists Centre for Quality Improvement, 2023) helpfully presents the interaction between the care team, other patients, the outside and inside world that are important to this form of security in an accessible diagram:

Figure 1 Relational Security Wheel



(Royal College of Psychiatrists Centre for Quality Improvement, 2023:5)

Of note is the importance of boundaries in the creation of relationships, the dynamic interactions between different elements that make up relational security, and the variables that are monitored in this form of security. Much of what is described in this diagram is created between people: emotional bonds, mutual understanding, trust and respect, and shared experiences (De Pau et al., 2021; Royal College of Psychiatrists, 2015). These metaphysical factors contrast with the much more tangible physical and procedural security. Relational security is more complex than physical or procedural security measures, yet it plays a crucial role in creating and maintaining peace and security within forensic settings. Understanding this complexity is essential when examining the conditions that enable coproduction, particularly in environments where patients present the highest risk to staff and others.

In the next section I will provide an outline of the concept of coproduction.

1.8 Coproduction

Coproduction is a compound word constructed of two parts: *co* indicating mutuality or something that requires others and *production* indicating that something is created (Collins 2003:1295). The Collins English dictionary defines it as '*indicating partnership or equality*' (Collins 2003:324). It is commonly used in theatre and TV to describe a collaborative process between two companies or writers with assets and skills that others require to produce anything from a play to a TV feature, also referred to as a '*production*'. In this example there is a physical product produced by the collaboration.

If we consider secure environments, such as prisons or secure forensic mental health care where there are physical and procedural restrictions on movement and interaction, the coproduction of peace and security does not describe the creation of a physical product. Rather, it describes how coproduction between staff and patients in secure care environments create psychological and physical safety despite staff typically being outnumbered. Effective relationships reduce the likelihood of physical conflict and promote stable social interactions through mutual respect, shared decision-making, and recognition of lived experience as expertise (Royal College of Psychiatrists Centre for Quality Improvement, 2023).

Theoretically Moskatova describes coproduction as '*a process of both differentiation and heterogenesis*' (Moskatova 2022:89). That is, it is a process of change (differentiation) that creates an intangible entity between people (heterogenesis). Unlike physical things, it has no substance and is ethereal. Peace and security are similarly ethereal but can be measured by proxy in secure mental health care by

monitoring the number of assaults or seclusions implemented (that is, when a patient is nursed separately from others on a ward). The interactions between staff and patients that lead to peace and security on the other hand can only be measured indirectly through their subjective experiences and reported changes in perception or attitude which may or may not be attributed to coproduction. This study therefore sets out to understand how rules-based environments in secure forensic mental health care affect forms of coproduction, and how staff working across the different levels of security conceptualise the process they understand to be coproduction.

As the application of the emergent concept of coproduction developed in different settings over time, from its initial coining by Ostrom and Whitaker (1973), so too did the definitions of what constitutes coproduction. Brandsen and Honningh helpfully examined the classical definition traditionally ascribed to Parks (Parks et al., 1981) and Ostrom (Ostrom, 1996a) to develop a synthesised definition:

'a relationship between a paid employee of an organisation and (groups of) individual citizens that requires a direct and active contribution from these citizens to the work of the organisation' (Brandsen and Honningh 2016:431).

However, it would seem likely that the autonomy and power sharing that is traditionally associated with coproduction (SCIE, 2022) appear to be absent or constrained in secure forensic facilities, particularly at the highest level of security, to such an extent that forensic staff understanding of the concept tends to be low (Webb et al., 2021). Pilgrim (2018) has similarly questioned whether coproduction can occur within such restrictive environments (see 2.6.1). However, other researchers have documented evidence of relational practices in forensic mental health care that successfully coproduce both service improvements and enhanced

peace and security, despite these constraints (Markham, 2021; McKeown et al., 2014; McKeown, Jones, Wright, et al., 2016). The secure forensic estate therefore appears to present barriers to coproduction as traditionally described (Brandsen & Honingh, 2016), but there is evidence from McKeown (2014, 2016, 2023) and Chandley et al. (2014) that a form of coproduction particular to secure care environments exists, but is often hidden by mental health recovery practice (Drennan & Alred, 2013). Chapter 2 below explores this in more detail.

To address a definitional confusion in the literature, this study distinguishes between four related but distinct concepts. Consultation is information gathering from patients about services, with decisions remaining with professionals. Collaboration is working together on agreed tasks, but within professional-determined frameworks.

Therapeutic relationships are professional relationships using clinical interventions focused on individual patient outcomes. And finally, coproduction is the joint creation of value (in this context, primarily peace and security) through shared responsibility, mutual recognition of expertise, and distributed decision-making power, albeit within institutional constraints. This study specifically examines instances where patients and staff jointly create and maintain the psychological and physical conditions necessary for therapeutic work - moving beyond individual therapeutic relationships to collective production of secure therapeutic environments.

In the next sections I will outline the relevant policy context, the research rationale and my own personal rationale for the study. I conclude by outlining the research questions to be addressed by the study.

1.9 Policy Context

Scotland was an early adopter of coproduction as a concept compared to the other UK nations (McGeachie & Power, 2015), prompted by a contradiction: a post devolution spike in citizen interest in democratic institutions (Ezzamel et al., 2004; Jones & Scully, 2006), followed by a concern in the following years about the rapid reduction in community based civil society organisations and its impact on democratic accountability (Scottish Government, 2011). Devolution decentralised significant elements of Scottish policy and law previously made in the UK Parliament with the creation of the Scottish Parliament. Consequently, in 2011 the Christie Commission described a new approach to public service reform through the creation of partnerships with communities (Scottish Government, 2011). This approach was supported by legislation including: the Public Bodies (Joint working) (Scotland) Act in 2014 which placed an emphasis on service user involvement and engagement in the design and governance of health and social care services; and the Community Empowerment (Scotland) Act in 2015, which emphasised the importance of community influence over public service design. These key pieces of legislation are also supported by strategies and support structures such as: the National Performance Framework (Government, 2024) which prioritises community empowerment; the Social Security Charter (Social Security Scotland, 2024) which commits the Scottish Social Security system to designing its' services with citizens, and the Scottish Approach to Service Design (Government, 2019) which prioritises service user coproduction.

Coproduction has been described as an extension of decentralisation, engaging citizens, third sector and civil society organisations in policy construction (Cairney &

Oliver, 2017). As Cairney (2022) illustrates, decentralising policy making risks creating a process where populism and the loudest voice overcomes evidence based policy making (EBPM). However, when promoting locally tailored and designed services as an antidote to central planning (Leadbeater & Cottam, 2007), Bevir (1999, 2013) cautions against reifying the term '*the centre*' or '*the government*' (Bevir 2013:152), which is suggestive of a defined process when policy makers in government rarely have the benefit of a process that fits the story of EBPM (Cairney, 2022). In reality the Scottish model of policy making combines the engagement of pressure participants (third sector and civil society organisations) (Cairney & McGarvey, 2013), the devolution of policy implementation to non-governmental arm's length organisations (op. cit) and the maintenance of central power. This was reflected recently in the response of third sector and lived experience organisations to the coproduction of amendments to the proposed National Care Service Bill in Scotland ("The National Care Service Bill (Scotland) as introduced," 2024). In this case the public story of co-creation and engagement belied the control exerted by civil servants tasked with delivering amendments to Ministers within a constrained timescale (Elder-Woodward et al 2024).

Policy that supports coproduction in Scotland is therefore attempting to address a number of issues. Firstly the flows of engagement and disengagement of the Scottish electorate from civic society since devolution (Lightbody & Escobar, 2021), and secondly the contradiction of being a leading innovator in participatory governance while still facing the pragmatic and immediate needs, and barriers, of the political system (Escobar, 2022). Scotland's policy environment for its interpretation of coproduction, despite these limitations, is therefore characterised by an integrated policy framework, dedicated institutional infrastructure, and significant sectoral

innovation (Elke Loeffler & Tony Bovaird, 2019). This confluence of factors has positioned Scotland as what Needham (2009) would identify as a transformative rather than merely additive coproduction landscape. The coproduction ecosystem is anchored in a progressive policy architecture that explicitly values citizen engagement and participatory governance, reflecting the Christie Commission foundational principle that

‘Effective services must be designed with and for people and communities’

(Christie Commission 2011:26),

creating what Voorberg et al. (2015) term the normative institutional logic for collaborative approaches.

Coproduction in Scotland also benefits from what Osborne et al. (2016) term an *interactive value creation* infrastructure. That is, organisations such as the Scottish Coproduction Network facilitate knowledge exchange, while the Health and Social Care Alliance Scotland operates as what Williams et al. describe as *‘boundary-spanning entities’* (Williams et al 2016:687), bridging professional-public divides. According to Durose et al. (2017), these intermediary organisations are crucial in translating policy rhetoric into implementable practice, creating what Brown and Duguid (2012) identify as communities of practice that sustain momentum beyond initial policy statements.

Scotland also demonstrates particular strengths in mental health coproduction, with the Scottish Recovery Network (Bradstreet & McBrierty, 2012; Ruthless Research, 2014; Woods et al., 2022) exemplifying what Slay and Stephens (2013) term *relational welfare* approaches. That is the development and integration of peer support, documented by McLachlan et al. (2021), representing what Brandsen and

Honingh (2016) describe as co-production in service design and implementation. For example, East Ayrshire's Vibrant Communities approach, evaluated by Brunner and Watson (2016), attempts to drive community engagement to Arnstein's (1969) higher rungs of citizen power through community-led planning (figure 5: 37) .

Scotland's third sector also operates as what Pestoff (2012) terms a *catalytic agent* for coproduction, with organisations like Disability Equality Scotland (Disability Equality Scotland, 2023) creating governance models that substantively incorporate what Crompton (2019) identifies as embodied knowledge in decision-making processes. These organisations function as exemplars that challenge what Bovaird and Loeffler (2012) identify as bureaucratic monopolisation of service design authority exemplified by the controlled use of coproduction in the National Care Service bill described above.

Despite these enabling conditions, significant challenges persist. Implementation inconsistencies create what Simmons et al. (2012) describe as a *postcode lottery* of empowerment. Professional resistance reflects what Agger and Larsen (2009) identify as institutional barriers to power-sharing, while resource constraints are examples of what Steen et al. (2018) calls the *co-destruction* risks in under-resourced initiatives. Nevertheless, Scotland's distinctive combination of policy commitment, institutional infrastructure, and sectoral innovation creates what John Alford (2016) would recognise as a uniquely fertile environment for exploring coproduction's transformative potential in public service design and delivery.

The policy environment has supported Scotland to be an innovator in developing and testing a form of coproduction specific to Scotland in the delivery of services (Flemig & Osborne, 2019; McGeachie & Power, 2015) and policy (Connolly et al., 2020;

Steiner et al., 2023). Despite a supportive policy environment, as chapter 2 shows, there is a dearth of documented coproduction in secure mental health conditions, which is why this study was necessary.

1.10 Research rationale

Prior to 2010 coproduction was rarely documented for people with mental ill health in general (Brewis, 2007). At that point published studies tended to focus on theoretical concepts (Bovaird, 2007; Boyle et al., 2006; Boyle & Harris, 2009; Brodwin, 2008), the coproduction of research (Gillard, Turner, Lovell, et al., 2010; Gillard, Turner, Neffgen, et al., 2010), service design (Freire & Sangiorgi, 2010; Hyde & Davies, 2004; Ordanini & Pasini, 2008) and models of community cooperation, such as time banking (Boyle, 2007; Dakin, 2007; Powell & Dalton, 2003; Reed, 2008). There were no examples at that time in forensic mental health. Since 2010 there has been growing interest in the concept and increasing numbers of published studies exploring coproduction in justice settings (Buck, 2020; Buck et al., 2020; Johns et al., 2022; Thom & Burnside, 2018; Weaver, 2013, 2019), and in forensic secure settings (McKeown et al., 2023; McKeown, Jones, Wright, et al., 2016; Pilgrim, 2018).

However secure forensic mental health services provide care for patients with a propensity for violence in an environment that constrains their rights as citizens (Pilgrim, 2018). In those environments classical definitions of co-production (see 1.8) may challenge existing views of safe boundaries which are thought to ‘*keep everyone safe*’ (RCPsych 2023:7). This appears to be at odds with the development of trust, reciprocity and autonomy, identified by Ostrom as central to coproduction (Ostrom et al., 2012) . However the application of relational security (described below) at different levels of forensic mental health care suggests that the addition of

coproduction may enable therapeutic staff to develop opportunities for 'safe' positive risk taking and to establish personal outcomes: developing skills that last beyond initial treatment through therapeutic partnerships that enable ongoing engagement in 'co-producing' treatment (Elbogen et al., 2006; Kreyenbuhl et al., 2009; O'Brien et al., 2009; Ward et al., 2012). The aims of this study are therefore to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction.

1.11 Personal rationale

In 2008 after five years designing mental health services and supporting communities to influence Scottish NHS Board decisions, I chose to radically change my career, and I became the workforce planning manager for Scotland's most secure facility providing care for forensic mental health patients. That first exposure to the physical barrier of the security procedure that separated administrative staff from the day-to-day work with patients was a shock to the system. This was because I had begun my career as an addictions counsellor and was immersed in relational approaches to engage with people in distress. Keeping everyone secure and safe at the same time as providing therapeutic interventions appeared to me to be a complex calculus influenced by staff exposure to and recovery from verbal and physical violence and its subsequent influence on the relationships with patients. This insight was central to the redesign of the hospital buildings, and the workforce plan I was employed to develop. The new therapeutic milieu reflected the Millan principles encapsulated in the then new Mental Health (Care and Treatment) (Scotland) act 2003 and its revision in 2015 (Millan, 2001; Scottish Government,

2015a). Two of the key underpinning principles are reciprocity and least restrictive alternative. That is, that where patients are compelled to accept treatment the health and care the system has a reciprocal responsibility to provide the most appropriate, effective services at the lowest appropriate level of security during and after that period of compulsion (Millan 2001:23). The Forensic Network (see 1.2) was charged with meeting these obligations by designing and establishing medium and low secure treatment facilities to provide a step down from the highest level of security (Walker et al., 2015).

In the course of my work, I managed to persuade the Director of Nursing that there was some benefit in me observing the day-to-day operation of wards to inform the workforce plan. It was in the course of that work that I noticed that some staff appeared to negotiate and adjust boundaries with patients to build and maintain personal, and as a result, positive therapeutic relationships. I also noticed that those staff were rarely assaulted and, in some cases, were protected by patients. I was intrigued by the skills that those staff were applying and keen to replicate those approaches elsewhere. That led me into the literature around the process of coproduction and generated a desire to understand how we could make coproduction between staff and patients happen in the most controlled of health care environments.

1.12 Research questions

As a result of the various ways that coproduction is understood it is not clear how staff in secure environments conceptualise and experience the concept in their day-to-day interactions with the patients they are supporting. This research therefore

aims to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction. It will do so by answering the following questions:

1. How is coproduction conceptualised by staff in high, medium and lower secure forensic mental health care facilities in Scotland and the Republic of Ireland?
2. What are the enablers and constraints for coproduction in these circumstances?
3. What does an understanding of coproduction in secure settings add to the classic definitions of coproduction?

1.13 Thesis outline

Chapter 1: Introduction

Introduces the background and context to forensic mental health in Scotland and Ireland. This chapter establishes the foundation for this research which examines coproduction in forensic mental health settings across Scotland and Ireland.

Chapter 2: Literature Review

The literature review examines coproduction from its philosophical foundations in Polanyi's polycentricity and Ostrom's common pool resource theory through to contemporary applications. The chapter reveals coproduction as a contested concept lacking universal definition,

ranging from tokenistic consultation to genuine power-sharing between 'regular producers' (professionals) and 'consumer producers' (service users).

Central to effective coproduction are Ostrom's three relational elements: trust, reciprocity, and autonomy. However, the review exposes power dynamics where organisations may use coproduction to distribute responsibility for failures whilst maintaining primary control. Particularly in the context of austerity, coproduction risks shifting service delivery and maintenance responsibility to communities without transferring corresponding power or resources.

A critical gap emerges regarding coproduction in secure forensic mental health settings, where institutional control, risk management, and restricted autonomy create fundamental barriers to authentic collaboration, and therefore coproduction. The chapter concludes by identifying the need for empirical research exploring how meaningful coproduction might function within these constrained environments whilst balancing legitimate security concerns.

Chapter 3: Theoretical Framework

This chapter sets out the theoretical framework that is used in this study. The framework synthesises game theory, organisational citizenship behaviour (OCB), and power dynamics to examine coproduction in secure mental health settings. Game theory provides a lens for understanding strategic interactions between staff and patients, moving beyond traditional rational choice models to explore how repeated interactions can foster

cooperation despite significant power imbalances. OCB explains the discretionary actions that both staff and patients undertake beyond formal requirements, creating informal psychological spaces where collaboration can flourish within institutional constraints.

The framework addresses how strategic accommodation - where patients simulate compliance rather than genuinely engage - can transform into authentic partnership through trust-building. Drawing on Ostrom's foundational elements of trust, reciprocity, and autonomy, it explores how therapeutic relationships can transcend compliance-based models. This integrated approach applied to secure forensic contexts explains how coproduction can succeed despite tensions between therapeutic goals and security imperatives, highlighting that the shift from physical to relational security enables meaningful patient involvement in care delivery.

Chapter 4: Methodology

This chapter sets out the methodological approach taken in the thesis. The ontological and epistemological underpinnings are based within social constructionism which, in turn, underpins the use of structured thematic analysis to the data. The research adopts an interpretivist paradigm, recognising that reality is constructed through experience and relationships. The theoretical framework draws on Elinor Ostrom's common pool resources theory, conceptualising peace and security as jointly produced through trust, reciprocity, and power-sharing.

The study employed a multi-site, multi-method design across four facilities in Scotland and Ireland, representing different security levels and

organisational contexts. Data collection combined semi-structured interviews and focus groups using vignettes with 33 professionals, predominantly nursing staff. Thematic analysis followed Braun and Clarke's six-phase approach, with comparative analysis across methods and sites.

Ethical considerations included multi-layered approval processes, informed consent procedures, and careful attention to confidentiality. The author's insider/outsider positionality was acknowledged through reflexive practice.

Key limitations include the focus on staff perspectives without patient views and constraints on both the representativeness of the sample and representation access to each site.

Chapter 5: Findings The Behavioural Gateway and Staff Archetypes in Secure Forensic Mental Health Setting

This chapter examines the findings and considers how rules-based environments in secure forensic mental health care affect coproduction processes, presenting findings from interviews with staff across different security levels. The chapter introduces the concepts of the *behavioural gateway* - the safety and symptom management thresholds patients must meet to access off-ward activities. This gateway serves as a key progress indicator, though staff struggle to distinguish genuine recovery from strategic accommodation.

Findings from this study suggest that there are two primary staff archetypes: *custodians* who prioritise procedural security through rule application, and *relationally close practitioners* who develop therapeutic relationships whilst maintaining boundaries. A concerning variant - the

malicious custodian or 'gunslinger' - deliberately provokes patients to justify imposing or reinforcing restrictions.

Environmental affordances also appear to significantly influence practice.

On-ward environments, particularly in high security, constrain relational opportunities due to space limitations, how 'settled' the population is, and the unpredictable behaviour of new admissions. Off-ward settings enable more therapeutic relationships with reduced emphasis on visible security measures.

These dynamics create a ladder of freedoms where patients progressively access environments offering greater autonomy and relational engagement. The findings demonstrate how staff approaches and environmental factors interact to shape therapeutic climates within security constraints.

Chapter 6: Findings Relationship Development and Coproduction in High-Risk Settings

This chapter explores how therapeutic relationships, and coproduction develop within secure forensic mental health settings despite their significant constraints. Key findings reveal that trust building varies considerably across security levels, with off-ward environments offering greater opportunities for normalised interactions compared to restrictive on-ward settings.

The research identifies reciprocity manifesting through patients protecting staff, engaging in shared activities, and mutual recognition of humanity beyond institutional roles. However, staff empathy emerges as a finite resource that can be depleted through exposure to violence and risk,

particularly when historical case information creates psychological barriers to connection.

A notable cultural division exists between on-ward and off-ward staff, with historical incidents on one site continuing to influence risk-averse practices. Despite these challenges, the study demonstrates that meaningful coproduction is possible through the *behavioural gateway* system, where patients progress towards increasing freedoms. Banter and humour serve as important mechanisms for safely testing boundaries and developing authentic relationships within appropriate professional limits.

Chapter 7: Discussion

This chapter synthesises findings from Chapters 5 and 6 to address the three research questions that examined coproduction in secure forensic mental health facilities across Scotland and Ireland. The research identified two key staff orientations: custodian (focused on procedural security) and relationally close (prioritising therapeutic relationships). The research challenges Pilgrim's assertion that coproduction is impossible in secure conditions by demonstrating that meaningful collaboration exists along a developmental continuum from compliance through cooperation to authentic coproduction.

The chapter examines the two key findings about staff orientations: '*custodian*' (prioritising procedural security) and '*relationally close*' (emphasising therapeutic relationships), demonstrating that these are contextual responses rather than fixed traits. The environmental factors are then examined as important facilitators or barriers to coproduction

possibilities, with off-ward settings and lower security levels providing greater affordances for reciprocal relationships.

Key theoretical contributions of this study include applying game theory to understand strategic staff-patient interactions and using affordance theory to explain how physical environments shape collaborative possibilities. The research reveals that Ostrom's triptych of trust, reciprocity, and autonomy operates in modified forms across security levels, with trust being conditional and situated rather than absolute.

The chapter addresses the three research questions about staff conceptualisation, enablers/constraints, and contributions to classical definitions of coproduction. It concludes with practical recommendations including staff rotation between ward/off-ward positions, managing '*teamness*' culture, developing patient-inclusive dynamic risk assessments, and future research incorporating patient perspectives. The study demonstrates that relationships themselves constitute a powerful form of security complementing traditional security measures.

Chapter 2. Literature Review

2.1 Chapter Overview

This chapter provides a critical overview of the existing literature on coproduction.

The review begins by exploring its philosophical and theoretical foundations, tracing its development from Michael Polanyi's concept of polycentricity through to Elinor Ostrom's work on common pool resources (CPR) and governance systems. It examines the range of definitions of coproduction across different contexts, and the ongoing debate about what constitutes coproduction.

The chapter then explores the key components of coproduction including the relationship between *regular producers* (professionals) and *consumer producers* (service recipients), the importance of trust, reciprocity and autonomy, and the power imbalances in coproductive relationships. It also examines how coproduction has been implemented across various sectors, particularly in health and social care settings.

The review also examines the unique challenges of implementing coproduction in secure forensic mental health settings, where restrictions on patient liberty, risk management, and institutional control create apparent barriers to the sharing of power. The chapter concludes by identifying the gaps in the literature regarding coproduction in secure environments.

2.2. Search Strategy and Methodology

A literature review presents an assessment or critical analysis of what is known about a subject area (Gregory & Denniss, 2018). For this study, a narrative review was chosen over a systematic review. While systematic reviews ask pre-determined, structured questions of the literature, and are often paired with meta-analysis, narrative reviews allow the reviewer to explore a subject in its broadest terms, which supports the development of post hoc research questions that interrogate gaps in existing knowledge (Sukhera, 2022). Given that the study of coproduction is an evolving field and that the methodologies used vary across multiple disciplines, a narrative review was necessary to provide an interpretative synthesis of the existing literature, identify knowledge gaps, and to develop appropriate research questions for this study (Siddaway et al., 2019). The flexibility possible in a narrative review means that a researcher can use techniques such as backward snowballing - reviewing the references in key papers (Wohlin, 2014; Wohlin et al., 2022) - to explore a wider range of related topics and to establish the theoretical framework and context for both the research and the empirical research question (Demiris et al., 2019). In fact, Siddaway argues that they are qualitatively systematic and are therefore best suited to qualitative studies (Siddaway et al., 2019).

To strengthen the methodological rigour, a data capture tool (Appendix 6) and the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (Figure 2) were used to systematically assess the relative strengths and weaknesses of research studies, including design and applicability to this research (Singh, 2013). The CASP process provided *"quick, simple, and easy to understand tools for answering common questions regarding a scientific study"* (Singh, 2013:77).

Figure 2 CASP Checklist

1. Was there a clear statement of the aims of the research?
Yes No Can't Tell
2. Is a qualitative methodology appropriate?
Yes No Can't Tell
3. Was the research design appropriate to address the aims of the research?
Yes No Can't Tell
4. Was the recruitment strategy appropriate to the aims of the research?
Yes No Can't Tell
5. Was the data collected in a way that addressed the research issue?
Yes No Can't Tell
6. Has the relationship between researcher and participants been adequately considered?
Yes No Can't Tell
7. Have ethical issues been taken into consideration?
Yes No Can't Tell
8. Was the data analysis sufficiently rigorous?
Yes No Can't Tell
9. Is there a clear statement of findings?
Yes No Can't Tell
10. How valuable is the research

2.2.1 Search Process

The literature search was conducted in three phases over the course of this part-time PhD:

- Phase one: Literature published between 1960 and 2015
- Phase two: Literature published between 2016 and 2018
- Phase three: Literature published between 2019 and 2024

Across these phases I used the 'abstracting' method described by Robson and McCartan (2002). That is, reviewing the abstracts of papers flagged by search terms for relevance, using the criteria described below to sift out irrelevant papers, and to ask the following questions: what is known about the topic, where the key debates in the subject area lie (Braun & Clarke, 2013) and the methodological approaches taken (Robson & McCartan, 2002). This method highlighted general papers that

specified coproduction, and subject adjacent papers that were broadly relevant but were not specific to mental health.

The initial search used the Strathclyde University library search service SUPrimo, ProQuest, PsychInfo, and Google Scholar, focusing on three specific concepts: coproduction, coproduction in mental health, and coproduction in forensic mental health. The unrestricted search yielded over 100,000 results, providing an indication of the breadth of published material using this term. I then narrowed the search terms (table 1) and applied inclusion/exclusion criteria (table 2).

Table 1 Search Terms Used

Coproduction	Coproduction in Mental Health	Coproduction in Secure Mental health
Public Administration	Public health	Secure
Governance	Social history and conditions	Justice
Policy	Social Pathology	Prison
Social History	Public Welfare	Social Pathology
Social Reform		

Table 2 Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
About coproduction	No explicit discussion of coproduction
About coproduction and secure mental health	Not accessible through the University of Strathclyde
About coproduction and mental health	Not in English
Peer review journals	Non-peer reviewed book chapters
In English	News articles
Empirical Research	Control trials that focus on testing interventions

Literature Reviews	Testing psychometric measures of mental health or coproduction
Qualitative Research	Abstracts only
Quantitative Research	TV, film, drama production
Mixed Methods Research	Business
Within date range: 1960-2024	Technology
Result of University of Strathclyde Suprimo search	Not coproduction of research design and implementation
Result of ProQuest search	Not coproduction of knowledge/learning in higher and further education
Result of a PubMed search	Not chemistry
Result of a Web of Science search	Not biomedical or medical device interventions
Result of a CINAHL search	Not evaluation
Result of a Cochrane Library search	Not medicine
Result of Psych Info search	Not food
Result of Google Scholar search	Not health technology
	Not quality improvement
	Not feedback
	Not social entrepreneurship
	Not commissioning
	Not coproduction between organisations

For the final phase (2019-2024), the search was extended to include specialist databases PubMed, CINAHL, Cochrane Library, and Web of Science to reflect the expanding interest in the subject. Boolean operators (AND, OR, NOT) were used to refine the results, excluding irrelevant fields such as technology, chemistry, food production, medicine, food, health technology, quality improvement, coproduction of knowledge and research coproduction

Qualifying articles were assessed using the CASP checklist (Critical Appraisal Skills Programme, 2024) (Figure 2), evaluating the validity of the method, results, and their relevance to the study. Both empirical and theoretical papers that were judged methodologically sound and theoretically relevant were included in the final selection (n=212). The RATS rubric (Relevance, Appropriateness of qualitative method, Transparency of procedures, Soundness of interpretative approach) guided this process (Clark, 2003). Qualifying articles were then sorted into categories (table below)

Table 3 Sorted Categories

Coproduction	
Category	Related terms
Core Concepts	• Definitions• Asset Based• Coproduction and Identity• Health Literacy• Personalisation
Stakeholders and relationships	• Civil Society• Professionals as Interlocutors• Relationships• Health Systems and Public Involvement
Implementation Approaches	• Formal and Informal Coproduction• Local versus National Approaches• Holographic and Holistic Approaches• Coproducing Transitions• Peer Developed Coproduction
Challenges and Barriers	• Responses to Austerity• Problems with Collaboration• Structural Barriers• Risk Management
Service Aspects	• Service Recovery• Recovery and Coproduction• Forensic Services• Place
Research and Evidence	• Empirical Studies• Theoretical Studies• Evidence for Coproduction• Anticipated Benefits
Guidelines and Implementation	• Policy and Practice• Collaboration

Additionally, reference lists from the selected papers were reviewed using backward snowballing (Wohlin, 2014; Wohlin et al., 2022), generating 80 additional texts, bringing the total of eligible papers to 292 prior to applying CASP, which resulted in a

final list of 95 papers. Analysis of the final list identified key themes which form the structure of this literature review (table below).

Table 4 Key Themes

Coproduction Key Themes		
Philosophical foundations	Coproduction and social capital	Defining Coproduction
Key Components	Coproduction as a magical concept	Applications of coproduction
Power dynamics and coproduction	Coproduction as a response to austerity	Coproduction and health literacy
When coproduction goes wrong	Challenges of coproduction in forensic secure care	

The following sections present a critical analysis of the eligible papers. It begins with definitions of coproduction and presents the themes described above.

2.3 Philosophical Foundations of Coproduction

2.3.1 Polycentricity and Common Pool Resources

Coproduction is underpinned by Michael Polanyi's theory of polycentricity (Aligica & Tarko, 2012; Polanyi, 2013) and its key claim that knowledge emerges from distributed, interactive processes where multiple centres of expertise collaborate to generate insights that no single authority could produce independently (Ostrom, 1990; Polanyi, 2013). The theory of polycentricity emerged from Polanyi's experience as a physical chemist and philosopher of science, developing a systematic analysis of the mechanism through which scientific knowledge advances: decentralised collaboration rather than centralised planning. His theoretical framework challenged assumptions about the best forms of knowledge production and governance and underpins contemporary concepts of coproduction. His epistemological framework built on his concept of "*personal knowledge*", (Polanyi,

2013) arguing that all knowledge contains tacit, embodied elements that cannot be fully articulated or centrally directed. His maxim "*we can know more than we can tell*" (Polanyi 2009:139) established that effective knowledge systems must accommodate implicit, experiential understanding alongside explicit, codified information. That is, Polanyi's work primarily focused on the differences between highly controlled research strategies that deliver generalised objective truth, and less controlled approaches that acknowledge the influence and importance of subjective reality. He argued that pure scientific methods often ignore the social interactions that lead to the development of knowledge, much of which comes from researchers' tacit rather than explicit knowledge:

"Researchers' efforts do not usually dissipate in unproductive directions because they share a common ideal; that is, their freedom is utilised to search for an abstract end goal (objective truth)" (Aligica & Tarko, 2012:238).

Polanyi's thesis was that freedom or autonomy from central control promoted creativity and efficiency by allowing local resources to adapt to their specific contexts.

While Polanyi's polycentricity offers valuable insights into distributed knowledge systems, his framework embeds particular assumptions about rationality, expertise, and social organisation that require further examination. His emphasis on *objective truth* as the organising principle for scientific communities reflects Enlightenment epistemology that feminist scholars like Haraway (1988) and Harding (1991) have challenged as inherently masculinist and exclusionary. Moreover, Polanyi's focus on scientific collaboration among intellectual equals may translate poorly to contexts involving structural inequality, where local knowledge and expert knowledge exist in

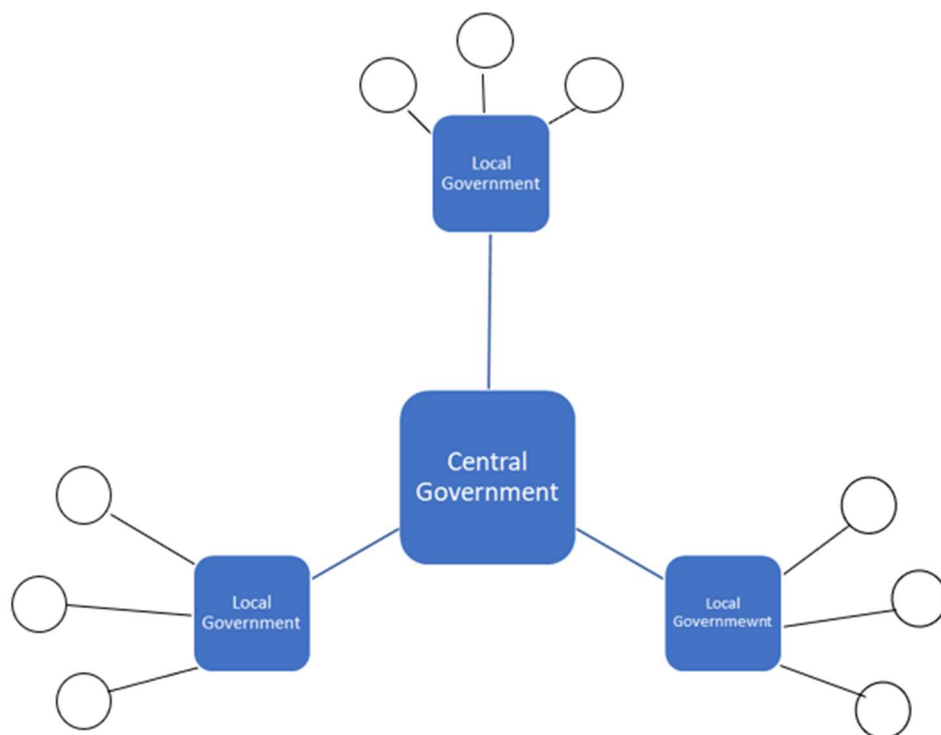
hierarchical rather than complementary relationships. While acknowledging this limitation, I will now explore the work that the Ostrom's developed from this foundation.

Vincent and Elinor Ostrom built upon Polanyi's concepts to develop a theory of political economy and governance which described devolved power across multiple centres of competence. These centres can work with or against one another to manage common pool resources (CPRs), analogous to common ideals described by Polanyi, also known as '*the commons*', to their mutual benefit (Carlisle & Gruby, 2019). CPRs are typically natural or human-created resources that are difficult to exclude others from, and whose use by one or more individuals reduces their availability to others. Common examples include forestry and fishing grounds (Ostrom et al., 2012).

While Polanyi's theory offers insights into how distributed power systems can support the creation of practical knowledge, it directly challenges existing theories of governance. For example, unlike New Public Management (NPM) approaches that emphasise the efficiency of centralisation (Hood, 1995), or hierarchical bureaucratic models that favour standardisation (Weber, 1978), polycentricity privileges local adaptation. However, this theoretical framework has limitations. For example, polycentricity may overestimate local actors' capacity for rational decision-making (Davoudi, 2012) and underestimate the not inconsiderable challenge of coordinating activities across multiple centres of power (McGinnis, 2016). These competing theoretical perspectives suggest that there is a fundamental tension between governance systems and the most effective means to manage complex public resources.

This theory of dispersed government forms the core of work initially developed by Vincent Ostrom and later expanded by Elinor Ostrom, describing a nested structure where autonomous communities manage local resources with decision-making power devolved from, but connected to, layers of administration linked to a national authority (Ostrom et al., 1961) This nested structure, illustrated in Figure 3, reflects Polanyi's insight that effective coordination can emerge from autonomous centres sharing common standards rather than requiring centralised control.

Figure 3 Polycentric systems (Ostrom et al 1961)



Vincent Ostrom et al. (1961) argued that compared to traditional centralised power, polycentricity accesses the efficiency of local knowledge and understanding of local resources, often missed by remote decision makers. The Ostroms contended that while government has a legitimate supervisory role over common pool resources, this oversight is only effective when governance frameworks adapt to and

incorporate local variations that reflect the characteristics of the resources being managed. In other words, one-size-fits-all policies fail because they do not account for unique conditions, challenges, and community knowledge associated with different resource systems, in different locations.

A key insight from this work is that the physical distance between central bureaucrats and the resources they attempt to manage can blind them to local incentives for rule-following. Ostrom uses fishing rights in the EU as an example: centrally determined catch quotas may threaten the viability of fishing fleets which, to survive, break those rules and land fish illegally (Poos et al., 2010). Those who break the rules are rarely reported because the rules are perceived as being disconnected from local conditions (ibid). This undermines the existing incentives for local sustainability, as central government officials miss what Hayek calls "*circumstances of time and place*" where "*bureaucrats in central agencies typically lack a sufficient personal stake to manage assets*" (Pennington, 2012:32-33).

2.3.2 Design Principles for Managing Common Pool Resources

Elinor Ostrom's groundbreaking research on common pool resources (CPRs) emerged from systematic field studies conducted over three decades (1965-1995), challenging Hardin's '*tragedy of the commons*⁴' thesis through rigorous empirical investigation of long-enduring resource management institutions.

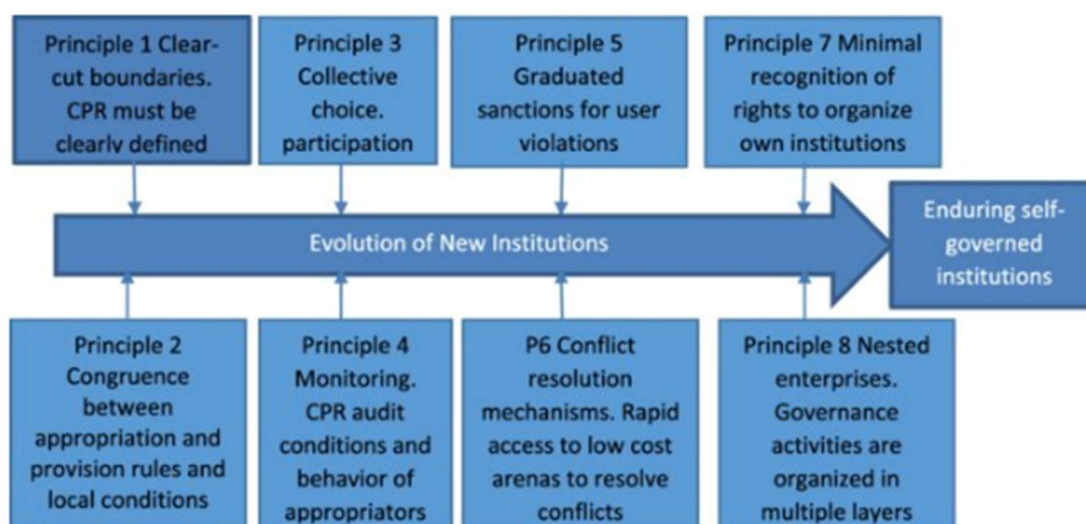
Ostrom's (1990) analysis drew on historic case studies of 14 CPR institutions that had successfully managed shared resources over periods between 100-1000 years

⁴ That the incentives to overuse and deplete a resource are greater than the collective need to maintain it

without experiencing resource depletion or institutional collapse. Her research methodology combined comparative ethnographic case studies of historic examples of CPR with the Institutional Analysis and Design Framework (IAD) developed with colleagues in the Bloomington School of political economy (Polski & Ostrom, 1999). The IAD is a systematic approach to examining how rules, norms, and strategies emerge and evolve within physical and social contexts (ibid). Ostrom used this framework to analyse over 5000 cases from her institutional database spanning six continents.

Ostrom's extensive research on common pool resources (CPRs) challenges the assumption that shared resources inevitably receive the least attention and as a result are quickly depleted without either privatisation or strong central government control (Aristotle, 1992; Hardin, 1968). Her empirical research identified eight design principles that are common in good management of CPR:

Figure 4 Ostrom's Design Principles



(Mairomi & Kimengsi 2021:3)

These principles represent

'...essential elements or conditions that help to account for the success of these institutions in sustaining the CPRs and gaining the compliance of generation after generation of appropriators to the rules in use' (Ostrom, 1990:90).

Successful management of CPR requires clearly defined boundaries for both the resource system and the individuals with rights to use it (Ostrom, 1990). This principle ensures that:

"appropriators [users] know who is in and who is out of a defined set of relationships and thus with whom to cooperate"
(Cox et al., 2010:15, parenthesis added).

Well-defined boundaries prevent free-riding and help communities to exclude outsiders who have not contributed to establishing and maintaining the resource (Ostrom, 2002). To be efficient the rules governing the use of a resource must align with local conditions, including environmental, cultural, and social contexts (Ostrom, 1990), acknowledging that one-size-fits-all approaches typically fail because they do not account for the unique characteristics of particular resources and communities. In addition Cox highlighted two distinct requirements: reinforcing that any rules meet the local conditions and that the benefits outweigh the costs of implementing any rules (Cox et al., 2010).

Ostrom specified that those affected by operational rules should also participate in modifying them (Ostrom, 1990). This principle ensures that:

"...individuals affected by a resource regime are included in the group that can modify these rules" (Ostrom, 2005:259).

Their participation in rule-making legitimises the rules and compliance while allowing local knowledge to inform the governance arrangements (Agrawal, 2003). Effective management of CPR requires those overseeing its use to actively monitor it and the behaviour of those using the resource (Ostrom, 1990). These *monitors* are often using the resource themselves (as *appropriators*) or individuals accountable to them (Ostrom, 2005). Dietz argues that this self-monitoring creates a system where:

"rule infractions are likely to be detected, which increases confidence among appropriators that they can cooperate without fear that others are taking advantage of them" (Dietz et al., 2003:1908).

Rule breakers subsequently face graduated sanctions proportional to the seriousness and context of the offence (Ostrom, 1990). However, rules may be broken for various legitimate reasons, including an emergency, a misunderstanding, or hardship (Ostrom, 2005). Having graduated and, on face-value, fair sanctions helps to maintain the integrity of the community of users while ensuring rule compliance (Anderies et al., 2004). To be effective, access to low-cost, local arenas for conflict resolution is essential for sustainable CPR governance (Ostrom, 1990). These mechanisms allow users to:

"...resolve conflicts quickly and in ways that are perceived as fair by members of the community" (Dietz et al., 2003:1909).

Without these mechanisms, conflicts can erode trust and cooperation over time (Stern, 2011).

In this model centralised authorities must recognise the autonomy of the users/appropriators and their right to self-organise (Ostrom, 1990). When external authorities undermine or fail to respect local rules, sustainability becomes difficult to

maintain (Agrawal & Ostrom, 2001). This principle emphasises that effective governance requires external authorities (such as governments) to respect local decision-making power. When local communities have officially recognised authority to create their own rules for resource management, they can develop systems tailored to their specific contexts while still operating within broader governance frameworks (Ostrom, 2010).

For CPRs that are parts of larger systems, governance activities are organised in multiple nested layers (see figure 3) (Ostrom, 1990). This principle acknowledges that different problems are best addressed at different scales, with:

"...appropriation, provision, monitoring, enforcement, conflict resolution, and governance activities... organized in multiple layers of nested enterprises" (Ostrom, 1990:90).

Nesting allows local knowledge to inform larger-scale governance while maintaining consistency across the system (Ostrom, 2009).

Cox et al. (2010) conducted the most comprehensive systematic evaluation of Ostrom's design principles to date, synthesising evidence from 91 independent studies spanning 40 years of research (1970-2010) across diverse geographical, cultural, and resource contexts to assess the principles' generalisability and explanatory power. Cox et al.'s most significant contribution was demonstrating that Ostrom's principles function as diagnostic tools rather than prescriptive solutions.

They concluded:

"The principles are better understood as broad guidelines that require significant adaptation to local contexts rather than universal rules for institutional design" (Cox et al., 2010:32).

That is, the principles work best as "*a framework for analysis*" (Ostrom, 2007:15) rather than a blueprint . As Wilson describes it:

"specific rules would vary dramatically across resource types, types of sociocultural and ecological contexts, and time" (Wilson et al., 2013:22).

However, Cox et al.'s meta-analysis suggests some methodological weaknesses in the evidence base supporting Ostrom's principles. Of the 91 studies examined, 67% relied on retrospective case studies without control groups, 45% had sample sizes below 50 participants, and only 12% employed longitudinal designs spanning more than two years. This methodological fragility raises questions about whether the principles represent genuine causal factors or are simply a correlation with successful outcomes. In addition, 78% of studies originated from Western contexts, with perspectives from other populations and the global south notably absent, suggesting a potential cultural bias in both the theoretical framework and supporting evidence.

Despite their empirical foundation much of the supporting evidence for Ostrom's design principles derive from relatively small-scale, homogeneous communities (Araral, 2014), raising questions about its applicability to large-scale or more heterogeneous settings. Conceptually, the principles may also paradoxically privilege institutional arrangements that reinforce existing power structures around common pool resources (Johnson, 2004). Additionally, empirical research on *bricolage* by Cleaver (2002) - the creation of a new resource from the locally available components - in the context of managing access to water and grazing in Africa suggests that the principle's emphasis on formal rule-making may overlook the importance of informal institutions and cultural practices. These limitations highlight

the need for caution when applying the design principles across diverse contexts, particularly in complex service environments like health systems.

Nevertheless, while initially developed for traditional CPRs such as fisheries, forests, and irrigation systems, the principles have been applied successfully to diverse contexts, including knowledge commons (Hess et al., 2008), healthcare systems (McGinnis, 2013), urban commons (Foster & Iaione, 2016), and digital commons (Bollier & Helfrich, 2019). This reflects the principles' utility in other contexts where resources are shared. The principles highlight why including service users in decision-making processes is important in developing contextually appropriate rules, to establish monitoring mechanisms that respect dignity, and create accessible conflict resolution procedures.

Ostrom's design principles represent an important contribution to understanding successful CPR governance in coproduction. They demonstrate that communities can develop sophisticated institutional arrangements for sustainable resource management without relying exclusively on market mechanisms or centralised control. The principles' relevance across diverse contexts suggests their value as *"the best guides to effective CPR governance that institutional analysis has to offer"* (Wilson et al., 2013:22). As societies face increasingly complex governance challenges, these principles provide a valuable framework for designing collaborative approaches to shared resource management and coproduction.

Ostrom's principles highlight the institutional conditions under which coproduction can thrive. Clearly defined boundaries, appropriate rules, collective decision-making, monitoring, conflict resolution processes, and nested governance structures create a foundation for meaningful participation that extends beyond natural resource

management. Importantly, these principles suggest that coproduction may depend not just on individual motivation but on institutions' willingness to foster trust and reciprocity among participants.

2.4 Defining Coproduction: A Contested Concept

2.4.1 The Problem of Definition

A universal definition of coproduction remains elusive across the literature (Jo & Nabatchi, 2016). The key components vary depending on the strategic objectives, operational adaptation, power distribution, and how the knowledge and expertise of contributors are valued. As a result, coproduction is applied in diverse ways (Brandsen & Honingh, 2016). Existing definitions are often:

"...functionally narrow, whereas coproduction is operationally broad which makes [them]...inaccurate and therefore less useful for operational purposes"
(Jo and Nabatchi, 2016:1104).

Additional granular phases of coproduction have also been explored in the literature: co-planning, co-design, co-delivery, co-creation, co-monitoring, and co-evaluation (Durose et al., 2017; Jo & Nabatchi, 2016; Roper, 2018). While these terms describe different activities associated with coproduction, they also suggest a managerialist bounded rationality - a rational choice limited by existing knowledge or experience within a system of governance (Jones, 1999). This granularity within managerial bounds *manages* coproduction and as a consequence reduces the influence of end beneficiaries to specific parts of a process, rather than embracing Ostrom's description of distributed power (Ostrom, 1996b). There is therefore a risk that the granular phases and bounded rationality combined serve to contain coproduction

and limit the influence of the end beneficiary on their contribution to or use of services.

This definitional ambiguity is not merely academic but serves specific political functions. As Bevir et al. (2019) argue, contested definitions allow powerful institutions to claim coproductive legitimacy whilst maintaining operational control. In addition, the granular phases described by Jo and Nabatchi (2016) may represent what Ferguson (2007) terms '*technologies of government*'—mechanisms that appear to distribute power whilst actually extending institutional reach into previously autonomous community spaces. When local authorities define coproduction as 'co-delivery' rather than 'co-governance,' they effectively constrain citizen influence to implementation rather than agenda-setting, preserving strategic control whilst distributing operational responsibility.

The reluctance of civil authorities to release power described by Fledderus J. (2016) also limits both partnership with citizens and any external risk an organisation might face. Rather than an organic process '*developing naturally*' (Collins, 2003:1150), civic authorities strategically retain power (McMullin, 2021) through norms, structures, and rules that structure decision-making, constraining the types of engagement that are possible (Trætteberg & Enjolras, 2024).

There is also a growing body of literature which identifies *covert coproduction* which occurs when:

"*citizens contribute resources to public services without explicit awareness of their role as coproducers*" (Williams et al., 2020:783) .

Unlike its transparent counterpart, covert coproduction uses what Zuboff (2019) terms *instrumentarian power*. That is, modifying behaviour subconsciously. This is

what Tummers et al. (2022) describe as *nudge governance*, where psychology and concepts of human behaviour are used to manage citizen contributions without their overt consent. Such approaches:

"...may achieve policy goals efficiently but raise significant concerns about procedural justice and democratic legitimacy" (Tummers et al., 2022. 335).

Covert coproduction occurs commonly on digital platforms that typically extract data - and value - from user-generated content and online behaviour. As Srnicek (2017) argues, '*users are both creators of content and the product being sold*' (Srnicek 2017:49), yet this value extraction remains largely invisible to participants. In public health initiatives, Eriksson (2019) documents how '*responsibility is subtly transferred to citizens through seemingly voluntary wellness programs*' (Eriksson 2019:211) that normalise self-monitoring practices while obscuring the broader structural determinants of health that remain unchanged. Similarly, in environmental governance, citizens are enrolled in *responsibilisation regimes* that make individuals responsible for collective challenges while leaving power structures intact (Soneryd & Ugglä, 2021).

There are then palpable ethical tensions inherent in covert coproduction. While advocates argue that,

"Bypassing resistance can achieve positive outcomes where direct approaches fail" (Revell et al, 2018:123),

critics reasonably argue that such approaches undermine democratic values and autonomy . As Alford (2016) argues,

"When coproduction is engineered without participants' knowledge, it violates basic principles of informed consent and treats citizens as means rather than ends" (Alford 2016: 92).

This critique is similar to what Osborne et al. (2021) identify as the *democratic deficit* in technocratic approaches to coproduced service design.

Political scientists like Mounk (2018) have connected these practices to broader concerns about *undemocratic liberalism*, while Brandsen and Honingh (2023) describe institutional logics normalising manipulation. For example Thomsen's analysis of digital government platforms found that:

'66% of studied initiatives contained elements of covert coproduction, with users unaware of how their data and interactions were being repurposed'
(Thomsen 2022:427).

Addressing these concerns requires what Ansell (2019) terms *collaborative transparency* - designing participatory processes where power dynamics and expectations are explicitly communicated. As Bovaird and Loeffler (2021) argue,

"Effective coproduction must be founded on mutual awareness and consent, not strategic manipulation" (Bovaird and Loeffler 2021:178).

The challenge remains balancing efficiency with ethics in increasingly complex service environments. As service systems continue to evolve, the boundary between facilitation and manipulation requires ongoing critical examination.

There is, then, an inherent difference in worldview and purpose between the bounded rationality of institutions, the expectations that lead to covert coproduction and both the lived experience, expectations and potential contributions of end

beneficiaries (Ewert, 2016). For instance, coproduction initiated by an institution, such as a national government, often has a predetermined outcome as its target. For example, analysis of the Scottish Government's adoption of coproduction to involve people in health and social services design suggest an overt intention to revitalize civic society alongside a less prominent intention to reduce costs (The Health and Social Care Alliance, 2025). This process risks professionalising and *commodifying* lived experience (Cowden & Singh, 2007) or adjusting that experience to fit existing structures rather than driving change (Morrow & Kettle, 2021; Slasberg et al., 2012, 2014; Slasberg et al., 2013).

In contrast, Elinor Ostrom's description of coproduction is of a complex relational process influencing a dynamic system rather than the goal-driven application of theoretical concepts to real-life situations. In Ostrom's approach, theoretical assumptions are adapted, amended, and updated based on the different drivers in each situation, or '*theory in use*' (Ostrom, 2012, adapting Argyris, 1982). That is, a mental model that coproduction users employ to rationalise and adapt to observed actions and reactions. In this respect, Ostrom's model of practical coproduction appears to meet Carroll's description of emergence (Carroll, 2017): there are multiple interacting parts, and the relationship between them creates coproduction as the sum of those parts. This is evident in the conceptual ambiguity in the literature. As Brandsen and Honingh note:

"...the research community studying coproduction has become more multidisciplinary over time, which has made the original formulations less suitable and, on some points, less clear" (Brandsen and Honingh, 2016:428).

This lack of consistent language and interpretation risks coproduction becoming a meaningless buzzword. However, in common with Carroll's description of emergence (Carroll, 2017), a simple definition will fail to describe the granularity of its application in reality:

"It is somewhat misleading to speak of coproduction as a single phenomenon; there are, in fact, many different types of coproduction." (Brandsen and Honingh, 2016:427).

This definitional challenge is further complicated in secure settings, with inherent limitations on citizenship rights such as choice and freedom of movement influencing views on whether coproduction can exist in those environments. This was explored by Pilgrim (2018), as detailed in 2.6.1 below. These tensions reflect more than semantic disagreements; they represent fundamental philosophical divides about the purpose and nature of coproduction itself. The contradiction between Ostrom's emergent, relationally-focused approach and the more managerialist, outcome-oriented definitions, such as that adopted by NHS England (NHS England Always Events, 2024), also explored in 2.6.1, suggests that there are competing values and power dynamics driving concepts of coproduction. As Durose et al. (2017) note, definitional choices have significant implications for who controls coproductive processes, how success is measured, and which voices are privileged. Brandsen and Pestoff (2006) similarly argue that the definitional ambiguity serves powerful institutions by allowing them to make a claim of being coproductive without fundamentally changing power structures. This underscores the inherently political nature of definitional debates about coproduction, which remain unresolved in both theory and practice.

2.4.2 Early Definitions: Understanding Consumer/Producer Contributions

Early definitions of coproduction highlighted the importance of voluntary contributions from citizens (Ostrom et al., 1973; Parks et al., 1981), such that it was described as:

"[A] mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals, or 'regular producers,' while 'citizen production' is based on voluntary efforts by individuals and groups to enhance the quality and/or quantity of the services they use" (Pestoff, 2006:506).

However, contributions are not always voluntary. Health and social care services rely on the active participation of care recipients - voluntary or involuntary - and their families. This is customary behaviour; it is expected and accepted. Without it, some services cannot be delivered effectively (see Ostrom et al., 1973 and the coproduction of law and order, for example). To receive the service, the recipient must contribute their time, engage with providers, and follow their recommendations. Without that contribution, the service is partial, and outcomes are general rather than personal. As Brandsen and Honingh describe it, using existing data from housing cooperatives in Germany to distinguish some of the diverse types of collaboration labelled as coproduction:

"If services have inherent coproduction, then free will does not enter into it: to make use of the service is to coproduce" (Brandsen and Honingh, 2016:429).

This theoretical underdevelopment is further complicated by the distinction between voluntary coproduction - where social capital facilitates collaborative choice - and inherent coproduction - where participation is a prerequisite for service delivery

regardless of social capital, suggesting that any comprehensive theory must account for how social capital operates differently across these distinct modes of collaborative engagement.

Brandsen and Honingh created a framework to illustrate the distinctions between coproductive and non-coproductive interactions which are collated and presented in the table below.

Table 5 Brandsen and Helderman's Framework

Coproduction	Not coproduction
collaboration between clients and a provider	collaboration between institutions-such as a provider and a commissioner
Collaboration in design or maintenance of a service	Passive receipt of the service
Working with others with similar challenges to design a service	Representing others on a consultative council

(After Brandsen and Helderman 2012).

It is notable that in contrast to Bovaird and Loeffler (2012), who describe coproduction as only occurring between professionals and service recipients, Brandsen recognises cooperation and collaboration within a group as coproduction, whilst passive receipt of a service is not. It is also not clear in this formulation why collaboration between institutions cannot also be coproduction since partnership working also relies on **trust**, **reciprocity**, and **autonomy** - hereafter referred to as *Ostrom's triptych* - for coproduction to exist (Dhillon, 2005; Ostrom et al., 2012). Ostrom's work highlighted that these three factors are constants in coproduction and the maintenance of common pool, resources (Ostrom et al., 2012; Pennington, 2012):

*‘Over time, the users have developed high levels of **trust** and **reciprocity** and have the **autonomy** to determine at least some of their own rules.’* (Ostrom et al 2012: 80 emphases added).

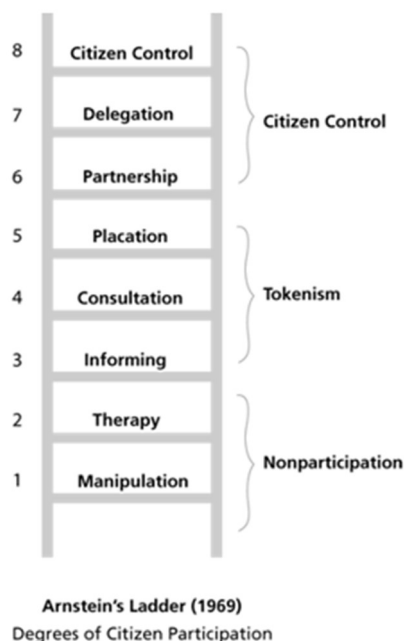
Ostrom's work showed that there is a relationship between these three elements in the management of CPR and coproduction. Autonomy supports communities to establish their own mechanisms for building trust and community norms around reciprocity. Meanwhile, trust and reciprocity reduce the costs of monitoring and enforcement, making autonomous governance systems more viable.

Evidence from this review also confirms that relationships are central to effective coproduction (Bandola-Gill et al., 2023; Gittel & Douglass, 2012; Palmer et al., 2019; Stokburger-Sauer et al., 2016). How those relationships are managed is where differences in approach across the literature are apparent, delineated by bounded rationality (what a system or individual believes can be achieved) and organisational or sectoral norms. Whilst relationships remain central, the outcomes expected - and who sets them - appears to determine the degrees of reciprocity and trust that are exchanged. As a result, the *‘common sets of key factors that span all coproduction activities’* (Jo and Nabatchi, 2016:1103) remains elusive. However, legal frameworks for coproducing policies to reduce public sector costs - established in England (Department of Health, 2014) and encouraged by policy in Scotland (SCDC, 2021) - take bounded rationality, rather than relationships, as their starting point for coproduction.

2.4.3 Coproduction Versus Participation

It is important to clarify distinctions between participation and coproduction, as they are often confused or used interchangeably (Nabatchi et al., 2017). This definitional ambiguity means that coproduction has been applied to any engagement with the public and/or consumers, including participation (Steen et al., 2018). This ambiguity risks applying a new term to non-participation and tokenism: old institutional behaviours described by the bottom rungs of Arnstein's ladder of participation. Arnstein's foundational framework categorises citizen engagement across eight levels, from manipulation and therapy at the bottom through to partnership, delegated power, and citizen control at the top, as illustrated below (Arnstein, 1969).

Figure 5 Arnstein's Ladder of Participation



Contemporary participation theory has evolved considerably beyond Arnstein's hierarchical model, developing more nuanced frameworks for understanding citizen

engagement. Fung's (2006) *Democracy Cube*, for example, reconceptualises participation across three dimensions - who participates, how they communicate and make decisions, and what authority they exercise - moving beyond simple power distribution to examine the quality and design of participatory processes. The emergence of deliberative democracy innovations such as citizens' assemblies, participatory budgeting, and digital engagement platforms has demonstrated that meaningful participation can occur across various institutional arrangements, not just through citizen control (Elstub & Escobar, 2019; Smith, 2009). These developments highlight that effective participation depends as much on process design, inclusion mechanisms, and institutional support as on formal power distribution. In health and social care contexts, *co-design* methodologies have emerged as distinct approaches that emphasise collaborative problem-solving and shared expertise rather than power transfer alone (Bate & Robert, 2023). This expanded understanding of participation provides important context for distinguishing coproduction from other forms of engagement: while participation may focus on voice and influence within existing systems, coproduction implies fundamental changes to how services are conceived, delivered, and evaluated through ongoing collaborative relationships.

Despite these theoretical developments, the practical challenge of distinguishing participation from coproduction remains. Practitioners have attempted to make clearer distinctions based on outcomes and influence. For example, the mental health charity MIND distinguishes participation from coproduction by focusing on the influence that engagement has on outcomes for people (MIND UK, 2022). That is, whether coproductive processes have any greater influence on what is produced than other forms of engagement. Similarly, the Social Care Institute for Excellence (SCIE) distinguish the two by describing participation as being 'consulted' (which

Arnstein categorises as tokenism rather than genuine participation) and coproduction as occurring between 'equal partners and co-creators' (SCIE, 2022)(SCIE, 2022:no page).

This emphasis on equality and shared creation points toward a fundamental difference between power-focused and relationship-focused approaches to citizen engagement. While Arnstein's ladder emphasises the redistribution of formal power as the key indicator of meaningful participation, alternative frameworks suggest that the quality of relationships and ongoing collaboration may be equally important. This distinction becomes particularly relevant when considering Ostrom's analysis of coproduction, where the interaction between trust, autonomy and reciprocity - Ostrom's triptych - emerges as central to successful collaborative arrangements (Ostrom et al., 2012). For Ostrom, the key output is not the product alone in community-based coproduction, but also the relationships that are created which make future coproduction more likely (Ostrom, 1996a, 1996b). This relational understanding suggests that meaningful coproduction can occur even when formal power remains unequally distributed, provided that genuine trust, reciprocity, and opportunities for autonomy exist within the collaborative process.

This tension between power-focused and relationship-focused approaches to understanding coproduction has practical implications for how organisations implement participatory practices. The evidence suggests that organisational adoption of coproduction may be reinforced by a growing academic literature promoting the reconceptualization of citizens as active contributors rather than passive recipients, with publications coming primarily from a health perspective (Eaton, 2019; Fairlie, 2015; Holland-Hart et al., 2019) and broader economic and sociological analysis (Boyle & Harris, 2009). However, despite this rhetoric of active

citizenship, the convergence of organisational and academic discourse typically positions coproduction at the level of consultation with influence - corresponding to the fourth rung of Arnstein's Citizen Power ladder - rather than achieving the delegated power or citizen control that defines higher levels of participation. This positioning serves both academic and organisational interests by promoting change without fundamentally challenging existing power structures.

The risk of organisational co-option becomes particularly evident when examining how New Public Management (NPM) frameworks have influenced contemporary approaches to citizen engagement. Broadly defined, NPM applies private sector management practices to public sector services, repositioning the citizen as a citizen producer rather than a passive recipient of welfare (Kleinhans, 2017). This repositioning represents

'a way of reorganizing public sector bodies to bring their management, reporting, and accounting approaches closer to (a particular perception of) business methods' (Dunleavy and Hood, 1994:9),

effectively transferring responsibilities once held by institutions to communities and individuals. While ostensibly intended to *'minimize governments' responsibilities and accountability'* (Steen et al., 2018:285), this reframing risks what Osborne and colleagues term co-destruction - where citizens withdraw from collaborative arrangements and thereby diminish rather than enhance public outcomes (Osborne et al., 2021; Steen et al., 2018; Voorberg et al., 2015).

The challenge of maintaining authentic coproduction against pressures for organisational co-option become magnified in coercive institutional settings, where the fundamental preconditions for both Arnstein's power-sharing and Ostrom's

relational coproduction operate under severe constraints. Secure forensic mental health facilities represent an extreme case for testing coproduction theory, as they combine therapeutic mandates with public protection requirements, creating inherent tensions between care and control. In such settings, traditional frameworks of citizen power become problematic when applied to individuals whose liberty is legally restricted, while relationship-based approaches face the challenge of establishing trust, reciprocity, and autonomy within fundamentally coercive environments.

A fundamental question for coproduction in secure settings is therefore whether meaningful collaboration can exist within inherently coercive environments, and if so, what forms this collaboration might take. This study recognises that forensic mental health operates through what Foucault and Rabinow (1982) termed '*disciplinary power*' - patients' bodies, movements, and choices are regulated through surveillance, normalisation, and examination. However, drawing on Scott's (1990) work on '*hidden transcripts*' and everyday resistance, and Moore's (2009) description of strategic accommodation, this research aims to illuminate how patients navigate coercive structures whilst maintaining forms of agency. Understanding coproduction in these constrained environments requires moving beyond binary models of compliance versus resistance toward more nuanced frameworks that can account for the complex ways individuals exercise agency within institutional constraints.

Based on this theoretical foundation, three potential modes of patient engagement emerge that exist along a continuum from compliance to authentic collaboration, each representing different ways that patients might respond to institutional power whilst maintaining varying degrees of agency: **strategic accommodation**- simulated compliance to access privileges whilst maintaining internal resistance (Moore, 2009); **instrumental cooperation** - genuine engagement in activities that serve patient

goals whilst accepting institutional frameworks; **authentic coproduction** - joint investment in creating conditions that benefit all participants, transcending compliance models. These modes challenge binary assumptions about compliance versus resistance in coercive settings, suggesting that meaningful collaboration may be possible even within environments where traditional forms of citizen power are constrained.

In summary, the distinction between participation and coproduction reflects a fundamental tension between power-focused frameworks like Arnstein's ladder and relationship-centred approaches described by Ostrom's triptych. While participation may remain at the level of consultation or tokenism without genuine power-sharing, coproduction represents a more equal partnership where outcomes reflect shared influence between institutions and service users. However, this distinction becomes complicated in practice, as organisations may strategically promote coproduction rhetoric while maintaining existing power structures, and institutional pressures toward co-option and co-destruction may undermine authentic coproduction. In coercive environments such as secure forensic mental health settings, these definitional distinctions become even more critical, as traditional frameworks of power and partnership need to be understood within the constraints and possibilities within institutional care. The three modes of engagement identified suggest that even within such constrained environments, meaningful collaboration remains possible, albeit in forms that may not conform to traditional definitions of coproduction or participation.

2.4.4 Public Service Logic and Definitions of Coproduction

Osborne (2018) offers a management theory perspective that potentially reconciles the challenges of sharing power and creating relationships in complex systems. His concepts of public service delivery logic (PSDL) and public service logic (PSL) reframe coproduction by shifting the focus from institutional power structures (Arnstein's concern) to value creation processes.

PSDL conceptualises value as embedded in service products delivered by organisations to passive recipients, whereas PSL recognises that value emerges through interactive processes between providers and citizens who actively integrate service resources into their own lives. Unlike descriptions of coproduction as simply a challenge to institutional power (Chen et al., 2025) or a mechanism for building social capital (Brandsen and Helderman, 2012), Osborne (2018) describes the creation of public value as the central reason for engagement. His formulation also usefully distinguishes coproduction from collaboration. While both involve the engagement of a range of actors, they differ fundamentally in structure and intent. Collaboration typically maintains professional-professional boundaries between organisations with complementary expertise, operating within defined timeframes and institutional arrangements (Thomson & Perry, 2006). Coproduction, in contrast, explicitly challenges power hierarchies by positioning citizens as active value creators rather than service recipients, blurring provider-user boundaries as relationships develop (Bovaird, 2007; Ostrom, 1996b). While collaboration primarily serves organisational efficiency, coproduction in its ideal form uses citizen knowledge to redesign services to better meet their needs whilst generating social capital that builds trust in the institution (Voorberg et al., 2015). Whilst these

definitional distinctions provide analytical clarity, real-life service arrangements rarely conform to either ideal type, typically exhibiting hybrid characteristics that draw on both collaborative and coproductive approaches.

Osborne's PSDL framework helps explain why institutional coproduction often remains at the lower rungs of Arnstein's ladder, describing a traditional model where an organisation incorporates contingent contributions from end beneficiaries to deliver a service. In these circumstances, coproduction is:

'...a process where the Public Service Organisation (PSO) is dominant and where the logic is linear and based upon product-dominant conceptions of production' (Osborne 2018: 225).

This description acknowledges the power asymmetry identified by Arnstein whilst providing a theoretical explanation for why coproduction's transformative promise often results in limited actual change: the organisational logic remains fundamentally unaltered, with citizen input incorporated into existing processes rather than transforming them. That is, powerful public organisations produce services similar to a manufacturing process that includes involuntary free labour from the end beneficiary. User engagement therefore involves following a professional's directions or providing feedback for the process to function effectively: the unpaid but crucial contributions that Ostrom and others identified as critical to service effectiveness (Ostrom, 1972; Ostrom & Ostrom, 2019; Parks et al., 1981).

This interactive relationship finds theoretical expression in Osborne's public service logic (PSL), which describes a partnership between service and end beneficiary where *'interactive value co-creation'* occurs (Osborne 2018:228). Co-creation, as a distinct element of coproduction:

'...assumes an interactive and dynamic relationship where value is created at the nexus of interaction' (Osborne 2018: 225).

The product is created in engagement with the end beneficiary and customised to use their assets effectively to meet their needs. Customers:

'...incorporate value propositions from service firms (that are configurations of resources) with other resources, such as their life experiences' (Osborne 2018:227).

In this model, PSDL underpins manipulative and instrumental mechanisms that primarily benefit agencies rather than end beneficiaries, whilst PSL describes differing levels of power and information exchange that are mutually beneficial.

Using Osborne's PSL framework requires understanding its theoretical foundations, particularly the distinctions between Product-Dominant Logic (PDL), Service Logic (SL), and Service-Dominant Logic (SDL). Product-Dominant Logic represents the traditional manufacturing perspective where value is embedded in units of output: tangible goods produced in closed processes and exchanged in discrete transactions (Vargo & Lusch, 2004, 2008). Services are a distinct product category characterised by intangibility, inseparability of production and consumption, heterogeneity, and transience. This inside-out approach assumes organisations can create and deliver value to passive recipients through standard service products (Trischler & Trischler, 2022, 2023).

Service Logic, developed by Grönroos (2006, 2008), challenges this paradigm by positioning services not as outputs but as processes of interaction. Service involves company resources interacting with customers so that value is created or emerges in customers' own processes (Grönroos, 2008). Importantly, SL maintains that value is

the customer's creation of value-in-use (Grönroos, 2008; Grönroos & Gummerus, 2014; Grönroos & Ravald, 2011; Grönroos, 2017). Value creation occurs within three distinct spheres: the provider sphere (where organisations develop service offerings and create potential value only), the joint sphere (where provider and customer interact directly, creating a platform for co-creation), and the customer sphere (where customers independently create value-in-use by integrating resources into their own value-creating processes) (Grönroos & Voima, 2013; Grönroos, 2017). Value co-creation occurs only in the joint sphere through direct interactions (Grönroos, 2011, 2012; Grönroos & Ravald, 2011; Grönroos & Voima, 2013), whilst the customer remains the sole value creator in their own sphere. This dyadic focus on the provider-user relationship characterises SL.

Service-Dominant Logic, introduced by Vargo and Lusch (2004, 2008), takes a different ontological position. SDL defines service (singular, not services) as the application of specialised competences (knowledge and skills) through deeds, processes, and performances for another entity's benefit or for the entity itself (Vargo & Lusch, 2004), positioning this as the fundamental basis of all economic exchange. SDL diverges from SL in asserting that value is always co-created by multiple actors through resource integration, with the beneficiary uniquely determining value phenomenologically (Vargo & Lusch, 2008, 2016). SDL adopts an ecosystemic perspective, recognising that value is created through the integration of resources provided by many sources (Vargo & Lusch, 2016). The service ecosystem, a relatively self-contained, self-adjusting system of resource-integrating actors connected by shared institutional arrangements and mutual value creation through service exchange (Vargo & Lusch, 2016), serves as SDL's primary focus for examining value co-creation at individual, organisational, and societal levels.

Osborne (2018) initially positioned PSL as drawing specifically on Grönroos's Service Logic rather than SDL, emphasising the dyadic relationship between the public service organisation and service user, with value creation firmly located in the user's sphere. However, as Trischler et al. (2023) and Kinder and Stenvall (2023) observe, PSL has shifted between and combined concepts from SL and SDL in a piecemeal fashion, with little consideration of their theoretical origins, compatibility, and subsequent implications. Whilst claiming SL as its foundation, PSL has increasingly adopted SDL concepts, such as the service ecosystem (Dudau et al., 2023), without adequately addressing tensions between these frameworks. PSL's treatment of coproduction has also oscillated: initially defined as unavoidable during service delivery (Osborne & Strokosch, 2013), it was later described as an optional process (Osborne, 2020; Osborne et al., 2021), mirroring SDL but contradicting PSL's earlier SL-informed description. This instability in PSL's core concepts requires acknowledgment, but it does not preclude the framework's utility for understanding the development of coproduction in secure conditions.

Trischler et al. (2023) and Kinder and Stenvall (2023) further argue that PSL's user-centred positioning, inherited from SL, is not compatible with how value is co-created in and beyond interactions with public service organisations. The ecosystemic nature of value creation in public services, involving multiple actors, institutional arrangements, and complex power dynamics across system levels, they argue, cannot be adequately captured through SL's dyadic lens. This limitation is particularly evident considering Trischler and Trischler's (2022) argument that user experiences cannot be designed or delivered by organisations; rather, organisations can only offer value propositions that users may integrate into their value creation processes within their subjective lifeworlds. Experiences are subjective, context-

specific, and phenomenologically determined by users as outcomes of their value creation activities, an insight that challenges frameworks positioning the provider-user interaction as the primary site of value creation.

Despite these theoretical tensions, PSL operates effectively as what Merton (1968) terms a 'middle-range theory': offering conceptual distinctions sufficiently developed to guide empirical investigation, particularly in the dyadic relationships at the centre of this study, despite wider theoretical disputes. This positions PSL not as a comprehensive explanatory theory but as a lens through which to understand mechanisms that lead to coproduction in constrained circumstances between staff and patients. Trischler et al. (2023) themselves acknowledge that PSL might be best understood as a mid-range theoretical framework rather than a grand theory. Mid-range theories, in Merton's (1968) formulation, occupy the space between minor working hypotheses and all-inclusive systematic efforts to develop unified theory: close enough to empirical data to be operationally testable whilst sufficiently abstract to transcend mere description.

The PSDL/PSL distinction therefore provides a useful diagnostic lens: it enables researchers to ask whether particular practices treat service users as passive contributors to organisationally defined processes or as active agents whose own value-creating activities the service seeks to support. The alternative frameworks present different trade-offs. Applying Grönroos's Service Logic directly would retain theoretical coherence but lose the public sector specificity that Osborne's adaptation provides, particularly the attention to how public organisations' accountability structures, democratic mandates, and coercive capacities shape the provider-user relationship in ways that differ from commercial service contexts. Trischler's ecosystemic approach, whilst theoretically sophisticated, would require analytical

attention to system-level dynamics and multi-actor configurations that exceed what studies focused on staff understandings and practices within specific organisational settings can address.

However, the utility of Osborne's framework for this study does not imply dismissing Trischler's or Kinder and Stenvall's insights. Rather, these critiques highlight what Osborne's framework cannot capture, helping to identify its boundaries and limitations. Just as a microscope and telescope serve different observational purposes, Osborne's focus on the provider-user dyad and Trischler's ecosystem perspective offer different analytical lenses. Osborne's further distinction between coproduction as a service delivery activity and co-creation as deeper value generation is a key insight, even if, as critics suggest, it may oversimplify the ecosystemic reality of value creation. These distinctions help differentiate degrees and types of collaborative practice: from token consultation through genuine partnership to transformative power-sharing.

For PSDL, value resides primarily in the service product delivered by the organisation, with limited recognition of how citizens integrate these resources into their own value-creating processes (Grönroos, 2008; Grönroos & Ravald, 2011; Anker et al., 2015). This inside-out approach often results in what appears to be collaborative practice but remains fundamentally instrumental: engagement serves organisational goals rather than genuinely facilitating citizen-led value creation. In contrast, PSL recognises that whilst interaction occurs in the joint sphere between provider and citizen, ultimate value creation happens in the customer sphere: in citizens' own lives as they integrate service resources with their personal experiences, knowledge, and assets (Grönroos, 2008, 2011, 2017; Grönroos &

Gummerus, 2014; Grönroos & Voima, 2013; Osborne, 2018; Osborne & Strokosch, 2021).

This distinction may explain why much institutional coproduction remains at the lower rungs of Arnstein's ladder: organisations may engage citizens whilst maintaining a PSDL logic where value resides in the service product rather than in citizens' own value-creating processes (Grönroos, 2006, 2008; Anker et al., 2015). Osborne's PSDL/PSL framework, by clearly articulating what each approach entails, provides criteria against which to judge whether staff and service users are engaging in meaningful collaboration or organisations are merely appropriating coproduction language.

Trischler and Trischler (2022) also emphasise that changing how value is co-created must be accompanied by institutional work: the breaking, making, and maintaining of institutions (Vargo, Wieland, & Akaka, 2015; Koskela-Huotari et al., 2016). This is particularly useful in understanding coproduction in settings where deeply rooted institutional arrangements fundamentally shape what forms of collaborative practice are possible. Such settings often reflect fundamental tensions: between therapeutic and custodial functions, between supporting recovery and managing risk, between respecting autonomy and maintaining security.

Introducing genuine coproduction into constrained contexts requires institutional change that may challenge established professional identities, risk management protocols, and organisational cultures. Some existing institutional frameworks may need breaking, such as assumptions that service users lack capacity for meaningful participation in planning or governance. Other rules and frameworks may need making, such as new norms around shared decision-making and protocols that

balance risk with opportunity. Still other rules require maintaining, such as continuing safeguards around safety, governance, and ethical treatment that rightly constrain what forms coproduction can take.

The Recovery movement in UK mental health services provides a cautionary example of how PSDL can capture and dilute coproduction. Shaped by service user and survivor activism in the 1980s (Wallcraft et al., 2003) and inspired by user-led solutions (Deegan, 1988), this movement generated evidence for the establishment of Recovery Colleges and new service models utilising lived experience as a resource (Slade et al., 2014; Slade, 2014). However, the original hope mental health recovery presented was described as being undermined by traditional services appropriating the terminology without making required institutional changes (Recovery-In-The-Bin, 2021). This illustrates precisely the risk Trischler and Trischler (2022) identify: inside-out approaches focused on organisational processes rather than genuinely facilitating users' value creation in their own lifeworlds. It also demonstrates how organisations can maintain PSDL logic whilst adopting PSL rhetoric, incorporating recovery language into fundamentally unchanged service delivery models.

The theoretical considerations above establish Osborne's PSL/PSDL framework as a useful analytical tool whilst acknowledging its limitations. The three key limitations that Trischler and colleagues identify remain pertinent: that value creation extends beyond organisational boundaries (the ecosystemic micro-level reality), that multiple actors beyond immediate service providers influence users' experiences (the meso-level multi-actor configuration), and that institutional arrangements profoundly shape what forms of coproduction prove possible (the macro-level institutional context). The PSDL/PSL distinction provides useful tools for examining how services

conceptualise and operationalise collaborative practice, helping identify whether coproduction initiatives represent genuine attempts to shift from PSDL to PSL logics or merely incorporate user input into fundamentally unchanged institutional processes. The framework as a mid-range theory illuminates certain aspects of coproduction whilst inevitably leaving others in shadow: a limitation that future research applying more sophisticated ecosystem frameworks might productively address.

2.5 Key Components of Coproductive Relationships

2.5.1 Relational Foundations of Coproduction

Elinor Ostrom's research established that successfully coproduced social policy depends on three key elements: reciprocity, autonomy, and trust (Ostrom, 1972; Ostrom et al., 2012). This represents a shift of focus from how policy is designed to recognising that the quality of relationships is an important factor in the successful implementation of social policy. Osborne et al. (2016) illustrate this principle:

*"One could have two identical residential homes, and which employed the same staff – but the experience and impact of each home would be different – because **this would be co-created by the interactions with the residents of the home.**" (Osborne et al 2016: 642, emphasis added).*

Successful coproduction consistently demonstrates Ostrom's original insight: that relationships built on trust, reciprocity, and autonomy remain essential foundations for effective collaboration, regardless of the specific theoretical framework applied.

Reflecting the range of approaches to coproduction in the literature, Osborne et al. (2016) and Voorberg et al. (2015) describe co-creation in distinct ways that reflect their theoretical priorities. Voorberg and Bekkers define co-creation as

"the involvement of citizens in the initiation and/or design of public services to (co)create beneficial outcomes" (Voorberg and Bekkers 2015:1347),

later expanded to

"citizens and public organisation work[ing] together to deal with societal issues" (Voorberg et al., 2017:178).

This approach positions co-creation as a subset of broader coproduction activities, adding another dimension to an already complex theoretical landscape.

These perspectives describe meaningful conceptual distinctions. Voorberg and Bekkers focus on structural citizen empowerment, giving citizens greater authority in the design and initiation phases. Osborne focuses on the quality of ongoing interactions that create value throughout service delivery, operating within his dyadic provider-user framework discussed in section 2.4.4. Voorberg's approach describes deeper transformations in traditional governance hierarchies than Osborne's more process-oriented perspective.

Osborne et al. (2016) elaborate these distinctions using a taxonomy that categorises different forms of coproduction using two dimensions: voluntary/involuntary participation and individual/collective action. They identify four types of participation: co-production (involuntary individual interaction), co-design (voluntary individual interaction), co-construction (involuntary collective interaction), and co-innovation (voluntary collective interaction addressing future challenges). In this framework, best value emerges from relationships supporting co-construction (generating

connection and wellbeing) and co-innovation (demonstrating the worth of collaborative efforts). Importantly, Osborne acknowledges that value can be co-destroyed as well as co-created (Osborne et al., 2016; Manna & Rosalba, 2017), introducing a critical nuance.

Table 6 Locus of Coproduction

		Locus of Coproduction		Towards the co-creation (or co-destruction) of value
		Individual Service	Service System	
Nature of co-production	Involuntary	I. <u>Co-production</u>	III. Co-construction	
	Voluntary	II. Co-design	IV. Co-innovation	

(Osborne et al 2016: 645. See also Bekkers and Tummers 2018)

Osborne's framework helpfully acknowledges the power dynamics in coproduction, including potentially coercive elements (such as communities facing the choice between managing a resource or losing it). However, this detailed categorisation may overcomplicate what might be better understood as a graduated spectrum of engagement. These variations in engagement reflect the institutional arrangements discussed in section 2.4.4, where deeply embedded rules, norms, and practices shape what forms of coproduction prove possible within specific organisational contexts.

2.5.2 Regular and Consumer Producers

The power dynamics that Osborne identifies become clearer when examined through Parks' classification of participants in public service creation. Parks et al. (1981) conducted groundbreaking empirical research establishing the foundational typology of participants in public service delivery through systematic analysis of police services across 80 neighbourhoods in three major US cities (Chicago, Rochester, and St. Petersburg) between 1977-1980, creating the conceptual framework that underpins contemporary understanding of coproduction roles and relationships. The study employed a comprehensive research design combining structured interviews with 2,400 residents across diverse neighbourhoods; systematic observation of 1,200 police-citizen interactions over 18 months; analysis of crime statistics and police response data; focus groups with 48 community leaders and 36 police officers; and comparative analysis across neighbourhoods with varying socioeconomic characteristics and crime rates.

The relationship between what Parks et al. (1981) term regular producers and consumer producers forms the fundamental interaction where these power imbalances and engagement variations can be seen. Parks et al. (1981) identified and define the three key roles in this process:

- Regular producers: Organisations or individuals who create goods and services in exchange for payment or other compensation
- Consumers: Those who exchange money or other resources to receive goods and services
- Consumer producers: Individuals who create goods and services for their own consumption, potentially sharing surplus with others

Traditional public service models operate with a clear division between providers (regular producers) and clients (consumers). In these models, services are typically not purchased directly but are provided based on needs determined by the provider. This arrangement often assumes a one-way relationship where consumers are passive recipients with little to contribute. Coproduction, however, represents a fundamentally different relationship. It involves an interaction between regular producers/service providers and consumer producers (service users who contribute unpaid labour in the course of receiving services). For example, patients who follow treatment plans or community members who participate in neighbourhood safety initiatives are acting as consumer producers.

Despite its foundational influence, Parks et al.'s research contains methodological limitations that deserve closer examination. The study's focus on police services in three US cities during a specific historical period (1977-1980) raises questions about generalisability across different service domains, cultural contexts, and contemporary governance arrangements. The research predates major shifts in public administration, including New Public Management reforms, digital governance platforms, and austerity-driven service reconfigurations. In addition, the binary classification of '*regular*' versus '*consumer*' producers fails to account for the hybrid professional-lived experience roles that characterise contemporary mental health services, where peer workers occupy liminal positions that challenge these categorical distinctions.

With Parks' limitations noted, coproduction functions as a political economy approach to resource management. It acknowledges what Pennington (2013) calls "*the significance of human imperfections*" (Pennington 2013:450) in the management of common pool resources, which relies on the development of rules over time based

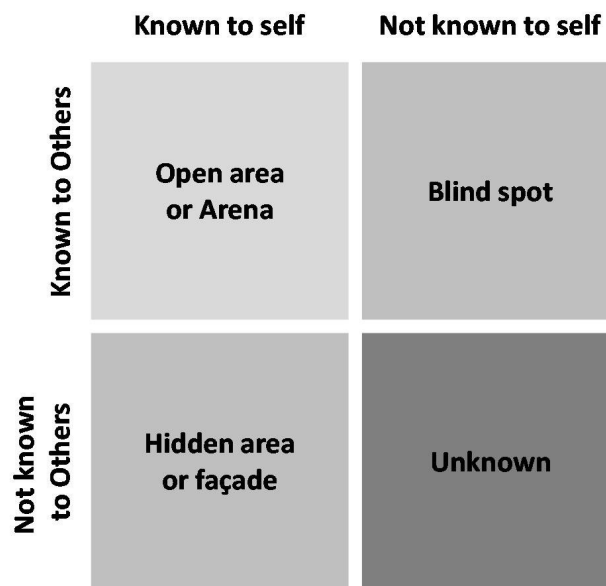
on interpersonal trust, reciprocity, and autonomy (Ostrom et al., 2012). External forces like central governments or supranational organisations lack local understanding of these "*rules in use*" (Argyris, 1982; Schön & Argyris, 1996): the difference between rules as they are defined in guidance or directions (rules in form) and how they are adapted and adjusted to address problems. This distinction between formal rules and rules-in-use connects directly to the institutional work discussed in section 2.4.4, where the breaking, making, and maintaining of institutions shapes what collaborative practices prove viable. External interventions can inadvertently damage the resources they legislate to protect by disrupting these locally developed institutional arrangements.

Despite the centrality of Ostrom's triptych to her approach to coproduction, the empirical evidence supporting these specific elements as necessary and sufficient conditions for effective coproduction varies considerably in quality and context. Verschuere et al. (2018) note that many studies asserting the importance of these components rely on retrospective case studies rather than controlled comparative research. Similarly, Alford's (2016) methodological review highlights that evidence for the relationship between trust and coproduction outcomes often suffers from inconsistencies in measurement influenced by a tendency to reverse causality: where the direction of cause or effect is misattributed such that the desired rather than the actual relationship is apparent. This suggests a need for more rigorous research designs that can establish causal relationships between these relational elements and coproduction effectiveness across diverse contexts.

In health and social care contexts, the bounded rationality of regular producers (Jones, 1999) creates limitations that consumer producers must navigate. Consumer producers then accommodate this limitation to access the benefits of the interaction.

Concepts like the Johari window (Luft & Ingham, 1961) illustrate how building trust and reciprocity whilst respecting autonomy could create relationships that access "*unknown-unknowns*": knowledge and assets that exist beyond traditional professional boundaries.

Figure 6 Johari window



The Johari Window Model

"*Unknown unknowns*" represent a central epistemological category within knowledge management frameworks, referring to knowledge domains that lie beyond our current awareness: we do not know what we do not know. Unlike known unknowns (recognised knowledge gaps), unknown unknowns are genuine blind spots in our conceptual frameworks. In professional practice, these represent significant barriers as they exist outside what is theoretically and practically known. Polanyi's description of tacit knowledge is a step towards resolving this conundrum by describing knowledge that is embedded in practice and becomes apparent to observers rather than practitioners.

Unknown unknowns in coproduction highlight the need for diverse perspectives from stakeholders beyond expert-only approaches, whilst simultaneously highlighting a theoretical tension about whether professional involvement is necessary at all. This is particularly apparent when researchers like Bovaird and Loeffler (2012) and Brandsen and Helderman (2012) specify the inclusion of professionals in their definitions of coproduction, even as evidence suggests citizen consumer-producers can independently collaborate to develop locally relevant solutions and forms of social capital that formal institutions may never recognise (Gutberlet et al., 2016).

The fundamental debate about the need for professional involvement directly shapes how participants understand and enact their roles within coproductive processes. When professionals are positioned as essential participants, citizen roles may be constrained by institutional expectations and power dynamics (Kirkegaard, 2020; Steen et al., 2018; Voorberg et al., 2015). Conversely, in citizen-led approaches, participants must navigate more fluid, self-determined identities without professional mediation (Verschuere et al., 2012; Williams et al., 2016). The question of who participates fundamentally influences how participants see themselves within the process, creating what Needham (2009) calls relational identities that evolve through interaction rather than existing as fixed categories.

The empirical evidence from Parks et al. provides concrete validation of Ostrom's insight that effective governance requires active citizen participation, whilst institutional structures shape the role repertoires available to participants. The complex role identities documented by research highlight how power operates not just through formal authority but through the construction of available subject positions and identity categories

2.5.3 The Dynamics of Role Identity in Coproduction

Whilst Parks et al.'s (1981) typology provides a foundational framework for understanding participant roles, recent research reveals that individuals navigate multiple, often contradictory role identities simultaneously rather than occupying single, stable positions within coproductive relationships.

Ewert (2016) conducted a comprehensive theoretical and empirical analysis examining how welfare state design influences citizen role identities in healthcare systems, drawing on comparative case studies across three European countries (Germany, Netherlands, UK) and original survey data from 1,247 healthcare service users to understand how individuals navigate the complex intersection of dependency and agency in contemporary care relationships. Ewert developed a novel framework bridging welfare state theory with identity theory to examine how institutional structures shape individual subjectivity. His central argument challenged binary conceptualisations of citizens as either passive recipients or active producers, proposing instead that individuals simultaneously occupy multiple, often contradictory role positions.

The roles that end recipients adopt or are socialised into represent an important dimension of coproductive relationships. How participants conceptualise their own identity influences their satisfaction with the experience and their subsequent support for coproductive approaches (Crompton, 2019; Loeffler & Bovaird, 2019). Ewert (2016) describes the complex interconnection between receiving care and contributing to healthcare systems, suggesting that participants navigate multiple role identities simultaneously rather than simply optimising a single role. Köppe et al.

(2016) elaborate on this dynamic through their heuristic⁵ model examining German welfare recipients in an insurance-based system. Within this framework, beneficiaries are simultaneously active coproducers of their own health outcomes and entitled service recipients. This creates a tension between their identities as autonomous agents and dependent subjects in that process. Niemietz (2015) notes that in contrast the UK's NHS citizen-state relationship follows a more traditional provider-recipient dynamic. These contrasting approaches suggest that the underlying funding models influence how involvement and coproduction are conceptualised within different systems.

Whilst funding-based identity frameworks represent important systemic influences, the mental health recovery movement demonstrates how role identities can evolve beyond these structural constraints to create entirely new categories of participation. Experts by experience represent a distinct category from traditional passive service recipients, bringing valuable subjective and qualitative insights to service provision. This expertise creates bridges between service users and providers, developing learning for both parties (Baker & Irving, 2016). For individuals with lived experience, this role transformation offers additional benefits: conferring status from a previously negative experience, building social capital, enhancing self-esteem, and potentially creating previously inaccessible employment pathways (Byrne et al., 2013).

Whilst these role transformations offer significant benefits, they also present complex challenges that unfold over time. Mayer and McKenzie's (2017) interpretative phenomenological analysis examines the longitudinal dimensions of these role

⁵ '...simple rules of thumb for rendering a judgment or making a decision.' Simon, H, (2018)"Bounded Rationality," *Stanford Encyclopedia of Philosophy*, first published November 30, 2018, <https://plato.stanford.edu/entries/bounded-rationality/> accessed 01/07/25

transitions, highlighting both the validation needs of experts by experience and the importance of protecting them from negative attitudes from their former care providers. Their study examined 25 self-selected males (aged 21-28) who delivered mental health services based on their own lived experience. Their research documented how these individuals developed '*multiple identities that remained dynamic and in flux*' (Mayer and MacKenzie, 2017:1185). This identity transformation represents what might be termed a transitional space where self-perception and potential evolve during the process of providing and learning about a service. However, this evolution contains a significant paradox: whilst employment based on mental health experience creates new opportunities, it simultaneously imposes new limitations by potentially fixing individuals within their 'expert by experience' identity (Scior et al., 2020).

An empirical study by Gillard et al. (2017) developed and evaluated a principles-based approach to implementing peer support worker roles in mainstream mental health services: establishing core principles to guide the work rather than a rigid framework focused on procedure. The researchers used participatory action research methods over a three-year period to engage peer workers, service users, staff, and managers across multiple mental health organisations in England to identify the core principles for effective peer support implementation. Data was collected via interviews, focus groups, and workshops involving 91 participants. The findings resulted in a framework of five core principles: preserving the distinctiveness of peer support, ensuring peer workers have agency, providing appropriate organisational support structures, focusing on relationship-building rather than standardised interventions, and developing inclusive approaches to evaluation. In testing these principles across different service contexts, the authors demonstrated

their utility in supporting implementation whilst maintaining the integrity of peer support values. This research empirically developed principles for peer support, including reciprocity which *'includes willingness to both give and receive support, of listening and sharing, and of learning from difference'* (Gillard et al 2017:137), that can be flexibly applied across a range of mental health settings whilst respecting the lived experience foundations of peer support work. Complementing these findings, Van Blerk's (2017) participative ethnographic research in South Africa with 25 young people living with homelessness and convictions demonstrates how pervasive institutional and cultural prejudice can complicate these identity transitions, creating persistent barriers that make it challenging for individuals to fully discard their previously assigned roles and stigmatised identities.

These studies show that roles in coproductive relationships are inherently dynamic and are not exclusively determined by regular producers. The dynamic character of role identity underscores the complex, evolving nature of authentic coproductive processes. This complexity reflects the broader challenge: that coproduction operates as a mid-range theory rather than a precisely defined concept. What practitioners and researchers attempt to describe is not a static process but an evolving set of relationships and identities that continuously adapt to different contexts and participants. This definitional challenge has led some to characterise coproduction as a 'slippery concept' (Ross et al., 2013:5) or 'like nailing a pudding to the wall' (Bovaird and Loeffler, 2003:316).

In this way, coproduction and the roles that participants perform within it share definitional challenges with systems theory (Luhmann et al., 2013), where understanding remains emergent and liminal: existing at the threshold between established categories (Meadows, 2008). Coproduction transforms seemingly

concrete concepts like consultation and engagement into something more fluid and adaptable to various situations. However, this conceptual flexibility creates practical challenges. Stakeholders may develop different definitions of authentic coproduction, creating inconsistencies and conflicts about whether specific practices truly reflect coproductive principles.

This conceptual elusiveness is an example of what Pollitt and Hupe (2011) identify as 'magical concepts' in public administration: concepts characterised by

'a high degree of abstraction, a strongly positive normative charge, a seeming ability to dissolve previous dilemmas and binary oppositions and a mobility across domains' (Pollitt and Hupe, 2011:241).

The 'magic' of coproduction lies in its capacity to hold multiple context-dependent meanings simultaneously whilst maintaining its appeal across diverse settings.

However, in common with PSL as described in 2.4.4., this does not prevent coproduction from functioning effectively as a mid-range theory that provides useful analytical tools and practical guidance, even whilst acknowledging its theoretical limitations and definitional fluidity.

The research on role identity in coproduction, whilst offering valuable insights, has methodological limitations. Studies by Mayer and McKenzie (2017) examining the coproduction of youth mental health (n=5) and Gillard et al. (2017) (n=91) examining peer roles in adult mental health, whilst providing rich qualitative data, rely on relatively small, self-selected samples that may not represent the diversity of experiences in coproductive relationships. Additionally, much of this research examines relatively brief periods, with few longitudinal studies tracking how role identities evolve over time (Scior et al., 2020). These limitations reflect broader

methodological challenges in studying fluid, context-dependent phenomena like coproduction. As Needham (2009) argues, existing research methods and their customary application may struggle to capture the complex, evolving nature of coproductive relationships. However, this limitation does not undermine the value of established methodological approaches when they are purposefully adapted and applied to explore different dimensions of coproduction. Rather than abandoning proven methods, there is merit in leveraging their established rigour and reliability to examine new research questions and contexts. The same methodological frameworks that may have limitations in one area of inquiry can offer valuable insights when redirected towards different aspects of coproduction (Busetto et al., 2020). This approach allows researchers to build upon existing methodological knowledge whilst expanding the scope of understanding in coproduction research.

Having established the theoretical foundations and key components of coproduction, including the relational elements essential to collaborative practice and the dynamic role identities that participants navigate, the analysis now turns to examining how these principles operate in practice across different contexts. The applications explored in the following section reveal the tensions between theoretical ideals and practical implementation, particularly highlighting how power dynamics and institutional constraints shape collaborative outcomes.

2.6 Applications of Coproduction

2.6.1 Coproduction, Citizenship, and Political Economy

Applying the concept of citizenship to mental health recovery represents a paradigm shift in how society understands the relationship between individuals living with

mental ill health and their communities. Rowe pioneered this approach (Rowe et al., 2012), describing citizenship as not solely the legal status it confers but as a multidimensional construct encompassing rights, responsibilities, roles, resources, and relationships (the '5 Rs') (Rowe et al., 2009). His framework emerged from extensive work with individuals experiencing homelessness, mental ill health, and issues with substance use in the United States. This concept of citizenship represents a conscious move away from purely clinical or medical models of mental health towards one that emphasises social participation and community integration (Rowe & Davidson, 2016). Central to Rowe's citizenship theory is the notion that individuals with mental ill health should be recognised as full and equal members of society with the capacity to make meaningful contributions. Unlike traditional approaches to mental health that focus primarily on reducing symptoms, this active citizenship model prioritises social connectedness, civic participation, and valued social roles (Rowe et al., 2012). Rowe's framework is inherently political, challenging structural inequalities and discrimination that exclude individuals with mental health from full participation in society. In his work Rowe acknowledges that citizenship is not simply granted but must be actively promoted through targeted interventions and systemic change (Pelletier et al., 2015).

MacIntyre et al. (2022) explored the practical applications of Rowe's citizenship framework in a Scottish context, highlighting a distinction in the perception of citizenship between Scotland and the United States. They also demonstrated its cultural adaptability whilst providing evidence that effective implementation occurs through peer support, community initiatives, and mental health service reforms. These mechanisms represents a practical manifestation of coproduction, mechanisms which MacIntyre et al. (2019) position as fundamental to citizenship

approaches in mental health. That is, where power is genuinely shared between professionals and those with lived experience, establishing partnerships that value experiential expertise equally alongside professional knowledge.

Cogan and MacIntyre (2019) introduce the importance of building relationships in citizenship to the debate, examining how social connections and interpersonal relationships form the foundation for meaningful citizenship experiences. They argue that citizenship cannot be understood in isolation from the quality and nature of relationships that individuals maintain with family, peers, professionals, and wider community networks. This relational perspective adds to Rowe's framework by emphasising that the relationships component of the 5 Rs requires particular attention when supporting individuals with complex needs to achieve full citizenship.

MacIntyre et al. (2022) went further in exploring how citizenship intersects with human rights frameworks and recovery-oriented practice, showing that citizenship approaches can help to address the social determinants of mental health, including poverty, discrimination, and limited access to housing and employment opportunities. Their research extends Rowe's work by emphasising the importance of belonging as a fundamental component of citizenship, arguing that fostering a sense of belonging is central to supporting recovery and social inclusion. This analysis also addresses the tensions between universal citizenship rights and the need for targeted supports to address the barriers faced by individuals with mental health conditions and learning disabilities.

Cogan and MacIntyre (2019) and MacIntyre (2018,2022) recommended practical initiatives to translate citizenship theory into practice. These include citizenship-oriented intervention programmes, peer mentorship schemes, and building

community capacity. The development of the Strathclyde Citizenship Measure (Cogan et al., 2022) provides a robust tool for measuring citizenship outcomes in health and social care practice and research. This approach emphasises collaborative partnerships between professional services, community organisations, and individuals with lived experience. Their work collectively demonstrates how coproduction can effectively support citizenship principles in service design and delivery.

As mental health services continue to evolve, the citizenship model offers a valuable framework for developing more socially integrated, rights-based approaches to supporting individuals with mental ill health. Quinn et al. (2020) extend this further by introducing the concept of collective citizenship, moving from individual citizenship and mental health to citizenship and solidarity. The implementation of coproduction through citizenship approaches, particularly utilising tools such as the Citizens Measure (Bellamy et al., 2017), occurs at the intersection of professional practice and lived experience. This cultural context of coproduction - particularly in personal health and social care - is central to meanings ascribed by end users, dependent on the role they choose or are free to play (MacIntyre et al., 2022).

However, the citizenship approach faces fundamental structural contradictions that remain inadequately addressed in the literature. While promoting rights-based participation, these frameworks operate within neoliberal welfare systems that increasingly individualise responsibility for structural inequalities. As Cruikshank (1999) argues, the citizenship discourse can obscure how *personal responsibility* narratives deflect attention from systemic barriers including poverty, discrimination, and institutional racism. The emphasis on individual citizenship may inadvertently

pathologise those who struggle to engage, constructing *non-participation* as personal deficit rather than rational response to exclusionary systems.

Critical analysis of these citizenship approaches reveals both strengths and limitations. The framework effectively challenges stigma and promotes asset-based perspectives of individuals with mental health conditions. However, questions remain about how to implement citizenship approaches within existing service structures, resource constraints, and in the constrained circumstances of secure mental health care (Ponce & Rowe, 2018). Nonetheless by positioning individuals with mental ill-health as citizens first and foremost rather than as merely service users, this framework promotes dignity, social inclusion, and meaningful participation (Rowe & Davidson, 2016). As mental health services continue to evolve, the citizenship model offers a valuable framework for developing more socially integrated, rights-based approaches to supporting individuals with mental ill health, with coproduction serving as an essential mechanism for realising the full potential of citizenship in practice (Quinn et al., 2019; Quinn et al., 2020). This implementation of coproduction occurs at what Osborne (2018:225) describes as the *nexus of interaction* and relies on partnerships that are fundamentally dependent on *state and governance traditions* (Voorberg et al., 2017:366; see also Pollitt & Bouckaert, 2017). The cultural context of coproduction - particularly in personal health and social care - is central to meanings ascribed by end users, dependent on the role they choose or are free to play (Ewert & Evers, 2014).

The nature of the relationship with a welfare system also sets the bounds on whether service recipients see themselves as active or passive consumers, or coproducers, based on apparent or actual power relationships with the service - a dynamic that directly influences the effectiveness of citizenship approaches that rely on active

rather than passive participation. In the German medical system, a combined state provided and insurance-based system, labels given to coproducers (e.g., expert patient or citizen consumer) can be both liberating and limiting as risk normally carried by organisations or governments transfers to individuals (Ferguson, 2007). Levasseur's case study of a non-profit childcare organisation in Canada involving 27 parents and board members suggests that the transfer of responsibility in coproduction places disproportionate risks on citizens compared to organisations with departments that normally manage them (Levasseur, 2018). Parents as consumer producers in this study had variable experiences in formal governance in addition to limited collective authority but multiple accountabilities to stakeholders. For co-production to be effective, Levasseur concludes, there needs to be a more balanced distribution of responsibilities and better support for citizen co-producers.

This imbalance of power and responsibility in coproduction reflects a broader pattern where apparent collaboration may mask underlying power inequalities that limit genuine participation. This is not limited to public services but extends to commercial environments where similar mechanisms operate but with different objectives. Behaviour management for example is inherent in commercial marketing processes. Some business models, like Build-a-Bear (Esmark et al., 2016), thrive on the semblance of independence and choice to coproduce a shopping experience that consumers will want to repeat. Esmark's quasi-experimental study with 289 subjects describes how Build-a-Bear customers can choose from numerous options that personalise products - but are guided to limited, costly options. This form of coproduction provides the illusion of control when much of the pathway is predetermined by product availability:

"At Build-A-Bear Workshop, a customer can either build a stuffed animal or have an employee do it (decisional control). Perhaps you want to build it yourself and look for signs on how to proceed (cognitive control). You find signage that tells you what each section of the store contains (e.g., stuffing station, accessories, etc.) and realize you have to follow a very specific process to make this animal (behavioural control)" (Esmark et al., 2016:423).

The similarity to self-directed care, which

"...seeks to empower participants by expanding their degree of choice and control in selecting services" (Alakeson, 2010:1),

is striking. In practice, choice is actually limited by professional filtering of options and the financial resources available, making the process confusing and sometimes disempowering for end users (Kendall & Cameron, 2014; Slasberg et al., 2013).

The application of Rowe's citizenship model to mental health settings contains a number of unresolved contradictions. While promoting rights-based approaches, it operates within systems where, as Pilgrim notes, compulsory treatment remains common practice. Pilgrim (2018), in his theoretical analysis of NHS England's The Care Act 2014 coproduction guidance in secure mental health, concludes that coproduction of support is not possible in secure conditions. Pilgrim listed the purposes of coproduction envisaged in the Care Act 2014 (NHS England Always Events, 2024; NHS England, 2015):

'When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered' (The Care Act 2014 guidance: 2.14);

against the security restrictions common across secure care to identify any inherent contradictions. He determined that restrictions to liberty as a consequence of detention, and therefore of citizenship, meant that coproduction as defined in the Act was not possible in secure conditions, citing Carr (2015) who found that *'involvement and empowerment took place outside the secure setting'* (Carr 2015:3). That conclusion, however, is premised on a particular conception of coproduction evidence (NHS England Always Events, 2024; NHS England, 2015) as the co-design, delivery and development of services as outputs, rather than the process of human interactions that contribute to the coproduction of peace and security, and thus the relational space and environment identified in this study (Pilgrim, 2018). This fundamental tension remains inadequately addressed in much of the coproduction literature.

2.6.2 Coproduction as Civic Engagement

The gap between the aspirational language about choice and the practical constraints in personal care services (Derges et al., 2014; Mladenov et al., 2015; Needham, 2011) becomes particularly apparent when examining service delivery and broader civic participation frameworks. Comparative research by Radzik-Maruszak and Bátorová (2015), illustrates this tension in practice. Their examination of civil servants' experiences with citizen engagement in Finland (Tampere) and Poland (Lublin) revealed significant variations in the implementation of co-design across different cultural and institutional contexts. The study demonstrated that the application of civic engagement principles produces different outcomes depending on local conditions.

The contrast between the two cities is important to note. Lublin employed diverse, multi-channel engagement strategies characteristic of new democracies after the collapse of the Soviet Union (Radzik-Maruszak & Bátorová, 2015). Tampere, however, utilised more limited methods primarily focused on gathering majority opinions - an approach aligned with traditional representative democratic processes.

While Radzik-Maruszak and Bátorová interpret Tampere's approach as demonstrating democratic maturity through clearly defined citizen influence, this view deserves closer examination. The restricted engagement channels in Tampere might equally indicate a reluctance to embrace more dynamic forms of citizen participation that could prove challenging to manage. Their research reveals a fundamental tension: Tampere's commissioners displayed a preference for process control, whereas Lublin's approach potentially offered more substantial opportunities for citizen-driven systematic change. This finding emphasises the importance of tailoring engagement strategies to specific contexts rather than applying standardised participation models across diverse settings.

This distinction highlights a fundamental question in civic engagement: whether administrative structures are genuinely open to citizen-led transformation or are they simply seeking to maintain control while creating an appearance of participation? This tension becomes evident in the way that public service professionals manage expectations of participation in practice. That is, the rational self-interest of council officials limits engagement to available resources, and the public service culture's bounded rationality limits possible outcomes. This rhetorical repositioning allows administrators to maintain operational stability while simultaneously demonstrating a nominal commitment to participatory ideals.

"To avoid the risk of sinking into the ocean of individual interests, needs and requests, which could lead to the 'paralysis by analysis', it is easier to work with more general, average-value, or simplified data, which, expectedly, would satisfy the majority of affected participants" (Radzik-Maruszak and Bátorov, 2015:89).

However, this clearly limits citizens' opportunities to influence outcomes.

Coproduction, and codesign in this case, favours a traditional provider ontology over the development of additional community assets and resources. Mature systems appear to be more likely to direct processes toward manageable channels, favouring traditional decision-making over innovation and wider engagement. Unfortunately, citizen perceptions were excluded from Radzik-Maruszak and Bátorová's study, weakening these conclusions (Radzik-Maruszak & Bátorová, 2015).

Public servants' imperative to manage expectations can paradoxically nullify the positive effects of agonistic processes in policy development (Dean, 2018).

Disagreements are perceived as negative rather than generative, and as engagement process failures or interest group hijacking. This is a fundamental misunderstanding of the tools being used in the strategic game being played by citizens: restricting resource access - their knowledge power - or non-collaboration (Rosanvallon & Goldhammer, 2008) as the key *counter* and agonistic powers citizens have in collaborative or coproductive relationships in democracy.

Interestingly Bovaird et al. (2016) and Hawkins et al. (2017) dismiss these as barriers to coproduction. However, these are powers citizens can use to challenge constraining governance processes where participation is defined by those with most power. As coproduction is an organic, negotiated process (Dean, 2018) both agonism and collaboration processes must coexist for coproduction to be a

conceptual and dialogic space where participants can openly explore, disagree and reconstruct what is possible together.

While Radzik-Maruszak and Bátorová's comparative analysis of participation as opposed to coproduction approaches in established and new European democracies provides valuable insights, Galuszka's (2019) research on housing and urban governance in the Global South reveals important contextual differences in the development of coproduction. In regions with fragile democratic institutions, power dynamics within coproduction can differ markedly from those observed in the Global North. For example, the absence of robust governance structures supporting service recipient participation can position public servants in disproportionately powerful roles, creating imbalances that undermine the ethos of coproduction. Under these circumstances, local activism and agonistic engagement often emerge as the primary avenues for citizens to exercise influence. Though manifesting as resistance, they facilitate protective forms of coproduction that parallel Ostrom's description of community regulation and informal governance mechanisms that safeguard finite resources (Ostrom et al., 2012).

The contextual limitations of agonism become particularly evident in secure forensic healthcare settings, where conflict has implications for patient liberty and care provision. In these environments, both psychological and institutional factors constrain opportunities for democratic participation or agonistic engagement, highlighting that contextual factors shape the feasibility and manifestation of coproduction across different settings. However, this tension between participation and practical constraints extends beyond specialised healthcare environments to mainstream civic governance where resource limitations dominate decisions. Civic authorities' incentive to manage coproduction processes is often bounded by

concerns about raising expectations beyond available funding, as described by Radzik-Maruszak and Bátorová. Their response serves dual purposes: ensuring that existing resources are not exhausted (described as fencing and packaging by Ostrom, 1994) and managing expectations by reducing potential options and engagement infrastructure to limit public engagement to the lifespan of the initiative. While bounding rationality provides organisational comfort, these limitations may be transmitted to participants, constricting the potential for change and innovation.

2.6.3 Collaboration and Coproduction

Alm Andreassen's 2018 synthesis of published studies of citizen involvement in Norway categorises health and social care collaborations with consumers in coproduction into three types: pseudo-democratic, hybrid-democratic, and co-worker democratic (Alm Andreassen, 2018). The first draws in service recipient volunteers as representatives to advise and guide the development of services, the tokenism rungs in Arnstein (Alm Andreassen, 2018).

The second type, hybrid democratic, employs traditional forms of public engagement with participants who are either self-selected or chosen by the service. To address concerns that the extended tenure for public representatives might favour strengthened service relationships over the contribution of lived experience, terms are kept short. Despite this safeguard all forms of engagement alter the relationship between participant regular producers and consumer producers (Maguire & Britten, 2018; Seward, 2009).

The third, co-worker democratic, employs people with lived experience to deliver services alongside qualified workers, such as peer workers. However, there are

common contradictions in practice. Pay, for example, demonstrates value and allows participants to see value accrued over time (op cit). While this may result in incentivising embedded citizen involvement in service delivery, it also risks co-opting citizens to meet service needs without meaningfully changing structures (Carey, 2011). Ultimately a lack of purposefully designed support systems and low pay across peer workers is an indication of how valued lived experience is to systems in reality (Hurley et al., 2018).

There is an additional challenge in developing peer services in health and social care systems. Qualified professional workers with practice experience may find a sense of parity with peer workers affects their professional and pecuniary status and as a result may resist such reward structures (op cit). There then appears to be an inherent, and in Alm Andreassen's analysis, inevitable conflict between the value ascribed to lived experience in policy, the reality of that value in monetary terms and the resistance from professionals who see lived experience undermining rather than complementing the value of their own role. This represents the fundamental existential threat that coproduction presents to Public Service Delivery Logic: that describing lived experience as the core driver for service development presents a challenge to traditional conceptualisations of the patient/carer relationship, and the role of professionals. Despite these challenges and barriers, paid peers have a status that service users do not and have demonstrable influence on service design and delivery (Alafaireet & Houghton, 2017), but not on the persistent hierarchy and structures of power inherent in health systems (Edmondson, 2018).

Different dynamics appear where the process of coproduction is not in commissioning services but in resolving local issues. For example, in a descriptive study of Medellin, Columbia, a municipality uses coproduction to support

compliance, helping the population address rent arrears (Duque Gómez & Jaglin, 2017). While residents do not 'own' the public housing, coproduction was used to generate a sense of co-ownership and shared responsibility. The authors describe what they term *co-learning* and *micro-negotiations* (Duque Gomez & Jaglin 2017:46): a series of meetings which both developed a shared understanding of the perspectives of service providers and resident, which in turn created a functional, and in some cases, a personal relationship through which to coproduce. Where there were disagreements, they were primarily used as a productive catalyst to generate new ways of thinking about a solution. However, the relationships created were temporary, contingent, and focused on compliance and behaviour modification. This, therefore, is an example of a dark form of coproduction being used to deliver public sector delivery logic. As with Moore's description of strategic accommodation - a psychological mechanism that allows people using services to maintain a degree of agency, whilst pragmatically acceding to a services demand upon them, until such time as they are free of that service's oversight (Moore, 2009) - the relationships were transactional, and the provider retains coercive power. This is perhaps an example of a transactional form of coproduction – although this may be more accurately described as compelled cooperation - with outsider groups that have yet to build trust with public administration.

Bejerholm et al.'s (2022) process evaluation of implementing a coproduced Recovery Guide across 22 inpatient mental health wards in Sweden offers contrasting insights into how coproduction manifests in institutional settings. Process evaluation is commonly

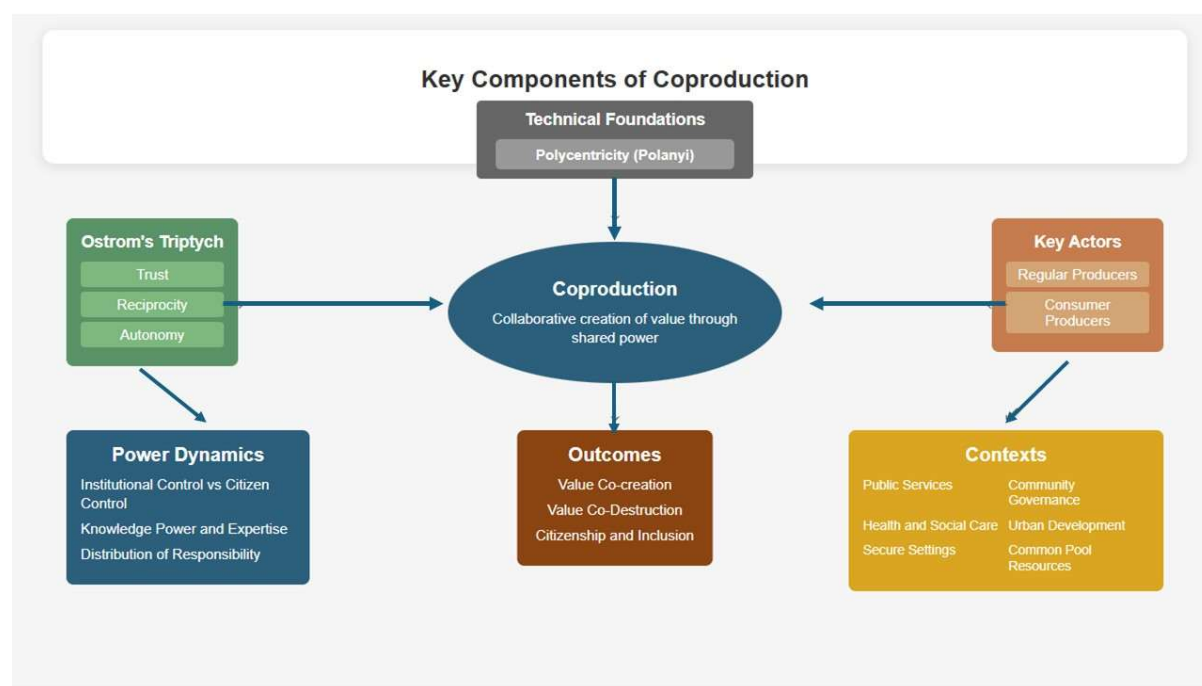
'used to monitor and document program implementation and can aid in understanding the relationship between specific program elements and program outcomes,'(Saunders et al 2005:134)

Despite initial barriers including resource limitations and dominant medical perspectives, 14 wards successfully implemented the intervention, reaching 53% of patients. Critical success factors included a legitimised intervention, engaged leadership, adequate staff capacity, and continuous support from service user organisations. The findings demonstrated that meaningful coproduction between stakeholders created trust and sustainable implementation practices that enabled the wards to resume the project after interruptions due to subsequently resolved staff opposition or resource challenges. This study highlights that coproduction in institutional mental health settings requires deliberate attention to both structural enablers and relational processes to succeed in environments that have traditionally followed more hierarchical care models.

In conclusion, the ceding of power, which may be central to genuine coproduction, is a challenge for those who hold it. Power can be very reluctantly released, particularly when control is normally exercised through limited but evidence-based data gathering and measuring methods (Nesti, 2018). Being epistemologically open - adaptable to innovative evaluation techniques that respond to local conditions - is particularly challenging for public servants used to programmatic, controlled and system-led approaches to change and development. The release of power to engage the knowledge power of coproducers (Bevir, 1999; Foucault & Rabinow, 1982; OECD, 2011) - reciprocity in Ostrom's triptych - is most often challenged by those holding it (Nesti, 2018).

The figure below summarises the key components of coproduction identified in the literature review.

Figure 7 Key Components of Coproduction from the Literature



2.7 Characteristics of Coproducers

The reluctance of institutions to relinquish control reflects a fundamental misunderstanding about what motivates citizens to participate. The assumption that diminished material outcomes reduce motivations to participate, however, is challenged by empirical research into what actually drives citizens. Vanleene et al. (2017), for example, in their case study of coproducer motivations in a deprived Ghent neighbourhood (n=37) found that material incentives are not significant motivators for engagement. Their cluster analysis suggests, contrary to observations on common resources by Aristotle (1992) and Hardin (1968), that solidarity with others in similar socio-economic positions and moral/ethical reasons for involvement were greater predictors of involvement overall. These drivers are enhanced when

target groups have existing, beneficial relationships with the officials involved. In this case, Vanleene suggest that incentives are personal. They categorise them as: material rewards, immaterial rewards, immaterial sanctions, solidary, normative, expressive, effectiveness, ease of involvement, and salience. Examples of possible incentives are presented in the table below.

Table 7 Vanleene's incentives

Incentive	Example
Material Rewards	Token payment/in kind rewards
Immaterial rewards	Community or organisational status as a result of involvement
Immaterial sanctions	Social opprobrium for not taking part
Solidary	Personal, family and community interests coincide
Normative	Behaviour or actions that are acceptable or expected by communities

The table above presents a framework of motivational incentives that influence citizen participation in coproduction. It progresses from extrinsic to increasingly intrinsic motivations across the five categories. Material rewards represent tangible benefits, while immaterial rewards confer enhanced social status. Immaterial sanctions function as negative reinforcement through social disapproval. Solidary incentives (community or coincidence of interest) reflect an alignment between personal, family and community interests - a key driver in disadvantaged communities according to Vanleene et al. (2017). Finally normative incentives represent behaviours deemed acceptable by community standards. This

classification challenges policy approaches that rely predominantly on material incentives, suggesting that effective coproduction must address more nuanced social and normative drivers of civic engagement. Indeed, altruism serves as a foundational element in effective coproduction (Brandsen et al., 2018; Pestoff, 2014), where participants contribute to collective outcomes without immediate personal benefit - the type of non-material motivation that traditional incentive structures often fail to accommodate yet proves essential for sustainable collaborative governance.

Despite these important insights into motivation, this body of research has notable limitations. Most studies rely heavily on self-reported motivations, which may reflect social desirability bias rather than actual motivational drivers (Van Eijk & Steen, 2016). Additionally, the cross-sectional nature of much of this research makes it difficult to determine whether identified motivations are causes or effects of participation, as highlighted in 2.5. Longitudinal research by Fledderus J. (2016) suggests that motivational factors may change substantially over time, questioning the stability of typologies such as Vanleene's. Also, the predominance of Western European contexts in this research raises questions about its generalizability to other cultural and governance settings (E. Loeffler & T. Bovaird, 2019).

Nevertheless this sociological understanding finds compelling parallels in evolutionary biology's explanations of altruistic behaviour across species. Trivers (1971) describes this using avian mutual aid systems, where alarm calls trigger collective predator mobbing responses across species boundaries. Despite considerable personal risk, these birds participate because of the solidary or the collective benefit to the nesting community outweighs individual vulnerability. Significantly, this cooperation operates conditionally - birds that fail to contribute to

collective warning systems find themselves excluded from community protection when threatened.

This conditional altruism also extends to human social systems through what Trivers identifies as reciprocity accounting, where

"...friendship, moralistic aggression, guilt, sympathy, and gratitude have evolved to regulate the altruistic system" (Trivers, 1971:50).

Fontaine (2012) translates this concept into economic terms as *utility interdependence*, using Derrida's exploration of gift-giving to conclude that participants often receive *symbolic recognition* (noted as an immaterial reward in Vanleene's taxonomy) as compensation - essentially an investment in *relationship futures* that invites reciprocity (Derrida, 1992).

Axelrod and Hamilton's (1981) game theory research further illuminate this process, demonstrating how simple tit-for-tat strategies in repeated prisoner's dilemma scenarios⁶ eventually foster cooperation and altruistic behaviour. Participants who respond in kind to negative interactions ultimately encourage others to revise their strategies toward cooperation over time. Crucially, their research demonstrates that single-encounter interactions typically result in mutual defection (essentially walking away), while sustained relationships across multiple interactions foster the cooperative conditions essential for coproduction to flourish.

Beyond altruism, subjective attractiveness of incentives appears to vary by coproducer characteristics or types. Congruent with Vanleene's incentives, van Eijk

⁶ The Prisoner's Dilemma is a fundamental game theory scenario in which two rational individuals, unable to communicate with each other, must decide whether to cooperate or defect, with the paradoxical result that choosing self-interest (defection) leads to a worse outcome for both than had they trusted each other and cooperated, despite cooperation carrying the risk of being exploited if the other defects.

et al. (2017) identified coproducer types using Q methodology ⁷: the task-bound rationalist, where producing community safety was subjectively important; the protective rationalist, involved because of rational self-interest (when reward outweighs cost); and normative rationalists, who believe this approach should become standard practice. Regardless of motivations, potential coproducers' involvement was dependent on effecting change and influence.

This finding is explored by Barbera et al. (2016), in their study of 25 patients discharged from long-term care with Italian Health Budget finance (also using Q-methodology). They identify two further participant typologies that exhibit distinct relationships with a desire to engage with coproduction: those characterised as *democratically passionate and active* who demonstrate resilience in sustained engagement, and *pre-contemplators* who exhibit cognitive dissonance by simultaneously desiring change whilst remaining reluctant to actively enable it (DiClemente et al., 1991). The identification of distinct participant typologies provides an insight into the engagement patterns within coproduction. However, these individual positions need be understood within the broader institutional contexts that shape opportunities to participate. That is, institutional systems, inherently rigid, shape the parameters within which coproduction can operate. These established frameworks selectively incorporate participants who already possess system knowledge and expertise, while simultaneously identifying supposed deficiencies in other potential contributors. This deficit-based approach creates a hierarchical dynamic where certain individuals must overcome perceived knowledge gaps before

⁷ Q methodology 'combines qualitative and quantitative methods to investigate the subjective views of those directly involved' (Herrington 2011:24), to highlight shared and diverse subjective viewpoints.

being granted full participation rights, effectively reinforcing existing power imbalances within the coproduction process.

Rantamäki (2017) describes this conundrum in a participatory action research study in Finland, combining observations of local forums, stakeholder surveys, service user interviews, and organisational observations. The dominant paradigm in public service delivery, they suggest, operates from a deficit perspective. It assumes that citizens lack the necessary knowledge to engage with systems effectively. This approach parallels problematic health literacy models that focus on educating populations about how to navigate complex services rather than redesigning those services to be inherently more accessible (Annarumma & Palumbo, 2016). Such frameworks place the burden of adaptation on service users instead of reforming institutional structures to accommodate diverse needs and capabilities. This resistance to structural reform extends beyond individual service interactions to characterise the broader approach to civic participation, where institutions prioritise short-term operational efficiency over transformative engagement. The periodic nature of coproductive engagement and a focus on instrumental outcomes (e.g., lower short term healthcare costs versus long-term systems change) present barriers to coproduction achieving longer-term impacts:

"In practice the emphasis has been on how to educate people to act in the context of existing democratic structures and procedures" (Rantamäki, 2017:251).

Typically, systems resist radical change, bounding rationality to what can be influenced and what has been determined by the institution to be knowledge that qualifies one as an influencer.

This structural resistance to change reinforces the dominant influence of public officials over coproduction initiatives. Tuurnas's 2016 case study in Tampere, Finland provides compelling evidence of this dynamic. Using a multi-method approach to examine a participatory community development project, Tuurnas concluded that policy frameworks often understand coproduction as an end goal rather than a means to build social capital with citizens. The study highlights an important disconnection: while policy describes coproduction primarily as a mechanism for meeting predetermined objectives, the empirical data suggests it functions more accurately as an iterative and therefore ongoing relational process. This process not only delivers outcomes but also transforms the relationship dynamics between public servants and the communities they serve.

Such transformation requires a significant shift in professional orientation. Officials must transition from positioning themselves as objective service deliverers to embracing roles as facilitators and enablers of effective coproduction. That is, adopting an approach focused on supporting community capacity rather than directly creating and implementing services themselves (Tuurnas et al., 2015).

Tuurnas' model illustrates the multifaceted nature of coproduction by showing how personal factors, local conditions, and resource availability collectively influence outcomes. Particularly important to note is the interrelationship between participant motivation and institutional capacity in coproduction. In Tuurnas' empirical investigation, while direct participation from individual community members remained limited, robust engagement occurred through established non-governmental organisations and community networks, effectively facilitating an external collective coproduction process. This finding suggests that the breadth and depth of personal and professional relationships within communities, alongside well-developed

organisational networks, are prerequisites within the political economy of successful coproduction.

Building on this understanding, Bussu and Tullia Galanti (2018) expand the analysis through their narrative review of 35 papers on leadership roles found in searches of the International Bibliography of the Social Sciences (IBSS) and the Web of Science (SSCI), determining that:

"A facilitative leadership can enhance the participation of weaker stakeholders and support their involvement by providing the necessary time and resources to voice their expectations and acquire the skills they need to co-deliver these" (Bussu and Tullia Galanti, 2018:357).

However, competing agendas to deliver better democracy and reduce public service demand are best understood as public service delivery logic outcomes (Osborne et al., 2016).

Frontline professionals frequently encounter conflicting organisational demands and policies that create challenges for implementation (Lipsky, 2010; Tummers & Bekkers, 2014). When faced with these contradictions, they engage in the pragmatic adaptation of formal rules and guidelines, Argyris and Ostrom's *Rules in Use* (Argyris, 1982; Ostrom et al., 2012). This adaptation process occurs in real-time during service delivery, rather than during planning phases. These professionals apply contextual judgment to interpret ambiguous situations and determine appropriate responses based on their professional expertise and understanding of service users' needs. This adaptive behaviour enables them to navigate institutional contradictions while delivering services in complex organisational environments. Kristiansen et al. (2015) explore this phenomenon in a case study analysis of

decision-making in three Norwegian care homes, combining 18 semi-structured interviews with observations of 40 meetings and nursing handovers. In this case organisational logics (doing more with less in austerity) contradicts professional logics of engaged care and treatment quality. Sense-making allowed nurses to maintain the care focus (contributing more *free resource* such as working beyond contracted hours) while accepting resource and staffing restrictions. This organisational and professional cognitive dissonance maintains a distance between their contradictory positions.

Coproduction models that aim for citizen control, the top of Arnstein's participation ladder, challenge the operational logic of institutions constrained by established organisational structures. However, it is important to recognise a significant critique of Arnstein's hierarchical model: that it predominantly analyses participation through the distribution of power (Tritter & McCallum, 2006) rather than examining the diverse incentives (described by Vanleene above) that motivate different stakeholder groups to engage in collaborative processes. This singular focus obscures the complex motivations for participation and the balance of expertise required for a project. For example, in specialised contexts, professional expertise remains critical - for instance, surgical procedures performed by qualified medical professionals are objectively preferable to operations overseen by citizen committees, regardless of democratic principles.

This necessary balance between technical expertise and democratic participation is frequently overlooked, as imperatives to reduce cost and improve public service efficiency dominate the political rhetoric on coproduction, often simplifying complex questions of appropriate governance to primarily economic considerations. Löffler and Watt (2009) made the academic case for more research exploring this central

facet in more detail. However, ten years later, Garlatti et al. (2019) found only "...20 papers have dealt in a meaningful way with this issue"(Garlatti, 2019:130) over four decades, suggesting that the rhetoric had outpaced the evidence. Furthermore, few studies have explored coproduction in one-to-one support/therapeutic relationships common in health and social care. Needham set out the research challenge in 2009 (Needham, 2009), that traditional methods and approaches fail to capture the complex nature of coproduction, the definitional ambiguities already highlighted in this review and determining who contributes what to the process over a longer period than is traditionally allocated to an evaluation. Needham views co-production as fundamentally reshaping traditional relationships between service users and providers (Needham, 2008), but highlights significant tensions in implementation. She emphasises that co-production involves complex power dynamics and emotional labour, where different rules and professional cultures can either facilitate or hinder genuine collaboration (Mortensen & Needham, 2023). Needham argues that policy rhetoric often promises the best of both worlds when combining co-production with other agendas like health and social care integration or standardised outcomes, but in practice these create tensions and conflicts (Allen et al., 2023). This risks what Needham describes as a game of pretend in coproduction. She advocates looking beyond grand narratives to understand how co-production actually works in situated local contexts, recognising both its transformative potential and practical limitations (Bevir et al., 2019).

Brandsen et al. (2024) also provide important empirical insights into professional decision-making regarding coproduction with vulnerable people. Their survey of 177 mental health professionals across five organisational units in the Netherlands revealed that the willingness to coproduce was primarily influenced by the

characteristics of supported people, specific aspects of the treatment process, and treatment progress - rather than professionals' demographic factors. Their findings demonstrate that professionals adapt their coproductive approach according to individual client needs and circumstances, suggesting a more nuanced, context-dependent application of coproduction principles than has been previously acknowledged. This challenges assumptions that professional attitudes toward coproduction are fixed, and instead highlights the dynamic, situational nature of decisions made during encounters with supported people. Their work suggests that improving coproduction in mental health contexts requires understanding these situational judgments rather than simply promoting coproduction as a universal approach.

This represents a significant gap in the literature, particularly as the power dynamics in local relationships differ fundamentally from those involving larger populations because the participants interact in closer physical and relational proximity. The intimate nature of these therapeutic interactions creates distinct power structures that warrant closer scrutiny, moving beyond the frameworks typically applied to larger-scale coproduction initiatives. This is particularly important when exploring the primary form of power that coproduction participants can exercise: what Rosanvallon calls *agonistic power* - the ability to withhold or restrict resources (Rosanvallon & Goldhammer, 2008). As noted above, Bovaird identifies this specific power dynamic as a significant barrier to successful coproduction processes (Bovaird et al., 2016).

However, the dynamic within therapeutic relationships engages overt power by a service (the potential for compliance-compulsion) and tacit negative incentives, such as the potential withdrawal of a service or cooperation. This may provoke the dynamic described by Moore (2009) above as strategic accommodation, as a tactic

used by service users, best understood as simulated treatment compliance to return to previous behaviour once the treatment or restriction is complete or removed.

These power dynamics create a more complex relational environment in therapeutic settings that requires careful consideration when designing and implementing coproduction initiatives. However, Moore's insight contains a logical flaw. As Trivers (1971) concludes, continuous engagement leads to the evolutionary development of conditional altruism. That is, accountability in long-term relationships fosters reciprocity and anticipatory reciprocity, or gifting, which Derrida (1992) describes as placing obligations on recipients, protecting relationships. Humans, in common with the birds studied by Trivers, have also evolved mechanisms regulating anticipatory reciprocity – or anticipatory and manipulative gifting - that is clearly instrumental:

"Moralistic aggression and indignation in humans was selected for in order (a) to counteract the tendency of the altruist, in the absence of any reciprocity, to continue to perform altruistic acts for his own emotional rewards; (b) to educate the unreciprocating individual by frightening him with immediate harm or with the future harm of no more aid; and (c) in extreme cases, perhaps, to select directly against the unreciprocating individual by injuring, killing, or exiling him" (Trivers, 1971:49).

The reciprocity calculus, Trivers suggests, balances the scale of advantage foregone by anticipatory reciprocators and the recipients' need. Evidence from evolution suggests that tit-for-tat strategies resolve morally dubious behaviour over time, even for asocial behaviour (Axelrod & Hamilton, 1981; Fledderus J., 2016). If participants know they will interact over extended periods, they know aberrant behaviour will be punished, particularly if Rosanvallon and Goldhammer's (2008) option of restricting

resources is not available. This creates a pareto equilibrium (Wang, 1993), where no participant gains advantages without impacting another's outcomes.

While this provides a useful insight into decision-making and cooperative evolution, even without altruism, Trivers (1971) highlights that:

"Individuals will differ not in being altruists or cheaters but in the degree of altruism they show and in the conditions under which they will cheat" (Trivers, 1971:480).

In secure environments, contraband smuggling and rule circumvention represent tangible examples of what Trivers categorises as *cheating behaviour* and what Cohen and Taylor would classify as escape attempts (Cohen & Taylor, 2003).

Beyond physical escape, psychological escape attempts may manifest in various forms, including substance use as a means to disconnect from the reality of incarceration (Bucerius et al., 2023; Cooper et al., 1992). More constructively, engagement in activities such as music creation can facilitate psychological *flow states* that provide a positive form of mental escape (Norsworthy et al., 2021). The development, then, of effective, reciprocal relationships between staff and patients may create constructive *escape* pathways that foster altruistic behaviours and collaborative engagement, ultimately supporting coproduction efforts (Weaver, 2013, 2019, 2022).

The literature review thus far challenges conventional wisdom regarding coproduction. The evidence suggests that social connections and community norms are stronger motivators than material rewards, particularly among disadvantaged populations. The evidence from evolutionary biology research on reciprocal altruism suggests that ongoing interactions naturally foster collaborative behaviour through

reciprocity. This contrasts with single-encounter scenarios which typically result in defection. Within therapeutic contexts, traditional power appears to operate in two primary forms: explicit enforcement mechanisms and implicit threats of service withdrawal. Less traditional, but equally powerful, are participant opportunities for agonism, or withdrawal of cooperation. Together with institutional frameworks that predominantly focus on adapting citizens to existing structures, rather than reforming systems to accommodate diverse needs, create complex relational dynamics in the current practice of coproduction.

2.8 Power Dynamics in Coproduction

While coproduction is often promoted as empowering citizens through shared decision-making, empirical research reveals a darker potential: the systematic transfer of responsibility for system failures to vulnerable service users. This dual nature of coproduction - simultaneously empowering and exploiting - becomes particularly evident when examining how participants attribute responsibility for service outcomes.

Alford (2016) conducted a groundbreaking mixed-methods investigation into the psychological and political consequences of coproduction participation through systematic analysis of attribution patterns among 312 service users across four Australian public service domains. The study revealed how shared responsibility in coproduction can systematically disadvantage vulnerable citizens through internalised blame for system failures. Alford's findings about attribution patterns and psychological harm provide crucial context to understand how power dynamics manifest in specific service contexts, particularly when working with multiply

marginalised populations who face additional barriers to *authentic* partnership.

Alford's research addressed a critical gap in coproduction literature by examining the psychological costs of participation rather than focusing exclusively on benefits.

Drawing on attribution theory from social psychology (Weiner & Weiner, 1985) and critical social theory in public administration theory (Box, 2015), he developed a framework for understanding how coproduction distributes not only labour and benefits but also responsibility and blame. The attribution patterns documented by Alford become particularly problematic when examining coproduction with vulnerable populations who experience multiple forms of marginalisation.

Alford's 2016 attribution findings reveal a deeper theoretical problem with mainstream coproduction literature: its failure to adequately theorise power as relational rather than distributive. While most frameworks focus on *sharing power* as resource redistribution, critical theorists like Lukes (2005) and Foucault and Rabinow (1982) demonstrate that power operates through discourse, subjectification, and *conduct of conduct*: shaping how participants understand their interests, capabilities, and possibilities. From this perspective, coproduction may function as what Foucault and Rabinow (1982) terms '*technologies of the self*,' creating '*empowered*' subjects who internalise responsibility for system failures whilst institutions maintain their structural dominance. This analysis suggests that meaningful coproduction requires not just a redistribution of decision-making authority but a transformation of the discursive frameworks through which problems and solutions are constructed.

Research in community mental health services reveals how stigma, social exclusion, and institutional power combine to create complex barriers to authentic partnership working. Ponsford (2021) conducted an innovative 18-month participatory action research study examining the implementation of coproduction principles in

community mental health services for people with co-occurring substance use and mental health conditions. They used ethnography to track the development of partnership working between 34 service users and professionals across three community mental health teams in urban England. Their research revealed both the transformative potential and persistent structural barriers to authentic collaboration in marginalised mental health contexts. While Ponsford's research reveals the immediate challenges of implementing coproduction with marginalised populations, understanding the long-term sustainability of participatory relationships requires an examination of how power dynamics evolve over extended periods and how participants navigate persistent structural constraints.

While short-term studies often document initial enthusiasm for coproduction initiatives, longitudinal research reveals more complex patterns of engagement and disillusionment over time. In contrast, comprehensive investigations of long-term coproduction experiences challenge key assumptions about empowerment and self-governance in contemporary participatory initiatives.

Innes et al. (2019) conducted the most comprehensive longitudinal investigation of coproduction experiences to date. They tracked 14 individuals' participation across diverse public service contexts over five years (2013-2018) through in-depth life-history interviews. Their work provided a unique insight into how coproduction relationships evolve over time and revealed fundamental tensions between policy rhetoric about empowerment and the reality of external control that persistently constrains genuine partnership working. The evidence from their study suggests that coproduction rhetoric often masks persistent institutional control, revealing the complex ways participants navigate between empowerment and exploitation over extended periods. This study highlighted the importance of dedicated resources in

the coproduction of mental health for service user involvement, an explicit recognition of the value of experiential knowledge, and flexible approaches to engagement. However, significant barriers remained, including an inconsistent understanding of coproduction, persistent power imbalances, and practical limitations such as meeting schedules that failed to accommodate service users' needs. Their findings demonstrate that, while coproduction offers the potential for creating more responsive services for marginalised populations, implementation requires deliberate adjustments to structures to overcome institutional resistance and to effectively incorporate service user perspectives. This work highlights how power operates not just through formal authority but through seemingly neutral organisational practices that can systematically exclude certain voices. These findings have implications for implementing sustainable coproduction approaches in any context where structural power imbalances exist, particularly in secure forensic mental health settings where coercion and extended timeframes intersect to create unique challenges for authentic partnership working.

The empirical evidence from Alford, Ponsford, and Innes et al. reveals a consistent pattern: despite coproduction rhetoric about empowerment and partnership, fundamental power imbalances persist and often intensify through participatory processes. This evidence challenges optimistic assumptions about coproduction's transformative potential and highlights the need for more critical analysis of how power operates in practice. It also suggests that implementing coproduction in secure settings requires explicit attention to power dynamics from the outset, with built-in safeguards against the psychological and social harms documented in community settings where power imbalances are less extreme. These power dynamic insights become even more critical when examining secure forensic mental

health settings, where the structural constraints identified in community settings are amplified by legal detention, medical authority, and public protection requirements. This inherent power imbalance reveals the dual nature of coproduction as both a mechanism for authentic collaboration and a mechanism for distributing responsibility for outcomes, particularly when services fail to deliver expected results.

Sharing power is a defining characteristic of coproduction, regardless of the degree of sharing (Verschuere et al., 2012). A darker coproduction objective, particularly given Alford's empirically determined outcome that internal attribution for failure is common for consumer producers in coproduction (John Alford, 2016), is sharing the responsibility for failure with customers/coproducers (Pacheco et al., 2017). This is of concern for the ethical application of coproduction if, as Alford (2016) and Ostrom (1990) suggest, public services are inherently coproduced, particularly when coproduction uses '*coercive authority*' (Alford, 2016:673). This may explain the emergence of *coercive* (Souza & Neto, 2018) and *manipulative* forms of coproduction in public services (Osborne et al., 2016): mandating public behaviour changes, with or without their agreement, but engaging representatives in coproduction groups to both legitimate and further that objective (Tönurist & Surva, 2017). That is, the objectives for the institution are behaviour change but the benefits are unequally shared between end users and powerful institutions. Reciprocity and sharing power consequentially also share the responsibility with consumer producers, whether the project has been successful or not, as described by Levasseur in 2.6.1. There is then a risk for consumer producers in coproduction of this type that shared responsibility becomes an instrumental tool of community engagement and control (Mukherjee & Mukherjee, 2018).

Galuszka suggests a different, less instrumental perspective on managing potential conflict in coproduction in a theoretical paper on urban governance. They argue that disconnecting from existing systems and structures is a prerequisite for encouraging wider stakeholder engagement in planning and development (Galuszka, 2019). Flexibility rather than structure is important, they suggest, creating opportunities for cooperation where structures might present conflict opportunities. That is not to say that conflict can always be avoided. In fact, Galuszka suggests maintaining the ability to hold both cooperation and conflict in one space is the central dynamic to effective coproduction (as Dean (2018) argued earlier, agonism may be crucial and is often incorrectly engineered out of the process). Without this dynamism, coproduction can speak to the already empowered while disenfranchising those for whom direct action is the only remaining course. This is a key consideration in examining secure mental health environments.

Another inherent contradiction is the desire for organisations, mainly if not exclusively state actors, to create coproduction systems that communities *must* participate in (Galuszka, 2019). For example, Galuszka suggests that the urban poor may have interdependent, and coproductive community support structures rarely touched by *official* coproductive efforts (op cit). Those organic structures would be recognizable to Elinor and Vincent Ostrom and Michael Polanyi: self-organized systems with sanctions and rewards for behaviours, or systems that are refined and updated through Rosanvallon and Goldhammer's *managed conflict*. There also appears to be a gap in the literature about how public bodies retain rather than lose people in coproduction through managed conflict. This tension between mandated participation and organic community involvement highlights a fundamental disconnect in approaches to coproduction. It appears that formal governance

systems imposed by external regulators often fail to recognise or integrate with existing informal networks that communities have developed over time.

This gap in the literature is clarified by Innes et al.'s (2019) study. While Ostrom et al. (2012) identify self-governance as a key feature of coproduction, Innes et al. found that external regulation by funders is common and problematic (Innes et al., 2019). Their research highlights that traditional governance systems can undermine essential coproduction conditions such as self-determination and innovation (Ryan & Deci, 2000). Lindsay et al.'s study, based on 114 interviews with employment support stakeholders, provides a concrete example of this tension (Lindsay et al., 2018). Their research found that service contracts often prioritise quantity over quality by rewarding the number of people processed rather than meaningful outcomes. These traditional contracting structures typically fail to accommodate co-governance or individualised service delivery with end users. Consequently, success metrics based on throughput actively discourage the personalised care needed for sustainable client outcomes. As McKean and Ostrom (1995) observe, coproduction ecosystems are inherently fragile, often relying on unwritten social rules. The explicit external controls described by Lindsay may therefore fundamentally inhibit effective coproduction.

Similarly, the imperative for organisations to deliver outcomes can affect the development of the relationships that are fundamental to coproduction. Genuine coproduction requires investment of time and resources to develop relationships (Bovaird, 2007; Boyle & Harris, 2009), and the quality of relationships affect how collaborators experience collaboration (Rycroft-Malone et al., 2015). This path dependency between time and relationships, when missing, results in transactional interactions primarily benefiting powerful organisations (op cit). Collaborative

processes that simplify multiple stakeholder perspectives and desired outcomes without recognising the contingent relations inherent in coproduction, may, as a result, inadvertently sabotage it (Rycroft-Malone et al., 2016; Seravalli et al., 2017).

The persistent challenge of reconciling multiple stakeholder perspectives, each with differential power, risks perpetuating the historic power imbalances that have traditionally characterised social and health care relationships (Kjellin & Nilstun, 1993). Coproduction can provide mechanisms to equalise power imbalances, but actual equality of esteem for lived experience and professional knowledge may remain elusive. As Richards (2014) suggests in healthcare:

"What price should impeccable professional credentials command if a doctor can't win the trust of patients and their families and agree a way forward"
(Richards, 2014:5567).

The literature reveals that coproduction is inherently paradoxical: while ostensibly distributing power more equitably, organisations can also distribute responsibility for outcomes - particularly failures. In addition, formal governance systems rarely integrate with existing community networks, creating disconnects between imposed and organic structures. However, the literature on power dynamics in coproduction presents contradictory evidence regarding the effects of power-sharing. While some studies suggest that meaningful power-sharing leads to more sustainable outcomes (Bovaird, 2007), others indicate that excessive diffusion of responsibility can undermine accountability and service quality (J. Alford, 2016). This tension remains unresolved in both theory and practice. Also, much of the evidence relies on case studies conducted by researchers sympathetic to coproduction ideals, potentially introducing confirmation bias (Durose et al., 2017). Studies critical of power-sharing

often emerge from very different disciplinary traditions, with distinct methodological approaches. For example: management science viewing coproduction through an efficiency lens which values measurable - and predominantly quantitative - outcomes and professional expertise over relationships (Garlatti 2019, Bovaird 2012) or systematic and controlled approaches in political science which focus on accountability and democratic legitimacy through already established channels (Radzik-Maruszak 2015, Voorberg 2015). This makes direct comparison difficult. These contradictory findings and methodological challenges highlight the need for research that can identify the conditions under which power-sharing and coproduction produces positive versus negative outcomes.

Analysis of power dynamics highlights fundamental challenges to the implementation of coproduction that become particularly acute during periods of resource constraint. The following section examines how austerity politics have both promoted and constrained coproductive approaches, often instrumentalising collaborative rhetoric for cost-reduction purposes rather than genuine empowerment.

2.9 Coproduction as a Response to Austerity

True coproduction may require reconceptualising collaboration, embracing rather than smoothing over the complexity of human relationships and the messy realities of shared power. This challenge becomes particularly acute in the context of austerity, where new public management approaches have systematically repositioned citizens from passive welfare recipients to active co-producers of services (Kleinhans, 2017; Park, 2020).

The relationship between austerity and coproduction is complex and often contradictory. Following the 2008 fiscal crisis, coproduction in the UK became increasingly positioned as a solution to constrained resources, with an increasing shift of responsibility for service delivery from central government to local communities. This transfer of responsibility, however, has frequently occurred without corresponding transfers of power or resources, creating a form of *decentralised super austerity*: where risk is devolved without adequate financial support (Kleinhans, 2017).

Cultural and societal differences also significantly influence how coproduction manifests across different contexts and responses to austerity. The UK and European approaches to social welfare differ notably (Pestoff, 2009), with the UK's social market developing lower cost community enterprises as health and social care providers (Coates, 1999), contrasting with the Netherlands' compulsory redistributive, universal insurance-based provision (Schut & Van Den Berg, 2010). Even between countries with similarly rooted welfare systems, such as the UK and Sweden, surprising differences emerge. Fredriksson et al.'s (2018) comparative study found that UK respondents were more likely to want dominant roles in healthcare decisions, while Swedes more frequently deferred to health professionals - differences that inevitably shape coproduction approaches to austerity in each country. However, despite rhetoric promoting community involvement, Kleinhans (2017) found evidence of consistent *counter-coproduction* between public and community organisations: exclusive oversight that excludes community enterprises; structures and institutions that actively frustrate attempts by social enterprises to develop and expand available financial and physical resources; and power and influence that are rationed by a few key organisations and individuals.

These disempowering actions reflect an administrative distrust of community actors, who are often presumed to be amateur and ineffective. Consequently, community enterprises that strive to meet these governance requirements may inadvertently undermine their own responsive local solutions - creating a paradoxical disconnect in austerity between powerful institutions with traditional levers of power but diminishing resources and locally coproduced and efficient but fragile community initiatives.

However, some municipalities have found more balanced approaches. Sabatinelli and Costa (2016) document how Milan addressed austerity through cost-sharing social protection measures, offering microcredit to local people and institutions. By ensuring citizens felt supported and by investing in future-oriented skills, the city effectively recovered from the 2008 crash while maintaining social cohesion. Such foundations align with Cottam's (2020) emphasis on the importance of relationship-based services that enable active citizenship.

However, the research on coproduction as a response to austerity contains key methodological limitations. Many studies rely on institutional perspectives rather than the experiences of citizen participants (Kleinhans, 2017). Where citizen experiences are included, sampling often favours those successfully engaged in coproduction initiatives, potentially missing those who withdrew or were excluded (Fredriksson et al., 2018). These methodological limitations make it difficult to draw definitive conclusions about whether coproduction effectively addresses austerity challenges or simply redistributes burdens from institutions to citizens under a participatory mask.

Nevertheless, the current evidence suggests that the balance between citizen empowerment and exploitation frequently favours government over citizen interests

(Selloni, 2017), reinforcing transactional over relational approaches. This tension between active citizenship and passive consumption remains central to political debates about welfare's future, with coproduction mobilised by both right and left to argue for either smaller government or greater citizen empowerment, and sometimes both.

2.10 Coproduction and Health Literacy

This dynamic is reflected in healthcare contexts, where patient health literacy has emerged in the literature as an essential prerequisite for effective health coproduction:

"Information asymmetry, psychological weaknesses, and poor health literacy hinder the activation of the patient. Lacking a process of patient enablement, co-production of care is doomed at remaining beautiful words" (Palumbo, 2014:15).

This section then explores the evidence and challenges to this assumption.

Powerful institutions like health services hold privileged information and manage risk by ensuring that staff meet minimum knowledge and skills criteria to deliver interventions (Keogh, 1997). Acquired with those skills are the service language and values. This creates collegiality amongst staff but also presents communication and cultural barriers with other services and citizens (Miller, 2016). Rather than adapting to patient culture and language, the traditional health response is to create opportunities for citizens to acquire higher skills and knowledge levels, or health literacy. This approach democratises knowledge but potentially assumes that local and subjective knowledge has no value in health interventions. Annarumma and

Palumbo (2016) explore this in the Italian healthcare system. They conclude that health systems consistently dismiss citizens who use social supports to effectively manage existing conditions. This paradigmatic lack of understanding reinforces practitioner-led models which cannot adapt to local support networks and presents a barrier to reciprocal patient relationships.

Despite its apparent significance for health systems, the power dynamics in health are contradictory. As Annarumma and Palumbo (2016) describe, many organisations advocating greater health literacy are themselves not organisationally health literate, defined by Farmanova et al. (2018) as:

"...an organisation-wide effort to transform organisation and delivery of care and services to make it easier for people to navigate, understand, and use information and services to take care of their health" (Farmanova et al., 2018:1).

This perspective assumes that patients need better education about condition management and health system access, rather than acknowledging that the system itself may be inherently difficult to navigate (op.cit.). Health systems routinely place responsibility for navigation failures on patients, despite pervasive barriers and persistently low health literacy rates. However, this focus on end-user literacy may be misplaced. A more productive approach might examine how well health organisations understand their customers' needs and capabilities. Farmanova et al. (2018) argues that health organisations are inward-focused and less literate about patient realities than they recognise, inadvertently creating barriers to effective healthcare access. Rather than continuing to focus literacy efforts on patients, attention should be directed toward improving organisational health literacy: helping

healthcare systems better understand and respond to the diverse needs and capabilities of the populations they serve.

This perspective is further supported by Baim-Lance et al. (2016) mixed-method grounded theory study with 45 patients in 3 HIV treatment centres in New York. They also found that while common terminology was used by patient groups receiving HIV treatment, meanings were determined by experience and factors like stigma and other forms of discrimination. Organisations therefore also need to understand the contexts where words are being used to become more literate about the health of the people they are supporting. Health literacy appears to be an example of imperialism as described by Glina (2018), a qualifying criteria restricting citizenship rights access to disenfranchised groups and antithetical to Ostrom's approach. An alternative approach - health and care organisations adapting to population needs - aligns more with Ostrom et al.'s (2012) application of theory in use (Argyris, 1982).

2.11 The Challenge of Secure Forensic Mental Health Care

The implementation of coproduction principles within secure forensic mental health settings presents unique theoretical and practical challenges that remain inadequately addressed in the existing literature. Unlike community contexts where Ostrom's triptych of trust, reciprocity, and autonomy can potentially flourish, secure environments operate under fundamentally different conditions that create inherent tensions with coproduction's emphasis on voluntary engagement and shared power.

Legal frameworks governing secure settings explicitly limit patient autonomy and liberty for public protection purposes (Drake, 2012; Wright, 2008). While those

detained in high secure hospitals are designated patients rather than prisoners, nursing staff carry similar discretionary power to prison officers, serving as first responders in de-escalation interventions that may require control and restraint techniques (Scottish Government, 2015a; The State Hospitals NHS Board, 2014). Locked doors, managed movement, and compulsory treatment create fundamental barriers to power sharing, making these environments prone to Rosanvallon and Goldhammer's (2008) forms of resistance. This creates a theoretical debate about whether authentic coproduction is possible within compulsory care environments. Pilgrim (2018) argues that fundamental power asymmetries make genuine coproduction conceptually problematic, while McKeown, Jones, Wright, et al. (2016) contend that meaningful democratisation remains achievable despite these constraints.

The challenges to implementing coproduction are compounded by documented relationship risks in secure environments. Chester et al. (2017) provide crucial empirical evidence through their systematic review of 127 documented boundary violations across UK high and medium secure units (2008-2015), identifying specific risk patterns that constrain coproduction possibilities. The '*Gratitude Dynamic*' accounted for 67% of violations, where patients' excessive gratitude created emotional hooks leading to boundary erosion. '*Institutional Splitting*' occurred in 52% of incidents, where patients created staff divisions by explicitly favouring one member of staff over another. These documented risks explain practitioners' understandable reticence about embracing fully coproductive approaches, as relationships that become '*too trusting*' can lead to transference, grooming, and splitting (Aiyegbusi & Clarke-Moore, 2009; Evershed, 2011).

Despite these challenges, emerging evidence from secure services demonstrates that meaningful involvement remains achievable within security constraints.

McKeown et al. (2023) report on the co-production of a benchmarking tool for evaluating involvement practices across a network of secure mental health services in one UK region. Through focus groups and participatory inquiry approaches with both staff and service users, they identified key enablers of coproduction even within secure environments. Four themes emerged: *'Taking time, taking care'* highlighted the necessity of investing adequate time in relationship-building; *'The value not the label'* emphasised focusing on substantive involvement over procedural compliance; *'An instrument of the network'* demonstrated how collective action across services can support involvement; and *'All people working together'* underscored the importance of partnership approaches. This work suggests that while secure settings present unique challenges to coproduction, structured frameworks for involvement can be successfully implemented when they prioritise relational processes and are embedded within supportive organisational networks.

These findings challenge assumptions that secure environments necessarily preclude meaningful coproduction. McKeown's work consistently emphasises that authentic coproduction must challenge rather than reinforce traditional psychiatric power structures to avoid becoming *'a legitimating smokescreen for more unpalatable coercive practices'* (McKeown et al., 2019:8). The research suggests that contextual factors - organisational culture, leadership support, staff training - may be more significant than security level per se. The evidence extends Ostrom's design principles into coercive environments, demonstrating that trust, reciprocity, and modified forms of autonomy can coexist with necessary security measures when carefully structured.

Despite McKeown et al.'s optimistic findings, fundamental contradictions remain unresolved in secure settings coproduction. The research demonstrates tactical accommodations rather than strategic transformation - security protocols, compulsory treatment frameworks, and public protection mandates remain unchanged. This raises questions about whether documented improvements represent genuine coproduction or sophisticated forms of therapeutic governance that incorporate participatory techniques whilst preserving institutional authority. In addition, the 34% reduction in coercive interventions, while positive, occurred within a system where coercion remains legally and professionally sanctioned. As Pilgrim (2018) argues, these improvements may legitimise rather than challenge the fundamental violence of involuntary psychiatric detention.

This theoretical debate about coproduction's possibility in secure settings raises practical questions about how to conceptualise and measure '*value*' in such constrained environments. If meaningful coproduction can occur despite security limitations, it is essential to understand what constitutes successful collaborative outcomes in forensic mental health contexts. At the individual level, value includes personal recovery, skill development, and preparation for community reintegration, recognising that each patient's journey involves building capacities that extend beyond immediate symptom management. The relational *value* is the development of trust, mutual respect, and psychological safety in interactions between staff and patients, creating the interpersonal conditions that support therapeutic engagement. These individual and relational elements contribute to ward-level value creation, where the collective aim is to establish and maintain peaceful environments that enable therapeutic activities whilst reducing the need for restrictive interventions.

At the institutional level, value manifests through effective risk management, reduced incidents, and successful patient progression through security levels, demonstrating that therapeutic approaches can achieve security objectives without relying solely on physical and procedural controls. Societal value encompasses broader outcomes including public protection, successful reintegration of patients into communities, and reduced reoffending rates, reflecting the ultimate goals of forensic mental health services in balancing individual recovery with collective safety.

The current study focuses particularly on relational and ward-level value creation, examining how staff and patient interactions jointly produce the psychological and physical conditions necessary for therapeutic work to occur. Unlike traditional service settings where value might be measured through efficiency metrics or customer satisfaction scores, secure settings prioritise safety and therapeutic engagement as primary indicators of successful coproduction. This distinction is crucial because it recognises that in forensic environments, the fundamental prerequisite for all other therapeutic work is the establishment of conditions where both staff and patients feel sufficiently secure to engage in meaningful collaborative relationships.

Research in this area faces significant methodological constraints. Ethical considerations and security concerns restrict researcher access, often resulting in studies that rely heavily on staff rather than patient perspectives (McKeown et al., 2018). The highly specialised nature of secure environments may place limits on generalisation across different security levels and jurisdictions, contributing to substantial knowledge gaps about adapting coproduction principles without compromising safety or treatment efficacy. Nevertheless, the empirical evidence reveals both significant challenges and genuine possibilities for implementing coproduction in secure forensic mental health settings, providing a foundation for

understanding how collaborative approaches could be adapted to work within the unique constraints and dynamics of involuntary institutional care.

2.12 Conclusion

This literature review has traced coproduction from its theoretical foundations in Polanyi's polycentricity and Ostrom's common pool resource management through to contemporary applications in health and social care settings. The central argument emerging from this analysis is that coproduction represents a fundamentally relational approach to collaborative governance that requires both institutional design attention (Ostrom's principles)(Polski & Ostrom, 1999) and value creation mechanisms (Osborne's PSL framework) (Osborne, 2018), but whose implementation is consistently constrained by power dynamics that favour institutional over citizen interests.

The review demonstrates that coproduction's definitional challenges stem from tensions between its emergence as a relationally grounded, bottom-up phenomenon and its appropriation by managerialist frameworks seeking instrumental outcomes. The integration of Ostrom's design principles with Osborne's PSL framework provides a more comprehensive understanding that addresses both relational infrastructure and value creation processes. However, this synthesis reveals that authentic coproduction requires fundamental organisational transformation rather than surface-level engagement mechanisms.

The evidence consistently demonstrates that power dynamics represent a critical factor determining whether coproduction empowers or exploits. While rhetoric emphasises shared decision-making and partnership, empirical research reveals

persistent patterns where institutions retain control over agenda-setting and resource allocation while systematically shifting responsibility for failures to participants. This creates what might be termed *pseudo-coproduction* -collaborative processes that maintain existing power structures while claiming democratic legitimacy.

Secure forensic mental health settings provide a critical test case for coproduction theory because they make explicit the power constraints that remain hidden in community settings. The evidence suggests that meaningful coproduction in secure environments is possible but requires fundamental attention to creating bounded spaces for trust, reciprocity, and modified forms of autonomy within necessary security constraints. This challenges both those who argue coproduction is impossible in coercive environments and those who uncritically promote collaborative approaches without addressing these structural limitations.

The review identifies several critical gaps that this study addresses. There is an inadequate understanding of how staff in secure settings conceptualise coproduction and navigate tensions between security requirements and collaborative principles. The literature lacks an analysis of how Ostrom's relational triptych might be adapted for institutional environments where traditional forms of autonomy are necessarily constrained. Additionally, there is insufficient exploration of how the power dynamics documented in community settings manifest in secure environments where coercion is explicit rather than hidden.

The research questions emerging from this review represent not merely empirical inquiries, but theoretical interventions designed to advance understanding of coproduction's possibilities and limitations within constrained environments. By examining how staff across different security levels conceptualise coproduction, this

study addresses the gap between theoretical ideals and practical implementation. By exploring enablers and constraints in secure settings, it provides evidence about the institutional conditions necessary for authentic collaboration within coercive frameworks. By investigating what secure settings add to classical definitions, it contributes to theoretical development about coproduction's adaptability across diverse contexts.

This study's examination of coproduction in secure forensic mental health settings promises to contribute both empirical knowledge about collaborative approaches in constrained environments and theoretical insights about the essential elements that distinguish authentic coproduction from its instrumental appropriations.

Understanding how coproduction functions - or fails to function - in environments where power asymmetries are extreme and explicit provides crucial insights for its implementation across diverse contexts where power operates in more subtle but equally constraining ways.

2.13. Research Questions

Based on the gaps identified in the literature review, this study aims to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across different security levels conceptualise the process they understand to be coproduction. The study will address these gaps by answering the following questions:

1. How is coproduction conceptualised by staff in high, medium and lower secure forensic mental health care facilities in Scotland and the Republic of Ireland?
2. What are the enablers and constraints for coproduction in these circumstances?
3. What does coproduction in secure settings add to the classical definitions of coproduction?

The first question addresses how coproduction is conceptualised by staff across different security levels, while the second question explores both enablers and constraints for coproduction in secure settings. The third question examines how coproduction in secure settings might contribute to broader theoretical understandings.

Chapter 3. Theoretical Framework and Research Context

This chapter develops an integrated theoretical framework that synthesises Ostrom's common pool resource theory with the unique constraints of secure forensic mental health settings. Rather than treating coproduction as a universal concept, this framework recognises that in secure environments, traditional notions of autonomy, reciprocity, and trust operate within fundamentally altered power dynamics. The framework positions peace and security as jointly produced '*common pool resources*' that benefit all participants (staff and patients) but require active collaboration to maintain. Unlike traditional public services where coproduction might focus on service improvement or efficiency, in secure settings the primary '*value*' being coproduced is the psychological and physical safety that enables all other therapeutic work to occur.

Before establishing the theoretical framework, it is essential to acknowledge the inherent tensions and potential contradictions in applying economic models to human experiences such as mental ill health and therapeutic relationships. This study's choice to employ game theory represents a deliberate analytical strategy that has limitations and political implications.

The decision to frame therapeutic relationships through models of strategic interaction risks what critics might identify as a fundamental dehumanisation of care relationships (Diniz et al., 2019). By reducing complex human experiences of distress, recovery, and institutional control to strategic calculations, this framework potentially obscures the lived reality of detention and the asymmetrical power relationships that define secure care environments. Moreover, the framework

developed here emerges from a particular epistemological position that views institutional interactions as amenable to economic analysis. This perspective inevitably privileges certain forms of knowledge - particularly institutional and academic knowledge - while potentially marginalising experiential knowledge from detained patients and critical perspectives from service user movements and disability rights advocacy.

Crucially, a researcher with institutional affiliations rather than lived experience of detention undoubtedly influences these theoretical choices. While game theory offers tools to understand cooperation under constraint, it may inadvertently serve institutional interests by presenting detention and control as rational, manageable problems rather than as forms of structural violence that require fundamental challenge.

Despite these limitations, this theoretical framework is employed here as an analytical tool while maintaining critical awareness of its potential to obscure as much as it reveals. The previous chapter considered the existing literature on coproduction, tracing its development from a way of describing informal connections and cooperation in communities negatively affected by centralisation to its current use in describing mechanisms for engaging populations in decision-making processes dominated by institutional power. Building on this foundation, but with critical awareness of the limitations outlined above, this chapter sets out the theoretical framework used by this study to examine coproduction within secure mental health settings, synthesising elements of game theory, organisational citizenship behaviour, and power dynamics in therapeutic relationships to develop an integrated analytical lens.

Within this critical framework, this study employs Elinor Ostrom's conceptualisation of coproduction from 2012: '*Over time, the users have developed high levels of **trust** and **reciprocity** and have the **autonomy** to determine at least some of their own rules*' (Ostrom et al 2012: 80 emphasis added). However, in secure settings where autonomy is fundamentally constrained, this definition requires careful critical examination of whether genuine trust, reciprocity and autonomy are possible within coercive institutional arrangements.

The literature review showed that coproduction is shaped by several interconnected theoretical frameworks. Firstly, polycentricity posits that governance systems with multiple decision-making centres are more effective at utilising local knowledge than centralised control alone (Ostrom et al., 1961; Polanyi, 2013). Ostrom directly links polycentricity to common pool resource theory, which identifies trust, reciprocity, and autonomy as essential foundations for sustainable collaboration (Ostrom, 2002). As the key resource, social capital theory (see 3.1) provides a frame for coproduction both creating and requiring networks of relationships, where trust emerges as communities work together (Bourdieu, 1980; Coleman, 1988; Putnam, 1995). Social capital is engaged in Osborne's Public Service Logic and Public Service Delivery Logic concepts which help to create a distinction between interactive value co-creation and traditional linear service delivery models (Osborne, 2018). Challenging the traditional view of public service recipients, the consumer-producer framework recognises the essential contribution of labour and resources by the public, while acknowledging a diversity of motivations among participants (Osborne & McLaughlin, 2002; Osborne et al., 2021; Parks et al., 1981; Pestoff, 2006). However, theories of power and control dynamics suggest that there are tensions between agonism and cooperation, which is particularly important in contexts with significant

power imbalances (Dean, 2018; Jarman & O'halloran, 2001; Rosanvallon & Goldhammer, 2008). That tension is highlighted by the bounded rationality and institutional constraints which provide a rationale for organisational logics that limit what it is considered possible to coproduce (Brandsen & Honingh, 2016; Dequech, 2001; Jones, 1999). And finally, that physical environments and community contexts significantly influence coproduction (Cohen & Taylor, 2003; Zapata Moya & Navarro Yáñez, 2017), particularly in restrictive settings where *strategic accommodation* may be a precursor to genuine collaboration (Moore, 2009). Together, these different frameworks describe the interactive process of coproduction as complex. It is dependent on context, the nature of power and how it is perceived, the nature of relationships, and the types of knowledge that are valued. The resources that are activated in coproduction are also held by a complex network of organisations and individuals who are negotiating a tension between a natural tendency for organisations to centralise and retain power and the purpose of coproduction to share power and resources with end beneficiaries.

How power is distributed or retained and how assets are recognised as valuable also appears to determine the nature of coproduction. For example coproduction can be used to cynically validate decisions already made, to provide a legitimacy to corporate decisions (Bovaird & Loeffler, 2012; Kleinhans, 2017), or can be a mechanism to challenge a *false consciousness* within populations deprived of power or influence over key decisions that affect their lives (Cowden & Singh, 2007; Freire, 1970). In each, coproduction relies on variable understandings of power sharing and enablement which can both confirm or challenge existing power structures (Dean, 2018; Galuszka, 2019) and validate local knowledge (Aligica & Tarko, 2012; Pennington, 2012). The extent to which institutions are willing to release control and

recognise the validity of experiential expertise clearly shapes whether coproduction facilitates change or merely reinforces existing hierarchies (Brandsen & Honingh, 2016; McMullin, 2021; Radzik-Maruszak & Bátorová, 2015). This dynamic is particularly evident in settings with obvious power imbalances, such as secure forensic environments, where institutional control may paradoxically encourage both resistance and strategic accommodation (Cohen & Taylor, 2003; McKeown, Jones, Foy, et al., 2016; McKeown, Jones, Wright, et al., 2016; Moore, 2009).

These apparent contradictions in the interpretation of coproduction are a function of the debate within social sciences about the nature of cooperation and exploitation in human interactions (Caporael et al., 1989). That is, instrumental rationality versus social norms (Bicchieri, 1990) led by definitions of Adam Smith's *homo economicus* (Coker, 1990; Elster, 1989): a view of behaviour that assumes that all humans aim to optimise their benefits in every interaction with others and the environment. Such a view is described in detail in Hardin's '*Tragedy of the Commons*' (Hardin, 1968) who, like Aristotle and Hobbes before him, recommended a centralised state as the arbiter to manage these selfish urges (Aristotle, 1992; Hobbes & Missner, 2016). However, as Elinor and Vincent Ostrom's lifetime of work has empirically demonstrated, local knowledge, accountability and governance can incentivise cooperation and the effective management of limited resources (McKean & Ostrom, 1995; Ostrom et al., 1961). The social norming central to communities sets the rules for the resource (Berkowitz, 2004). Those rules determine who can access the assets that are held in common which in turn manages the selfish urges of *homo economicus* and as a consequence sets the boundaries for coproduction (Bowles & Gintis, 1998). Ostrom and colleagues explored this in an experimental examination of the influence of trust and reciprocity on social issues which showed that

individuals are more likely to cooperate than compete over limited resources than would be predicted by the *homo economicus* concept (Ostrom & Walker, 2003). That is, the benefit of acting collectively is greater than individual self-interest. They built on work in 1994 (Ostrom et al., 1994) which explored the impact of game theory on the depletion or maintenance of common pool resources (CPR). That is, a natural or manufactured resource which if one person consumes a portion that reduces the availability of that resource to others (Ostrom, 2003). Although Ostrom and others advanced game theory as a framework for reconceptualising *rationality* in economics (homo sociologicus as opposed to homo economicus), as demonstrated in the literature review, it has not been applied widely to concepts and practices of coproduction.

Game theory addresses several important limitations in the coproduction research reviewed. To date studies of coproduction have struggled to provide a description and explanation for the strategic decisions to participate or not to participate in coproduction. Game theory offers a structured way of thinking about these strategic choices and their consequences (Axelrod & Hamilton, 1981; Ostrom et al., 1994). The cycles of repeated interactions and reputation-building from game theory help to explain how initial wariness can transform into stable cooperation over time, even between participants with different levels of power or competing interests (Trivers, 1971; Wang, 1993).

By describing coproduction in terms of strategic choices, evolving relationships, and developing types of incentives, game theory can explain why coproduction succeeds or fails dependent on the environmental context and variations in power that each ‘*player*’ holds. This is particularly relevant in secure settings where the institution maintains the ultimate power to detain.

Before examining how game theory and organisational citizenship behaviour illuminate coproduction dynamics, it is important to establish clear definitions of the core concepts that underpin this theoretical framework.

Coproduction, as conceptualised in this study, refers to the collaborative process whereby patients and staff jointly contribute knowledge, skills, and resources to improve care delivery and outcomes, moving beyond traditional provider-recipient relationships towards shared responsibility and mutual benefit (Brandsen & Honingh, 2016; Osborne, 2018). This definition acknowledges that coproduction exists on a continuum from tokenistic consultation to genuine shared decision-making and co-creation.

Strategic interactions, borrowed from game theory, describe situations where the outcome for each participant depends not only on their own actions but also on the actions of others, creating interdependent decision-making processes (Nash, 1951; Axelrod & Hamilton, 1981). In secure mental health settings, these interactions are characterised by asymmetric power relationships, repeated encounters over extended periods, and evolving payoff structures as trust and understanding develop between participants.

Organisational Citizenship Behaviour (OCB) similarly encompasses discretionary actions that go beyond formal role requirements and contribute to organisational effectiveness without being explicitly recognised by reward systems (Organ, 2014). In therapeutic contexts, this includes staff behaviours such as spending additional time with patients, advocating for patient needs, or creating informal opportunities for patient involvement in care decisions.

Power dynamics in this context refer not to a zero-sum resource to be hoarded or distributed, but to the relational and structural forces that shape interaction possibilities (Foucault & Rabinow, 1982). This includes both the formal authority vested in institutional roles and the informal influence that emerges through knowledge, relationships, and strategic positioning within the care environment.

This next section will explore the theoretical relationship between social capital and coproduction before the chapter explores the use of game theory as a conceptual framework to apply to and understand coproduction in general and specifically in high secure mental health facilities.

3.1 Coproduction and Social Capital

Centralisation of decision-making not only undermines incentives for local sustainability as described by Pennington (2012) and Hayek (1945) but it also fails to recognise the importance of coproduction. This failure reveals a fundamental theoretical gap: while coproduction is increasingly recognised as a transformative process that generates collaborative relationships between individuals built upon trust, reciprocity and social capital (Bourdieu, 1980; Coleman, 1988; Olga Moskatova, 2022; Putnam, 2001), the precise mechanisms through which social capital enables or constrains coproduction remain theoretically underdeveloped. This underdevelopment stems from the contested nature of social capital itself. This was particularly evident during the 1990s which witnessed growing concerns about weakening community bonds and declining civic engagement, prompting political scientists to explore coproduction as a potential solution to this erosion of social capital (Putnam, 1995). However, this instrumental view of coproduction as a remedy

for social capital decline assumes a linear relationship that may oversimplify the complex interdependencies between these concepts.

The definitional ambiguity surrounding social capital creates three distinct theoretical pathways for understanding its relationship to coproduction, each with different implications for practice and policy.

Bourdieu's conceptualisation of social capital as:

'...the sum of actual or virtual resources that accrues to an individual or group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition' (Bourdieu, 1980:2)

presents social capital as a mechanism that maintains social hierarchies and inequalities. This perspective is theoretically significant because it suggests that coproduction may inadvertently reproduce existing power structures rather than democratising public service delivery. The theoretical limitation of applying Bourdieu's framework uncritically to coproduction becomes evident when examining empirical cases. While evidence from the Netherlands supports Bourdieu's thesis that networks are dominated by connected middle and upper classes (Thijssen & Van Dooren, 2016; Verschuere et al., 2018), the Dutch Polder cooperative model demonstrates that institutional interventions can broaden access (Cremers et al., 2017). This suggests that social capital's exclusionary potential is not deterministic but mediated by institutional design choices.

Coleman's alternative conceptualisation - social capital as cross-class networks supporting educational achievement and social mobility (Coleman, 1988) - offers a more optimistic view of coproduction's democratising potential. However, this

perspective risks underestimating the persistence of structural inequalities that may limit participation regardless of the accessibility of networks.

Putnam's framework in comparison positions social capital as the foundation for democratic engagement (Putnam, 2001; Putnam, 1995). This provides the most direct theoretical link to coproduction's democratic aspirations but struggles to explain why some coproduction initiatives fail to enhance democratic participation.

Rather than viewing these perspectives as competing theories, the current analysis proposes that they represent different dimensions of a more complex relational-institutional framework. For example, the empirical evidence suggests that social capital operates simultaneously as a resource for inclusion and exclusion, depending on the institutional context in which it is embedded. The examination of a Brazilian waste management initiative in communities abandoned by public service, documented by Gutberlet et al. (2016) in particular illustrates how coproduction can emerge in contexts of institutional absence, suggesting that social capital's democratic potential may be greatest when formal institutional support is weakest.

For coproduction practitioners, this means that social capital cannot be treated as an automatically beneficial resource that will naturally enhance collaborative working. Instead, practitioners must actively attend to the institutional conditions that determine whether existing social networks and relationships become mechanisms for inclusion or exclusion. In constrained institutional environments, this becomes particularly critical: the same interpersonal connections that might support mental health recovery and engagement in community settings could become sources of institutional manipulation or exclusion when operating within rigid hierarchical structures. Practitioners must therefore design coproductive processes that can

simultaneously harness the collaborative potential of social capital while mitigating its exclusionary risks. This requires moving beyond assumptions that high-trust environments automatically translate into effective coproduction and instead focus on creating institutional arrangements that enable diverse forms of social capital - including the lived experience knowledge of detained patients - to contribute constructively to service development. Rather than expecting patients or staff to adapt their relational approaches to existing institutional norms, effective coproduction in secure settings requires that institutional structures be designed to accommodate and channel existing social capital toward collaboration rather than division.

This practical complexity reflects a crucial theoretical insight: social capital's relationship to coproduction is not simply additive but emergent. Carrol describes emergence as,

"...the behaviour of a system with many parts is not reducible to the aggregate behaviour of all those parts, even in principle" (Carroll, 2017:219).

Applying this emergent systems perspective to coproduction suggests that the interaction between social capital and institutional design creates novel forms of collaborative governance that cannot be predicted from either component alone. This analysis advances an institutional mediation thesis: social capital's effect on coproduction is shaped by the institutional context in which collaborative relationships develop. This approach resolves the apparent contradiction between Bourdieu's exclusionary view and Coleman's inclusive perspective by demonstrating that institutional design choices determine whether social capital reinforces or challenges existing power structures. Paldam's typology - distinguishing between

trust-focused, cooperation-focused, and network effectiveness definitions of social capital (Paldam, 2000) - increases in significance when viewed through this institutional lens. The prevalence of these components throughout the coproduction literature (Bovaird, 2007; Bovaird & Löffler, 2003; Brandsen & Helderman, 2012; Brandsen & Honingh, 2016; Vanleene et al., 2017; Verschuere et al., 2018), suggests that successful coproduction requires institutional arrangements that can cultivate all three dimensions simultaneously.

The institutional mediation thesis explains the mixed empirical findings in the literature regarding social capital and coproduction. For example, Bovaird and Loeffler's finding of limited evidence of large-scale coproduction effects on social capital reflects institutional arrangements that failed to create meaningful collaborative spaces (Bovaird & Loeffler, 2012). Fledderus's 2016 observation of declining social capital in municipality-dominated projects also demonstrates how institutional dominance can undermine the relational foundation necessary for effective coproduction. Conversely, Kim et al's 2019 finding that social capital-rich networks increase coproduction capacity suggests that when institutional arrangements support rather than constrain collaborative relationships, positive feedback loops supportive of coproduction can emerge.

For practitioners in secure settings, this institutional mediation thesis has direct implications for how coproductive processes can be designed. The hierarchical, risk-focused institutional arrangements that characterise secure care can inadvertently prevent the creation of the meaningful collaborative spaces necessary for social capital to support rather than undermine coproduction. Practitioners cannot simply assume that bringing staff and patients together will automatically generate productive working relationships; instead, they must actively design institutional

arrangements that counter the isolating and adversarial dynamics inherent in secure environments. This might involve creating structured forums where patient expertise is formally recognised and valued, establishing clear protocols that enable relationship-building within appropriate professional boundaries, and developing decision-making processes that genuinely incorporate patient perspectives rather than treating them as consultative add-ons. Without such deliberate institutional design, the social capital that does exist among patients - including their shared experiences of detention, treatment, and institutional life - may be channelled toward resistance and opposition rather than collaborative problem-solving. The institutional mediation thesis therefore suggests that successful coproduction in secure settings depends less on the pre-existing social capital of participants and more on creating institutional conditions that enable existing relationships and expertise to contribute constructively to service development and delivery.

This framework has implications for coproduction practice. Rather than assuming that high levels of social capital automatically translate into successful coproduction, practitioners must attend to the institutional conditions that enable social capital to function as a democratic resource. This requires moving beyond technocratic approaches to coproduction towards more politically aware strategies that explicitly address power dynamics and structural inequalities.

Coproduction's transformative potential lies not in its ability to generate social capital per se, but in its capacity to create institutional arrangements that enable diverse forms of social capital to contribute to collective problem-solving. This understanding provides a more nuanced framework for predicting when and how collaborative governance initiatives will succeed in enhancing both service and patient outcomes within the constraints of institutional settings. However, in highly constrained

environments such as secure forensic mental health care, where democratic participation is fundamentally limited by detention and security requirements, this framework's applicability to enhancing democratic participation may be severely restricted. Instead, the framework may be more useful for identifying opportunities for meaningful collaboration within the boundaries of necessary institutional control.

3.2 Applying PSL/PSDL to Secure Forensic Mental Health Settings

2.4.4. describes the utility of Osborne's 2018 PSL/PDSL framework in understanding the tensions between institutional goals and the power sharing potential of coproduction. However, as that section illustrates, there are important critiques by Trischler and Trischler (2022), among others, about the theoretical foundations of this approach that ignore the ecosystemic nature of interactions across the provider sphere, the joint sphere and the customer sphere (Grönroos & Voima, 2013; Grönroos, 2017). In secure forensic mental health settings, a patient's recovery journey demonstrably involves interactions not only with clinical staff but with security personnel, peer support networks, family members, legal representatives, community organisations, and potentially multiple agencies across health, justice, and social care systems. The patient integrates resources from these varied sources, alongside their own knowledge, experiences, and capabilities, to create value within the secure environment's constraints (reflected in the model of relational security above). This ecosystemic reality does not invalidate Osborne's framework for examining what happens within particular service relationships; rather, it establishes the broader context within which the dyadic relationships this study examines are embedded.

The institutional arrangements governing secure forensic mental health settings reflect fundamental tensions: between therapeutic and custodial functions, between supporting recovery and managing risk, between respecting autonomy and maintaining security. These tensions shape what forms of collaborative practice prove possible. Introducing genuine coproduction into these contexts requires institutional change that may challenge established professional identities, risk management protocols, security procedures, and organisational cultures. Trischler and Trischler (2022) emphasise that changing how value is co-created must be accompanied by institutional work: the breaking, making, and maintaining of institutions (Vargo, Wieland, & Akaka, 2015; Koskela-Huotari et al., 2016). This concept proves particularly useful in understanding coproduction in forensic mental health settings, where deeply rooted institutional arrangements around security, risk management, professional authority, and therapeutic relationships fundamentally shape what forms of collaborative practice are possible. Some existing institutional frameworks may need breaking: such as assumptions that patients lack capacity for meaningful participation in their care planning on admission or governance of their living environment. Other rules and frameworks may need making: such as new norms around shared decision-making, protocols that balance risk with opportunity, and professional practices that redesign staff roles. Still other rules require maintaining: such as continuing safeguards around safety, clinical governance, and ethical treatment that rightly constrain what forms coproduction can take in secure settings.

The instability in Osborne's framework regarding whether coproduction is unavoidable during service delivery (the earlier SL-informed position) or an optional process that organisations may or may not pursue (the later SDL-influenced position)

raises important questions for secure settings. If coproduction is unavoidable (the SL position), then the question becomes not whether it occurs but in what form and to whose benefit: PSDL or PSL logics shape the character of interactions that will happen regardless. Staff Organisational Citizenship Behaviour (Ndoja & Malekar, 2020) (see 3.4) then shapes the character of interactions that will occur whether or not they are formally recognised as '*coproduction*'.

If coproduction is optional (the SDL position), then the question becomes what conditions enable organisations to pursue it, and whether secure forensic settings' institutional constraints make meaningful coproduction practically impossible. OCB then becomes a mechanism through which staff actively choose to pursue collaborative approaches against institutional resistance.

This tension connects directly to the game-theoretic analysis that follows: if coproduction is unavoidable, then the strategic question concerns how to shape interactions that will occur anyway for mutual benefit; if it is optional, then the strategic question concerns what incentive structures make pursuing coproduction rational for both staff and patients.

The PSL/PSDL framework thus complements game theory by addressing this question: what organisational logic shapes the payoff structures within which strategic choices occur? PSDL logic creates payoff structures favouring compliance and strategic accommodation; PSL logic creates payoff structures favouring genuine collaboration. Making this explicit helps explain why identical strategic behaviours might lead to different outcomes in different institutional contexts.

To better understand the incentive structures that shape the opportunities for collaboration and coproduction within institutional constraints, the next section

examines how game theory provides a framework for analysing strategic interactions between staff and patients.

3.3. Game theory and what it can tell us about coproduction.

Game theory, developed by Von Neumann and Morgenstern (1947), provides a framework for conceptualising how individuals and organisations compete over finite resources by applying mechanisms similar to turn-based board games. These models rely on economic concepts of human behaviour, assuming engagement by rational individuals who seek to maximise their own benefit in every interaction with society, irrespective of the impact on others.

This rational actor model, *Homo Economicus*, was first described by Adam Smith in *The Wealth of Nations* (Adam Smith, 2012) and became central to economic theory. However, as Morgan (2006) points out,

'Smith's economic man [sic] shows himself to be a complex mixture of instincts, talents, motivations, and preferences. Self-interest is a necessary motivation but by no means a sufficient description of this portrait, for all of his character traits are vital to Smith's account of how the economy works'
(Morgan 2006:2 parenthesis added).

This inherent complexity, which emerged from earlier concepts of passions as drivers of economic behaviour, makes generalisation across cases impossible (Callon, 1998). Consequently, economists typically rely on Weber's concept of an *'ideal type'* (Weber, 2009) - a simplified theoretical construct rather than attempting to capture real-world complexity (Sen, 1977). Notably, the intricacies of human

interaction with society, particularly altruism and reciprocation (Seyfarth & Cheney, 1984), are excluded from this ideal type.

Game theory therefore provides simplified models of strategic interactions that create manageable analytical frameworks, though these simplifications necessarily omit aspects of real-world decision-making complexity. The game of chess is a good example of this: with approximately 10^{40} potential options per move, players respond to each other's actions, creating intricate webs of interconnected strategic decisions. However, if both players have optimal information and employ perfect strategy, each game should theoretically end in a draw (Storer, 1983). This is more evident in simpler games like noughts and crosses, where experienced players consistently achieve draws because optimal counterstrategies are apparent. This demonstrates a key concept: rational actors with complete information will reach Nash equilibria: stable states where no player can benefit by unilaterally changing their strategy (Nash, 1951).

The prisoner's dilemma, first outlined by Flood (1951), most effectively illustrates game theory in human interactions. Two arrested players in separate cells cannot communicate. The optimal individual strategy is to inform on the other: if one stays silent while the other informs, the informer goes free while the silent player faces incarceration. However, if both inform, both receive a conviction. For rational *homo economicus*, the optimal solution would be to inform, potentially achieving freedom while leaving their colleague to face twenty years imprisonment. Yet if both follow this logic and inform on each other, both receive five years. The most effective mutual solution - both remaining silent and receiving one year each - is less attractive because of the risk that a rational prisoner will seek to maximise benefit at the other's expense.

Single-shot interactions of this nature can be presented as follows (Flood, 1958):

Table 8 Single shot games

	A	B
A	1,1	1, -1
B	-1,1	0,0

Option AA represents the Pareto equilibrium (Buchanan, 1962), the option that is advantageous to each player, while increasing the payoff for any player would create inequity and dissatisfaction for the other. Option BB assumes each player anticipates the other will act as a rational economic person seeking maximum benefit, therefore informing on them. In this scenario, there is no benefit from diverging from the rational choice: Nash equilibrium (Nash, 1951).

Game theory literature suggests that defect-defect (BB) is favoured over cooperation (AA) as the dominant strategy for rational players, despite cooperation predicting greatest mutual benefit. This assumes players have no social capital or trust between them - ameliorating factors in real-life interactions (Sakamoto, 2024). Quackenbush (2004) argues that rational choice is misnamed, suggesting what economic theory actually describes is instrumental rationality - a simplification of complex realities influenced by relationship frames resulting in common non-rational judgements (Tversky, 1984). Real human decision-making is complex, influenced by bias, contingent, and rarely rational (Tversky & Kahneman, 1974).

While Elinor and Vincent Ostrom first described coproduction based on empirical explorations, and touched on games and common pool resource management in

1994 (Ostrom et al., 1994), it was not until 2003's *Trust and Reciprocity* (Ostrom & Walker, 2003) that Elinor Ostrom and colleagues illuminated the complex decision-making realities in human relationships and economics. However, this was not in the context of coproduction, which for Ostrom represents an incidental manifestation of reciprocal social relations. Subsequent authors - Bovaird et al. (2015), E. Loeffler and T. Bovaird (2019), Escobar (2020), Brandsen and Honingh (2023) - have treated coproduction and game theory as distinct rather than integrated frameworks. Nagatsu (2021) provides the exception, exploring coproduction's impact on common pool resource management from purely economic methodology perspectives.

When applied to secure forensic mental health settings, game theory reveals key implications extending beyond simple cooperation-defection dynamics. Temporal effects (Sheppes & Gross, 2011) become important where relationships develop over months or years rather than discrete encounters. The shadow of the future (Van Lange et al., 2011) - patients' and staff's expectations about continued interaction – will also have an effect on strategic calculations (Axelrod & Hamilton, 1981). When patients anticipate extended stays, the incentives for building cooperative relationships increase as defection strategies become less attractive as they impact on reputation over time (see Trivers above).

Information asymmetries (Clarkson et al., 2007) also shape strategic interactions in a complex way. Staff possess institutional knowledge about policies, procedures, and discharge processes, while patients hold experiential knowledge about their own needs, preferences, and intervention responses. Game theory suggests that revealing information, by either party, can signal trustworthiness and invite reciprocal disclosure (Watson, 2010). However, in secure settings, information sharing is

complicated by safety considerations and power differentials that may make vulnerability risky for patients and staff alike.

Environmental constraints (Kimberly, 1975) also modify traditional game-theoretic predictions about cooperation. Physical and procedural security measures create '*forced cooperation*' scenarios where participants cannot exit the game. This constraint paradoxically may facilitate deeper cooperation over time, as both parties must find ways to make the extended interaction tolerable and productive (Hirschman, 1970). The institutional setting also provides mechanisms for monitoring and enforcing cooperative agreements absent in many other contexts, potentially making trust-building more predictable and sustainable.

The available empirical research also supports key game theory predictions when applied to therapeutic relationships in secure settings. Studies of therapeutic alliances in forensic contexts demonstrate that repeated positive interactions foster cooperation over time, even when initial relationships are characterised by mistrust and resistance (Adshead, 2001; Barnao et al., 2015). Sturm et al. (2021) for example found that patients experiencing consistent, predictable staff responses were more likely to engage authentically in treatment, supporting game theory's prediction that repeated games and their effect on reputations encourage cooperation (Segal & Sobel, 2007). Strategic accommodation behaviour has also been documented across multiple secure care studies, with patients reporting initial '*game-playing*' to progress through the system before genuine therapeutic engagement (Coffey, 2006; Vojt et al., 2013). This transition from strategic to authentic engagement occurs more readily when staff demonstrate genuine care beyond security requirements, consistent with game theory's emphasis on designing payoff structures to encourage cooperation (Safran & Muran, 2000).

This study addresses the theoretical gap by applying game theory to coproduction in secure settings where power dynamics create unique conditions for strategic interactions. Using Elinor Ostrom's interpretation, I examine how patients and staff create the common pool resource of trust and reciprocity (considered here as sharing power and supporting autonomy) leading to peace and security. Peace and security function as common pool resources - difficult to exclude others from and where additional consumers do not subtract from available resources (Becker & Ostrom, 1995). The research aims to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff across different security levels conceptualise processes what they understand to be coproduction.

3.4 Organisational Citizenship Behaviour, Intrinsic Motivation and Game Theory in Coproduction

Key components in work culture, and in coproduction, are the discretionary actions that are not traditionally recognised by reward mechanisms, but which are central to organisational efficiency and effectiveness (Organ, 2014; Organ & Konovsky, 1989). Both '*Organisational Citizenship Behaviour*' (OCB) (Ndoja & Malekar, 2020) and coproduction share these voluntary and discretionary contributions that enhance the services that they contribute to, relying on intrinsic motivation (*'it is the right thing to do'*) (Ryan & Deci, 2000), rather than external incentives (*'I do this to gain an external reward or to avoid punishment'*). Understanding OCB is particularly relevant in secure forensic settings because the formal constraints of security protocols might

otherwise limit opportunities for coproduction. However, as noted, repeated interactions make cooperation more likely over time (Axelrod & Hamilton, 1981). Within those repeated opportunities for interaction, staff who exhibit OCB may create psychologically informal spaces – using banter for example, or engaging patients in service or treatment redesign - within the security constraints where patients can exercise genuine agency and contribute meaningfully to service design and delivery (McKeown, 2019; McKeown et al., 2023; McKeown et al., 2018). This becomes central to understanding how coproduction can function in environments where power imbalances are pronounced and formal opportunities for collaboration may be restricted.

What is expected of health and social care workers is formally outlined in their job descriptions. However, Organisational Citizenship Behaviour involves going beyond these written requirements, performing additional tasks and taking extra initiative that is not officially mandated or rewarded. These discretionary efforts – the opposite of *homo economicus* - are what organisations actually depend upon to deliver optimal services to patients and clients, creating a gap between formal role expectations and the practical requirements for service excellence. Which is why a work-to-rule (Rideout, 1973) has proven to be an effective means to express dissatisfaction with an employer short of strike action.

Defined as sticking to the letter of your job description, workplan or strictly to the rules of the job, a work-to-rule is effectively the withdrawal of goodwill by the workforce to undertake tasks beyond their literal job description. The implication is that a job description does not encompass the full breadth of the areas of control and responsibility. In the language of game theory, a work-to-rule is an example of

strategic defection when an organisation relies on OCB to deliver the best possible service.

In relationship based social and health care, where the variables affecting human behaviour are particular and individual, the tasks and autonomy to complete those tasks are equally variable and may not always be illustrated in a job description. Lipsky (2010) describes this as street level bureaucracy: the practical policy and practice decisions taken by frontline workers that are beyond their formal job description (Evans & Harris, 2004). In health care this is the hidden work of judgement and discretion beyond their prescribed roles (Allen, 2014) . It has also been documented in coproduction research where effective practitioners transcend traditional job boundaries and fixed role descriptions (Needham & Carr, 2009), creating a cooperative strategy with others, activating empathy and altruism (Bovaird et al., 2015; Van Eijk & Steen, 2016), where a traditional *game* would suggest defection, or only doing what is formally required, as per the rational strategy for *homo economicus*.

The manifestation of OCB in secure mental health settings presents unique characteristics that distinguish it from OCB in typical organisational contexts. The contextual constraints mean that staff OCB often involves working within rather than around institutional rules, finding creative ways to demonstrate care while maintaining security protocols. This might include advocating for patients in multidisciplinary meetings, spending personal time learning about patient interests, or facilitating family contact beyond minimum requirements. Reciprocal OCB may also emerge from patients, who might informally mentor new patients, support peers during difficult periods, or contribute to ward activities beyond their individual treatment. This patient OCB challenges traditional conceptualisations that focus

primarily on employee behaviours, suggesting that organisational citizenship can be a mutual process that enhances community well-being rather than simply organisational efficiency. However, the constraints of risk and vulnerability shape the expression of OCB in secure settings. Staff who engage in OCB may face professional risks if their additional efforts are misinterpreted as boundary violations or security breaches by other workers. Similarly, patients who exhibit OCB might be viewed with suspicion by workers as potentially manipulative. These dynamics require careful navigation and institutional support for positive OCB to flourish while maintaining appropriate therapeutic boundaries.

Research evidence for OCB in healthcare settings suggests support for its relevance to secure mental health contexts. For example Jin et al. (2022) show that staff OCB correlates with improved patient outcomes across various healthcare environments, with particularly strong effects in relationship-intensive settings, a finding supported by evidence in the coproduction literature (Van Eijk & Steen, 2016). In mental health contexts specifically, nurses who engage in OCB report greater job satisfaction and patients demonstrate improved treatment engagement (Torlak et al., 2021).

Cross-cultural studies of OCB suggest variations that may apply to different secure care contexts. Moorman and Blakely (1995) in their seminal paper indicate that collectivist cultures show higher levels of OCB, while individualist cultures require stronger institutional support for OCB to emerge. This finding may partially explain variations in coproduction approaches between different national secure care systems and suggests that cultural factors should be considered when designing coproduction interventions. Longitudinal studies of OCB development show that organisational support and role modelling are crucial for sustaining discretionary behaviours over time (Burks et al., 2012). In secure care contexts, this suggests that

coproduction initiatives require sustained institutional commitment and visible leadership support to create cultures where staff feel safe to engage in OCB that supports patient involvement and collaboration.

While game theory helps to describe strategic interactions and decision-making processes, OCB describes the actions that both staff and patients take that go '*above and beyond*' their traditional or expected roles. Together, they create a more nuanced analytical framework for examining coproduction dynamics. They provide an explanatory framework for strategic decisions and connect the formal structures in secure environments with the informal practices that support coproduction which in turn can suggest new ways of developing coproduction in high degrees of restriction.

3.5. Implications for therapeutic care

There are additional insights into the mechanisms that can support good care by using game theory to explore coproduction in secure mental health. That is, that the relationships in secure care form a series of strategic interactions, with key power traditionally held by care staff. In these environments therapeutic relationships and security are paradoxical. While treatment aims to foster autonomy and personal growth, it occurs within environments where that autonomy is significantly restricted (Livingston et al., 2012; McKeown, Jones, Wright, et al., 2016). Game theory helps us to understand this dynamic by conceptualising these relationships as repeated interactions with evolving payoff structures (the outcome of the interaction) (Sakamoto, 2024).

Unlike one-shot games where defection is often the dominant strategy, secure settings by their nature consist of long-term, repeated interactions. Evidence from game theory suggests that this form of repetition tends to lead to cooperation, even if those in the relationship were initially in conflict (Axelrod & Hamilton, 1981). This challenges the assumption that unequal distributions of power have a corrosive effect on the therapeutic alliance (Jarman & O'halloran, 2001; Livingston et al., 2012). It suggests instead that consistent and predictable engagement between patients and staff can build trust, and as a result build a therapeutic alliance despite the predominance of security (Martin et al., 2020; Safran & Muran, 2000).

The application of game theory and OCB concepts varies significantly across the security gradient, with different environmental factors shaping strategic interactions and discretionary behaviours. High security environments most closely approximate total institutions, where the payoff structures heavily favour institutional compliance and strategic accommodation may be the most rational patient response to overwhelming power imbalances (Goffman, 1961; Moore, 2009). In these settings, staff OCB becomes particularly crucial for creating psychological spaces where genuine cooperation can emerge, as formal structures provide limited opportunities for patient agency.

Medium security settings present more complex strategic landscapes where patients have greater autonomy within constraints, potentially allowing for more varied cooperation strategies. The reduced physical security may require - or facilitate - increased relational security, creating opportunities for collaborative approaches to risk management. Staff OCB in these environments might focus more on facilitating patient choice and involvement in care planning, while patients may have greater scope for reciprocal citizenship behaviours.

Lower security environments approach the characteristics of therapeutic communities, where the strategic game shifts towards preparing for eventual community reintegration. Here, game theory suggests that cooperation strategies should increasingly resemble those found in community settings, with reduced emphasis on institutional compliance and greater focus on developing autonomous decision-making capabilities. OCB in low security settings may involve both staff and patients taking responsibility for creating therapeutic milieux that benefit the entire community. These security-level variations suggest that effective coproduction requires different theoretical emphases across the continuum. High security environments may require sustained attention to trust-building and strategic accommodation, medium security settings might focus on balanced power-sharing approaches, while low security environments could emphasise collaborative preparation for community integration.

The phenomenon that Moore (2009) describes as '*strategic accommodation*' requires to be understood as resistance to institutional power. Rather than conceptualising patient compliance strategies as barriers to authentic therapeutic engagement, these behaviours represent sophisticated forms of resistance that maintain psychological autonomy within coercive circumstances.

When patients simulate treatment compliance to facilitate discharge (Coffey, 2006; Vojt et al., 2013), they demonstrate a clear understanding of institutional power dynamics and deploy available strategies for regaining their freedom. This represents rational action rather than therapeutic failure. The problem lies not in patient *inauthenticity* but in institutional arrangements that make genuine cooperation appear impossible or risky for patients.

Strategic accommodation presents an important challenge to therapeutic engagement in secure care. That is, that any treatment approaches reliant on genuine insight and behavioural change will be undermined when patients engage this strategy (Aiyegbusi & Clarke-Moore, 2009; Howells & Day, 2007). The key therapeutic challenge then becomes transforming what begins as strategic accommodation into authentic engagement by altering the perceived payoff structure of cooperation for patients (Slade, 2014; Tummers et al., 2022).

As Cohen and Taylor (2003) document in their analysis of resistance in total institutions, what appears as non-compliance or strategic behaviour often represents the preservation of autonomous selfhood within environments designed to eliminate it. Understanding these dynamics requires moving beyond individualistic explanations toward a structural analysis of how institutional arrangements themselves create the conditions that necessitate strategic responses.

This of necessity means creating mechanisms that support a genuine interaction between staff and patients that results in both learning and mental health recovery for patients and staff that can transcend the reality of compliance based environments (Bendapudi & Leone, 2003; Kara, 2017; McKeown et al., 2018). This shift requires a different understanding of therapeutic power dynamics. Rather than viewing power as a zero-sum resource (*I have the power to compel you to do X*), therapeutic approaches informed by game theory are connected to a patient's knowledge power (Foucault & Rabinow, 1982), recognises that power can be generative - creating new possibilities through collaboration, that would not be available through coercion or strategic accommodation (Cleary, 2003; McKeown, Jones, Wright, et al., 2016). As a consequence OCB becomes a particularly important therapeutic tool within secure settings (Organ, 2014; Organ & Konovsky,

1989). That is, staff who consistently go beyond their job description to create informal psychological spaces where cooperation can flourish despite institutional constraints (Burks et al., 2012; Davis & Ellis, 2002; Ndoja & Malekar, 2020). Demonstrating genuine care and concern, and being safely flexible within the restrictions of procedural and physical security may influence how patients perceive the therapeutic *game* (Gormley, 1996; Needham, 2009). When staff demonstrate OCB, patients have evidence that cooperation leads to better outcomes than can be achieved by defection or strategic accommodation (Batson, 2003; Van Eijk & Steen, 2016). This approach from the patient's perspective then makes genuine engagement increasingly rational (Deci et al., 1991; Ryan & Deci, 2000). Importantly, these informal, relationship-based approaches fall within the guidance for relational security (Royal College of Psychiatrists Centre for Quality Improvement, 2023) rather than undermining it.

Integrating game theory and OCB also helps to illuminate Cohen and Taylor's (1971) *escape attempts* in this context. Physical escape attempts represent the most obvious form of defection in the therapeutic game, but psychological escape attempts through substance use, disengagement, or disruption can be equally challenging for therapeutic progress (Bucerius et al., 2023; Cooper et al., 1992; Norsworthy et al., 2021). Effective therapy would recognise these escape attempts as rational, strategic responses to security constraints rather than simply as rule violations (Drennan & Alred, 2013; Moore, 2009). By understanding the function these behaviours serve for patients, therapeutic interventions can be adjusted to address their underlying needs while establishing more productive strategies for their agency and autonomy within necessary security constraints (Chester et al., 2017; Weaver, 2013, 2019, 2022).

For Ostrom's triptych of trust, reciprocity, and autonomy to be meaningful the conditionality of these elements in secure care needs to be better understood. Unlike community settings where trust can develop organically, secure environments require '*earned trust*' (Liebling, 2008). Reciprocity operates within institutional boundaries, manifesting through mutual protection, shared activities, and recognition of humanity rather than traditional resource exchange. And finally, rather than full autonomy, secure settings offer '*earned autonomy*' - progressive freedoms that increase as patients demonstrate readiness for reduced restrictions (ibid).

In this theoretical framework Ostrom's triptych of trust, reciprocity, and autonomy emerges as particularly relevant for therapeutic relationships in secure settings (Ostrom et al., 2012). The evidence suggests that trust develops through consistent, predictable staff behaviour that demonstrates concern for patient wellbeing beyond security (Adshead, 2001; Barnao et al., 2015). Reciprocity is more likely when therapeutic interactions involve genuine exchanges where both parties contribute and receive something that they value (Derrida, 1992; Trivers, 1971). Autonomy, while necessarily limited in secure environments, can still be meaningfully supported by providing choices and leadership opportunities within treatment programmes and involving patients in care planning decisions (McKeown, 2019; McKeown et al., 2023; McKeown, Jones, Wright, et al., 2016). These elements create conditions where therapeutic relationships can transcend the inherent power imbalance to foster genuine collaboration (Dhillon, 2005; McKeown et al., 2023; Rowe & Davidson, 2016). As trust develops through repeated positive interactions, patients may shift from viewing treatment as an externally imposed requirement to seeing it as a shared endeavour with personal benefit (Axelrod & Hamilton, 1981; Kurzban et al., 2015; Strathern, 2000).

Seeing coproduction through the lens of game theory also helps us to understand the mechanisms that support mental health recovery (Leamy et al., 2011; Slade & Longden, 2015). By explicitly recognising patients as active collaborators rather than passive recipients of treatment, recovery approaches have a greater potential to transform the strategic dynamics of therapeutic interactions (Deegan, 1988; Rowe & Pelletier, 2012; Slade & Longden, 2015). This transformation would require staff to consistently demonstrate that patient contributions are genuinely valued, that collaboration yields better outcomes than compliance, and that treatment aims to enhance rather than restrict autonomy in the long term (Baker & Irving, 2016; Quinn et al., 2021; Rowe & Pelletier, 2012). Should patients experience these dynamics consistently over time, genuine therapeutic engagement becomes increasingly rational, potentially replacing strategic accommodation with an authentic partnership (Osborne, 2018; Ostrom, 1996b; Pestoff, 2006).

Game theory therefore offers a valuable conceptual framework for understanding and enhancing therapeutic relationships in secure settings (Hechter, 1992; Nash, 1951; Sakamoto, 2024). By recognising these relationships as strategic interactions with evolving payoffs, secure care systems can identify approaches that transform compliance-based treatment into genuine collaboration despite significant power imbalances (Dean, 2018; Galuszka, 2019; Ostrom & Walker, 2003).

The challenge for therapeutic practice in secure environments becomes creating conditions where cooperation genuinely benefits both parties, where trust can develop despite institutional constraints, and where patients can exercise meaningful autonomy within necessary security parameters. For example, McKeown, Jones, Foy, et al. (2016) document understandings of cooperation within forensic secure care as '*compliance with the medical model*' (McKeown, Jones, Foy et al: 234), but

that such cooperation is viewed as instrumental and not to be trusted. The evidence from this study suggests that mutual distrust, despite compliance as cooperation, is effectively addressed by staff '*taking the time to explain decisions*' (ibid:237), creating the space for relational engagement of patients in the decisions that affect them. Achieving this balance requires moving beyond traditional compliance-based models toward frameworks that recognise patients as strategic actors with legitimate interests and valuable contributions to their own recovery (Brandsen & Honingh, 2016; McMullin, 2021; Ponce & Rowe, 2018).

The integration of game theory and OCB frameworks raises fundamental questions about the goals and effects of improving cooperation within secure mental health settings. While these theoretical tools offer insights into strategic interaction and discretionary behaviour, they may inadvertently serve to legitimise institutional control rather than genuinely democratise therapeutic relationships.

The framework's emphasis on transforming strategic accommodation into authentic engagement assumes that institutional goals represent legitimate endpoints for cooperation. However, these goals may serve institutional efficiency and professional power rather than patient-defined recovery. The apparent cooperation that emerges through improved incentive structures may also represent successful management rather than genuine collaboration.

Drawing on Foucault 's (1977) analysis of disciplinary power, the challenge for therapeutic practice becomes distinguishing between cooperation that serves controlling functions and collaboration that genuinely enhances patient autonomy and self-determination. This distinction cannot be made through improved strategic frameworks but requires ongoing critical examination of whose interests are served

by particular forms of cooperation and whose voices are centred in defining beneficial outcomes. Meaningful collaboration in secure settings may require fundamental changes to power structures, decision-making processes, and outcome definitions rather than better strategies for encouraging patient compliance with existing arrangements.

The analysis of game theory and Organisational Citizenship Behaviour reveals how therapeutic relationships in secure settings operate as complex strategic interactions where cooperation can emerge despite fundamental power imbalances. However, this theoretical exploration also demonstrates the risk that sophisticated analytical frameworks may serve to legitimise rather than challenge the structural inequalities that characterise secure care environments.

3.6 Summary: Key Theoretical Positions on Coproduction in Secure Settings

This chapter has established an integrated theoretical framework for understanding coproduction in secure mental health settings. The framework synthesises five complementary analytical perspectives: social capital theory for understanding the relational preconditions of collaboration; public service logic for understanding how organisational logics shape what forms of coproduction are possible; game theory for understanding strategic interactions; organisational citizenship behaviour for understanding discretionary actions that create space for collaboration; and critical perspectives on power for maintaining awareness of whose interests particular forms of cooperation serve.

The table below summarises the key theoretical positions that inform this study's approach:

Table 9 Theoretical Framework Summary

Theoretical Framework	Key Concepts	Application to Coproduction in Secure Settings
Social Capital Theory	Trust networks, inclusion/exclusion, institutional mediation	Explains how institutional design determines whether social capital enables collaboration or reinforces exclusion; highlights that coproduction outcomes depend on institutional context rather than pre-existing relationships alone
Public Service Logic (PSL/PSDL)	Value co-creation, service delivery logic, institutional work, provider-user relationships	Explains how organisational logics shape payoff structures; distinguishes between instrumental engagement (PSDL) and genuine collaboration (PSL); identifies the institutional work required to shift between logics
Game Theory	Strategic interactions, Nash equilibrium, repeated games, prisoner's dilemma, shadow of the future	Explains how power imbalances shape cooperation decisions; illustrates how repeated interactions and reputation effects transform initial wariness into stable cooperation over time
Organisational Citizenship Behaviour	Discretionary actions, intrinsic motivation, going beyond formal roles, street-level bureaucracy	Describes how staff create psychological spaces for coproduction within security constraints; extends to patient OCB as mutual citizenship that enhances community well-being
Therapeutic Relationship Dynamics	Strategic accommodation, earned trust, earned autonomy, conditional reciprocity	Illuminates the challenge of transforming compliance into authentic engagement; reframes strategic accommodation as rational resistance rather than therapeutic failure
Total Institution Theory	Mortification processes, identity preservation, escape attempts, institutional control	Contextualises the environmental constraints on coproduction across security levels; explains how institutional arrangements create conditions that necessitate strategic responses

This integrated framework conceptualises therapeutic relationships as strategic interactions with evolving payoffs over time. It explores how power imbalances shape cooperation, how strategic accommodation emerges as a rational response to institutional control, and how trust, reciprocity, and autonomy can flourish even within significant constraints.

The study's multi-site design across different security levels and national contexts allows for comparative analysis of how these theoretical dynamics manifest in practice, identifying specific barriers and enablers to coproduction across diverse secure care environments. In particular, it can show that despite the constrictions of physical and procedural security, the relationships forming the basis for relational security can create psychological spaces necessary for meaningful coproduction in secure mental health settings.

Having established the theoretical foundations and identified the significant gaps in the current understanding of coproduction within secure forensic mental health environments, the next chapter details the methodological approach designed to address these deficits through empirical investigation. The chapter sets out the philosophical underpinnings, research design, data collection methods, and analytical framework that will enable a systematic exploration of how staff across different security levels understand and practice coproduction with patients in these highly constrained environments.

Chapter 4. Methodology

4.1. Introduction

This chapter details the methodological approach used in this study to investigate coproduction in secure forensic mental health settings. Coproduction is complex in environments where security concerns and risk management are paramount. This study examines how staff across the security gradient of secure forensic mental health settings understand and practice coproduction with patients, exploring the tensions and opportunities that arise in a context where autonomy is necessarily constrained.

The methodological approach is informed by the theoretical framework established in Chapter 3, which positions Ostrom's interpretation of game theory as the analytical lens for understanding decision-making processes between patients and staff. This theoretical foundation shapes the research design by directing attention toward the collaborative construction of trust and reciprocity as common pool resources, influencing both the research questions and the analytical approach described in this chapter.

The research addresses three primary questions:

1. How do rules-based environments in secure forensic mental health care affect forms of coproduction?
2. How do staff working across different levels of security conceptualise coproduction processes?

3. What factors enable or inhibit coproductive relationships in secure care environments?

These questions emerged from two sources. Firstly, my observations during my professional experience in secure care, where I observed staff and patients developing mutually beneficial relationships within highly regulated environments. Secondly from the review of the available literature.

This chapter begins by outlining the philosophical foundations underpinning the research, specifically the interpretivist paradigm that guides the study. I then describe the research context and design, including the selection of the sites, the sampling strategy, and data collection methods. The analytical approach, ethical considerations, and my own positionality as researcher are then discussed, before concluding with a chapter summary.

4.2. Research context: Secure Mental Health Services

Secure forensic mental health services are environments where there are tensions between therapeutic care and the imperatives of security. These environments support mental health recovery while managing palpable risks. This, then, presents a potential barrier for coproduction between staff and patients. This section examines how each facility's security classification shapes its operational practices, organisational culture, and approach to patient involvement. It explores how Goffman's concept of the *total institution* manifests differently across the security gradient (table below), with varying levels of what he termed *mortification processes* – procedures that strip individuals of identity markers and autonomy (Goffman, 1961). By understanding these contextual factors, we can better interpret how the

strategic interactions described in game theory might play out differently across these environments, and how organisational citizenship behaviours among staff might create psychological spaces for meaningful collaboration despite institutional constraints.

Table 10 Study sites levels of security

Security Level	Scotland	Ireland
High Security	The State Hospital	Dundrum Hospital
Medium Security	Medium Secure 1, Medium Secure 2	Dundrum Hospital
Low security	Medium Secure 1, Medium Secure 2	

4.2.1. Security Gradients and Institutional Structures

All four sites studied provided care for people experiencing significant disruptions in their mental health and who were also assessed as meeting the legal requirements for restrictions such as detention to keep them and others safe (Scottish Government, 2015a; Timmons, 2010). They represent different points along the security spectrum, from high secure national facilities to medium and low secure units, allowing for comparative analysis of how institutional constraints influence coproduction possibilities. The study consisted of two sites with the highest level of security, and two sites with combined medium and low levels of security. The Forensic Network in Scotland provides clear distinctions between these security levels as outlined in Chapter 1.

Each site represents a point along the gradient of what Goffman (1961) termed *total institutions*, which he defined as:

"a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life" (Goffman, 1991:11).

Goffman describes the characteristics of total institutions as:

'First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried out in the immediate company of a large batch of others, all of whom are treated alike and required to do the same things together. Third, all phases of the day's activities are tightly scheduled with one activity leading at a pre-arranged time into the next, the whole sequence of events being imposed from above by a system of explicit, formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution.' (Goffman, 2019:17)

This concept is seen most clearly at the highest security level, where facilities like The State Hospital and Dundrum Hospital contain individuals living with serious mental health conditions who are likely to remain in that environment for extended periods, with their lives controlled by procedural and physical security measures. These high secure institutions deprive patients of liberty, both in who they associate with and their freedom to move around and beyond the campus and may also make treatment decisions on their behalf (The Forensic Network (Scotland), 2006). To

patients, these decisions may often feel irrational as a consequence of the control exerted upon their lives for their safety and that of others.

What Goffman termed *mortification processes* (Goffman, 1991) - procedures that strip individuals of identity and autonomy - vary in intensity across the security gradient. These processes include a clear distinction between the institution and the outside world, security and admissions procedures, deference required in interactions with staff, the stripping of individuality and identification as a patient, and the requirement to be social with people not of one's choosing. These processes influence staff culture most prominently at the highest tier where security concerns are the highest, with diminishing effects in lower security environments. The extent of these mortification processes shapes working practices and potentially influences what staff perceive as possible in terms of patient involvement and collaborative care.

It is important to note that in addition to the processes identified above, the psychology of space also affects the interaction of patients and staff with one another and their environment. For example the existence of security devices such as airlocks, locks and controlled access can provide security but also paradoxically create fear (Chaudhury & Cooke, 2014). However, clearly defined spaces, such as those that are designated for sports and recreation or other enjoyable activities accrue significance and associations for patients (Lawson, 2010), which in turn are associated with the staff that work in those areas (Ricciardelli et al., 2023), which in turn are commonly associated with flow states (Norsworthy et al., 2021)

How obvious the security conditions are varies across the gradient. The high secure sites are characterised by tall perimeter fences or walls, while further down the

gradient the low secure facilities, hosted with medium secure facilities in one site, rely primarily on relational security and physical security that impedes rather than prevents security breaches. Nevertheless, locked and alarmed doors with prominent airlocks are common across the forensic estate. These are the physical features of the environments where coproduction and the strategic interactions that are described by game theory in this study occur.

4.2.2 Selective Anonymisation of sites

Both the State Hospital in Scotland and Dundrum/The Central Mental Hospital in Ireland are singular and unique in their respective health systems. The State Hospital is Scotland's only high security forensic mental health facility. Dundrum similarly is the only facility in Ireland's health system with a comparable function. This means that any reference to their unique operational and functional characteristics would make them easily identifiable despite anonymisation. This would both make any attempt at pseudonymisation ineffective whilst appearing disingenuous to readers familiar with these systems. It would also have proved impossible to explore the impact of the transition of the State Hospital from Scottish Prison Service to NHS management, and the impact of the 2008 financial crisis on the redeployment of community nurses to Dundrum and its subsequent effect on culture and practice without inadvertently revealing their identity. The workforces in both national facilities at the time of the study were circa 600 staff in the State Hospital (Scottish Government, 2015b) and an estimated 400 staff in Dundrum (Timmons, D October 2015: personal communication).

In contrast the medium security facilities in the study represent multiple institutions in Scotland, making anonymisation and participant confidentiality more effective. This was important for these sites in particular because the workforce is substantially smaller than the named facilities, which would make identifying participants more likely. In addition, the sole commercially provided facility was not named in order to ensure that there were no negative business consequences from participation.

At the time of this research, all four study sites were experiencing disruption: either in transferring from one location to another, the physical environment being transformed or experiencing the after-effects of external forces such as the financial crash. These transitions also represented shifts in security paradigms, staffing models, or physical environments that potentially influenced staff perceptions of what was possible in terms of collaborative care.

4.2.3 Study Sites: Historical Development and Transitional Contexts

The State Hospital was originally built between 1936 and 1938 as a replacement facility for the *criminally insane* who were being detained in Perth Prison. The first prisoners were not transferred until 1957, and the facility remained managed by the Scottish Prison Service until 1994 (Long, 2017) when it transferred to the NHS in Scotland. The hospital underwent a radical physical and operational transformation between 2008 and 2011 following the review of Scotland's Mental Health Act (Crichton, 2009), which closed the female ward, reduced the number of available beds, introduced regional medium and low secure units, and local female units, to provide more tailored psychiatric care in more appropriate modern facilities. Staff at the time data was collected included those with experience of the pre-1994 prison-

managed facility, nurses trained in the post-1994 on site nursing school, nurses trained at university to degree level, and those recruited from elsewhere.

Dundrum Hospital serves a function similar to The State Hospital, although within the Irish system patients who would be eligible for care in the higher tier The State Hospital wards are typically managed in the prison system with psychiatric care provided as an outreach service (Timmons, 2010). While Dundrum Hospital provides what it describes as high secure care in the Irish system, it is equivalent to a Scottish combined medium high tier and medium security service, providing detention and treatment for both men and women (Timmons, 2010).

Important historical and staffing differences between the two high secure sites appear to have influenced their approaches to coproduction. Traditional on-site nurse training was interrupted in the UK NHS in 1990 with the introduction of university-based training (Jacobs et al., 1998). Ireland followed suit with undergraduate programmes in 2002 (Timmons, 2010), when Dundrum Hospital nurse training transferred to universities, interrupting a traditional route for transmitting the historical, rule-dominated culture. In addition, during the 2008 financial crisis a cohort of newly qualified, university-trained Irish nurses with community practice ambitions found their career opportunities in community mental health dramatically reduced and were subsequently redeployed to Dundrum Hospital. Both the break with traditional training and the influx of community-oriented practitioners may explain differences in approaches to coproduction between Dundrum Hospital and The State Hospital, despite serving similar patient populations.

Another notable difference is that Dundrum Hospital had retained an admissions ward, while The State Hospital, following campus redevelopment, had begun admitting new patients directly to continuing care wards (The State Hospitals NHS Board, 2008). This practice, also common to the lower security sites, may affect the sense of stability on wards and consequently the opportunities for coproduction in high security environments.

The Medium Secure 1 is a commercial medium and low secure site in Scotland. At the time of this research, it was transitioning from a model where senior medical staff were supplied by The State Hospital, to directly employing its own psychiatrists, with the aim of adopting a more relational security-focused approach to managing patient behaviour. The Nurse Manager indicated that the facility had made a strategic and operational decision to create opportunities for staff and patients to *coproduce* the management of behaviour and risk (using the therapeutic approach to the management of violence and aggression for example (Sookoo, 2009)). This decision was a recognition that there was a therapeutic benefit in engaging patients in planning for situations where they had the least control, based on the evidence from the use of advance directives in other environments (Jóhannesdóttir et al., 2025), as well as a business decision to offer a unique form of secure care to their customers.

Medium Secure 2, the Scottish NHS medium and low secure site, was created following the closure of a Victorian medium secure hospital. The staff were undergoing a physical transition from a remote, rural campus with prominent physical security to a purpose-built town centre facility without high walls and fences, though ingress and egress remained tightly controlled. The staff had training and experiences similar to those at The State Hospital, and the facility's medical director

was also a Consultant Psychiatrist from The State Hospital. In theory this would create a continuity of historical practices.

Across the sites, these transitions represented disruptions to previous operating conditions, with the paradigm of care being shifted from a predominance of physical to relational security measures to manage risks on site. Some staff resisted this shift in security practices, reflecting a personal lack in confidence with these approaches (Tulloch et al., 2022).

In this context physical security refers to its obvious manifestations like fences and locked doors, while procedural security encompasses staff actions to ensure doors remain locked and patients are in appropriate spaces. Relational security, being less tangible, refers to monitoring interactions between patients and between patients and staff to understand how relationships influence behaviour (Royal College of Psychiatrists Centre for Quality Improvement, 2023).

4.2.4 Comparative Security Frameworks: Scotland and Ireland

The Scottish and Irish approaches to forensic mental health care reflect different policy contexts that potentially influence service delivery and opportunities for coproduction. The Scottish system operates within a structured *managed care network* (Walker et al., 2015) – the Forensic Network - that clearly delineates high, medium, and low security facilities with specific criteria for placing patients (Crichton, 2009). The Mental Health (Care and Treatment) (Scotland) Act 2003, subsequently updated in 2015 (Scottish Government, 2015a), incorporated human rights principles into mental health law, establishing that if a patient requires to be detained for treatment it must be at the lowest possible level of restriction. This legislative

framework led to an increase in appeals against excessive security and prompted the development of a more graduated secure forensic care system (Slater et al., 2016).

The Irish system operates under different constraints, with Dundrum Hospital functioning as the highest level of dedicated mental health security outside of the prison system. The system has faced significant funding challenges since 2008 (Evetovits, 2012), which consequentially may have incentivised innovative approaches to fill gaps in funding (Eggleston, 2018). The most prominent innovation was exemplified by the senior nurses interviewed (Clinical Service Managers or CSMs) who had qualified as community psychiatric nurses when community posts had been deleted in response to the 2008 financial crisis, as noted above. These practitioners saw themselves as bringing a different community nursing perspective into forensic care, with a move towards more relational approaches and relational security within their facilities.

The contrast between the consistently funded and but slow to change Scottish system and the underfunded and as a consequence adaptable Irish system provides a useful comparison of approaches. It allows this study to explore these different contexts and influences on coproduction. The comparison within and across national borders allows this study to explore how coproduction is practiced within varying structural, cultural, and resource constraints.

4.3. Philosophical and Theoretical Foundations

This research is situated within an interpretivist paradigm, which describes reality as constructed and interpreted through experience and between people (Silverman,

2015). Within this paradigm, ontological reality (what exists) is understood as being influenced by local circumstances and relationships, while epistemic knowledge (what is valid knowledge in this subject) is negotiated and experienced differently by individuals (Guba & Lincoln, 1994). A useful metaphor for understanding this paradigm is the window through which we see the world (Marshall & Rossman, 2011). While positivist approaches assume a realist window where what is observed can be verified as objectively real, interpretivist approaches recognise that each observer's perspective is valid relative to their position. As Braun and Clarke (2013) note, when verification is not possible - for example, when prisoners can view only a small part of the world from their window - then what is seen from their perspective is all that can be known and therefore constitutes their reality. A researcher using an interpretivist paradigm gathers these differing views to understand what is common across those perspectives and what is unique to each position.

An interpretivist stance is appropriate for this study for several reasons. Firstly, from the literature review it is clear that there are a limited number of research papers on coproduction in secure care, making an exploratory interpretivist approach valuable to understand how this concept is operationalised. Secondly, the research questions focus explicitly on staff perceptions and interpretations of the coproduction process, which are inherently subjective. Thirdly, the secure care context shapes how coproduction is understood and enacted, which means any approaches that do not take the context into consideration would be of limited value (Guba & Lincoln, 1994).

In contrast to positivist paradigms that seek context-free observations and universal laws, interpretivism values the meanings that participants attach to their activities (Guba & Lincoln, 1994:106). This approach acknowledges that understanding how coproduction functions in secure care requires the researcher to engage with the

interpretive frameworks of the people who use it daily. As Gadamer notes, "*every translation is interpretation*" (Gadamer 2013:384). That is, we are always interpreting data through our own lens, translating experiences into terms we can understand. This hermeneutic or interpretative process creates an understanding rather than making a broad claim to knowledge that can perfectly reproduce others' experiences.

Sitting within the interpretivist tradition, this study broadly draws particularly on Husserl's approach to exploring phenomena to discover themes and commonalities that might be usefully used in other contexts (Husserl, 1999). Husserl believed that hermeneutics could expose common human experiences of phenomena, revealing what Wertz (1984) terms '*the constitutive or the essence of a phenomena*'. That is, to identify the components that make up a phenomenon, and the consistent qualities which makes it identifiable. This approach allows the researcher to explore subjective experiences that might otherwise be difficult to measure through traditional positivist methods (Eckartsberg, 1986; Valle et al., 1989).

Paramount reality as described by (Berger & Luckmann, 1966) is also important to consider when exploring the perspectives of the staff interviewed in this study. For participants, paramount reality's foundations are built upon their subjective experiences, professional training, and workplace encounters. This reality is personal rather than universal and is shaped by unique experiences, history, upbringing, and potentially trauma. This study claims that the experience of coproduction in secure settings can be understood as a constructed reality particular to each participant's circumstances. This claim has parallels with how mental health recovery has been understood as a highly personal process determined through experience rather than universal definition (Leamy et al., 2011).

The ontological position underpinning this research requires deeper examination given its influence on methodological choices and analytical approach. This study adopts a constructionist ontology, which posits that reality is not discovered but constructed through social processes and human interaction (Berger & Luckmann, 1966). In the context of secure forensic mental health care, this means that concepts such as '*coproduction*', '*recovery*', and '*therapeutic relationships*' do not exist as fixed entities waiting to be uncovered but rather emerge through the ongoing interactions and negotiations between staff, patients, and institutional systems.

This ontological stance has particular relevance for understanding coproduction in secure settings. Rather than assuming that coproduction represents a universal practice that can be measured consistently across contexts, a constructionist approach recognises that what constitutes '*coproduction*' is actively constructed by participants within their specific environmental and cultural constraints. The meaning of collaboration, power-sharing, and patient involvement emerges through daily practices, institutional policies, and professional relationships rather than existing independently of these contextual factors.

This constructionist ontology contrasts sharply with positivist approaches that might seek to measure coproduction through standardised scales or objective indicators. Instead, it acknowledges that the reality of coproduction in secure care is multiple and context-dependent - shaped by factors such as security level, professional culture, patient characteristics, and institutional history. What staff in a high secure facility understand as meaningful patient involvement may differ significantly from practices in medium secure settings, not because one is '*correct*' and another '*incorrect*', but because each represents a legitimate construction of collaborative practice within its specific constraints.

The constructionist position also recognises that research itself contributes to the construction of reality. Through asking questions about coproduction, providing spaces for reflection, and facilitating group discussions, this research process potentially influences how participants understand and subsequently practice collaborative approaches. This reflexive relationship between research and practice aligns with the study's interpretivist epistemology, acknowledging that knowledge emerges through interaction rather than objective observation.

Furthermore, this ontological position acknowledges the role of power and institutional structures in shaping constructed realities. In secure forensic settings, the construction of coproduction occurs within contexts characterised by significant power imbalances, regulatory requirements, and safety concerns. These structural factors do not determine reality but provide the materials and constraints within which social construction occurs. Understanding how staff navigate these constraints in constructing collaborative relationships requires attention to both agency and structure - how individual and collective meaning-making operates within institutional parameters.

4.4 Research Design

4.4.1 The Multi-Site Comparative Approach

This qualitative study uses a multi-site, multi-method design to capture a wide range of perspectives on coproduction across different secure care settings. The data was gathered across four sites representing different security levels, organisational contexts, and national health systems. Full details of the context and the sites studied are described in 4.2 above.

Several alternative research designs were considered before adopting this multi-site comparative approach. A single-site ethnographic study would have provided deeper contextual understanding but limited transferability across different security levels and organisational contexts (Hammersley & Atkinson, 2019). A cross-sectional survey design could have captured broader professional perspectives but would have sacrificed any nuanced understanding of coproduction processes that may have emerged through qualitative exploration (Creswell & Poth, 2016). An exclusively quantitative approach using validated scales was discounted because existing coproduction measures have not been validated in secure forensic contexts (Marsilio et al., 2021), and the exploratory nature of the research questions required inductive rather than deductive inquiry (Patton, 2014). The multi-site design was ultimately selected to balance contextual depth with comparative breadth, enabling analysis of how different security levels, organisational structures, and national contexts influence coproduction understanding and practice.

4.4.2 Data Collection Methods

Several data collection approaches were considered before selecting the multi-method design employed in this study. The exclusion of patient perspectives represents the most significant methodological limitation of this research and requires explicit acknowledgment as contradictory to studying coproduction authentically. This exclusion essentially transforms the study from an investigation of coproduction itself into an examination of staff perspectives on the potential for coproduction, a distinction that has implications for the validity and scope of any claims made.

Direct observation of staff-patient interactions was initially proposed as it would have provided naturalistic data on coproduction in practice but was rejected by all of the site's research ethics committees due to concerns about informed patient consent, given their condition, and the potential for inadvertent coercion in secure settings (see section 4.8.1). Document analysis of care plans and meeting minutes was considered but discounted because institutional documentation typically focuses on risk management rather than collaborative processes, potentially missing informal coproduction practices (Prior, 2002). Structured interviews were discounted in favour of semi-structured approaches to allow the exploration of unexpected themes whilst maintaining focus on the research questions (Kvale, 2009).

The decision to exclude patient voices was driven by practical considerations rather than methodological soundness: the additional ethical complexities, extended approval timescales, and institutional resistance to including detained patients as research participants. This methodological choice reproduces the very power imbalances that coproduction seeks to address, privileging professional perspectives in defining what constitutes meaningful collaboration while rendering silent those whose involvement is ostensibly being studied. The research therefore represents a form of extractive inquiry *about* rather than *with* the people most affected by collaborative practices in secure settings.

Rather than investigating how coproduction functions in secure care, this study examines how staff construct understandings of the potential for collaboration and the coproduction within institutional constraints. The findings cannot speak to the reality of coproductive relationships but only to professional perceptions of what such relationships might entail.

The research took place over five distinct phases:

1. The literature review: Establishing the conceptual foundations and identifying gaps in existing knowledge of coproduction in secure settings.
2. Key informant consultation: Engaging with six experts in secure care to refine the research focus and develop appropriate vignettes for focus group discussions.
3. Individual interviews: Conducting semi-structured interviews with staff across all four sites to explore individual understanding and experience of coproduction.
4. Focus group discussions: Facilitating group discussions using case vignettes at three sites to observe the process of collective meaning-making about coproduction.
5. Analysis: Conducting thematic analysis of all data to identify patterns and develop conceptual understanding of coproduction in secure settings.

Two complementary methods were employed to gather data about staff understanding and practice of coproduction: semi-structured interviews and focus groups with vignettes. Individual interviews allowed for the in-depth exploration of the interviewee's personal understandings, experiences, and reflections on coproduction. The interviews also provided a private space for participants to discuss potentially sensitive aspects of their practice that they might be reluctant to share in group settings.

Group discussions were facilitated using the vignette case studies (Appendix 2). This method was intended to allow an observation of the process participants used to

collectively construct and negotiate their understanding of coproduction. As noted in chapters 5 and 6, unusually the vignettes provoked discussion about concrete experiences with actual patients rather than the theoretical example presented to them. The limitations of the vignette approach in this study are explored in chapter 7. This multi-method approach provides a form of methodological triangulation, allowing the findings to be compared and verified across the different forms and contexts of data collection contexts while mitigating the limitations of any single method.

4.5 Sampling and Participant Recruitment

4.5.1 Key Informant Consultation

Prior to beginning the formal data collection process, six key informants within The State Hospital were consulted to help refine the research focus and develop appropriate vignettes for focus group discussions. These informants were selected through purposive and availability sampling (Suri, 2011) based on their expertise in secure care. The group consisted of a social work manager; a practice education facilitator with responsibility for hospital-wide mental health recovery approaches; a consultant psychiatrist who also sat on the research ethics committee; the Patient Focus Public Involvement facilitator; the Forensic Network's consultant nurse and a psychologist.

This process did not constitute a formal part of data collection, and the data provided is not included in the data set for analysis, but the interviews guided the development of the approach to the research, data collection instruments and protocols. The informants also helped to ensure that the vignettes presented realistic scenarios that were reflective of typical presentations in forensic mental health care.

4.5.2 Study Participants

A total of 33 professionals participated in the study, recruited through purposive sampling to reflect the range of disciplines involved in patient care. Table 4.1 presents the distribution of participants by professional role and site.

Table 11 Participants by Professional Role and Site

Site	Individual Interviews	Focus Group Participants	Focus Groups Conducted
The State Hospital	8	0	0
	1x Advocate 1x Senior Staff Nurse 1x OT 1xConsultant Psychiatrist 1xconsultant psychologist 1xAdvance Nurse Practitioner 1x Nurse Consultant 1x psychologist		
Medium Secure (Scotland) 1	8	6	1
	1x Advocate 1xPsychologist 4xStaff Nurse 1x Consultant Psychiatrist 1xCharge Nurse	5xStaff Nurses 1xCharge Nurse	
Medium Secure (Scotland) 2	9	7	1
	3x Health Care Assistant 1x Charge Nurse 1xPsychiatrist 3xStaff Nurse 1xNurse Manager	7xStaff Nurses	
Dundrum Hospital	8	8	1
	7x Clinical Nurse Managers	7x Clinical Nurse Managers 1x Nursing Officer	

	1x Nursing Officer (equivalent of a nursing assistant)		
Total	33	21	3

Recruitment procedures, as outlined below, varied across sites due to different organisational structures and research ethics committee requirements, necessitating a flexible approach whilst maintaining consistent selection criteria.

The State Hospital: Initial contact was made through the Executive Management Team, who identified departmental managers responsible for staff with recovery-oriented practice experience. These managers were provided with study information and asked to identify eligible staff members. Rather than managers directly approaching staff, I requested contact details for potentially suitable participants and made direct contact via email, explaining the study and inviting voluntary participation. This approach aimed to reduce any perceived pressure from management hierarchy.

Medium Secure Sites (Scotland): Access was facilitated through the West of Scotland Forensic Network. The Nursing Director at each site identified charge nurses and senior staff who could advise on recruitment. Following ethical approval, these gatekeepers provided me with access to ward areas during staff meetings, where I presented the research and invited participation. Interested staff provided contact details voluntarily, with no management oversight of who chose to participate. Follow-up individual emails confirmed participation details.

Dundrum Hospital (Ireland): Recruitment followed a more structured institutional process. The Director of Nursing identified suitable Clinical Nurse Managers based on their involvement in person-centred care initiatives. Initial contact was through a

group presentation to senior nursing staff, followed by individual emails to express interest. Due to operational constraints, the hospital management pre-selected participants based on availability and experience criteria, representing a limitation in the recruitment approach.

Several recruitment challenges emerged. Planned recruitment through multidisciplinary team meetings at two sites was cancelled due to operational pressures, resulting in an adaptation to ward-based recruitment. The small number of non-nursing professionals across the sites necessitated direct approaches through department heads, potentially creating selection bias toward more institutionally aligned participants. Response rates to the recruitment request varied, from 65% at Medium Secure 1 to 85% at The State Hospital, possibly reflecting different organisational cultures regarding research participation.

The recruitment process extended over eight months due to the need to coordinate with operational demands across four sites, and travel to and from Ireland. This extended timeframe allowed for relationship building with gatekeepers but also risked changes in staffing and organisational priorities affecting sample composition.

Of these participants, 18 were registered nurses, 4 were nursing assistants or health care assistants (HCA's) or nursing officers, (nursing represented 67% of the sample), 4 were psychologists, 3 were psychiatrists, 2 were advocates and 2 were occupational therapists (OT). 16 were female (48%), broadly reflecting the general demographic in the sector (Scottish Government, 2018). The mean age of participants was 41 years, with a range from 23 to 60 years.

Participants were selected based on their interest and regular participation in person-centred and mental health recovery-oriented activities (Leamy et al., 2011;

McCormack & McCance, 2006). This orientation, while distinct from coproduction, shares features such as support for autonomy, responsibility, meaning, and purpose. Within the sites, this was evidenced by staff generating ideas with patients for social and educational opportunities and working *alongside* patients (NHS Scotland, 2001; Richards et al., 2013).

4.5.3 Sampling Limitations and Challenges

Several factors affected recruitment of subjects to the study. First, The State Hospital and Dundrum Hospital did not provide permission to interview on-ward staff. This is important but missing data from the frontline of high secure care. Second, I was not given permission to interview social work staff at any site, because of the small number of staff relative to the overall workforce (7 social workers in the State Hospital versus 320 nursing staff) and the subsequent disruption to service delivery that this would have represented. Third, the Irish site had no psychiatrist available for interviews or the focus groups. Fourth, psychiatrists across all sites declined invitations to participate in the focus groups. Finally, operational constraints at The State Hospital at the time that focus groups were planned - staff were unable to get off the ward to attend - meant that focus group did not take place. This is, again, important missing data.

The sampling strategy of necessity combined targeted recruitment to try and ensure representation of the key professions with availability sampling based on staff schedules and clinical activity (Given, 2008; Suri, 2011). While individual participants cannot represent their entire profession, the multi-site approach and the combination of methods intended to mitigate this limitation by allowing a comparison across sites

as well as using focus groups to verify both individual perspectives and to surface collective perceptions.

The institutional selection processes meant that the sample was biased toward professionally compliant voices - those who management considered appropriate representatives of their services. The recruitment through management channels, particularly at medium secure sites, raises questions about whether participants felt genuinely free to express critical perspectives about institutional practices or whether their responses were moderated by awareness of institutional oversight.

These sampling limitations mean that claims about *staff perspectives* are actually claims about *institutionally selected staff perspectives*, with unknown implications for how different viewpoints might have emerged from excluded groups. The research therefore reproduces rather than challenges the hierarchical structures that shape who can speak about coproduction and whose knowledge is considered legitimate.

4.6 Data Collection Methods and Procedures

4.6.1 Methodological Decisions

The selection of semi-structured interviews as the primary data collection method required careful consideration of alternatives and a systematic evaluation of their suitability for the research aims. This section sets out the methodological decision-making process that led to the chosen approach.

Structured interviews using predetermined questions with fixed response options were initially considered but ultimately rejected for several key reasons. Firstly, the exploratory nature of this research - investigating a phenomenon (coproduction) that has not been extensively studied in secure forensic settings - required flexibility to

pursue unexpected themes and meanings that participants might raise. Structured approaches would have constrained this exploration, potentially missing important insights about how coproduction manifests in these unique contexts. Secondly, existing research instruments for measuring coproduction (such as those developed by Voorberg et al., 2015, or Brandsen & Honingh, 2016) have not been validated in secure forensic environments and may not capture the contextual nuances that shape collaborative practice in these settings. Using unvalidated structured instruments risked imposing external definitions of coproduction rather than understanding how participants themselves construct and experience such collaborative practice. Thirdly, the sensitive nature of discussions about professional practice, particularly potential barriers to patient involvement, required an approach that could build rapport and trust. Structured interviews typically limit this relationship-building, potentially constraining participants' willingness to discuss complex professional dilemmas or systemic challenges.

Unstructured interviews, whilst offering the maximum flexibility for exploring participants' perspectives, were discounted due to several methodological concerns. Given the multi-site nature of this research, some level of consistency across interviews was essential to enable meaningful comparison between sites and professional groups. Purely unstructured approaches risked producing data that varied so significantly in focus and depth that systematic analysis would become problematic. Additionally, the research questions required the exploration of specific aspects of coproduction (understanding, barriers, facilitators, contextual influences) that might not emerge naturally in entirely unstructured conversations. I determined that the risk of missing important dimensions of the phenomenon was too high given the limited research literature available to guide analysis. Furthermore, unstructured

interviews place significant demands on interviewer skill in maintaining focus whilst allowing freedom of expression. Given the extended data collection period (12 months) and the need for consistency across multiple sites, the additional structure provided by semi-structured approaches was necessary to maintain methodological rigour.

A focus group method was initially evaluated as a standalone method but ultimately selected as a complementary approach rather than the primary method. The advantages of focus groups - their capacity to generate discussion, surface collective meanings, and to observe social interaction around coproduction - made them valuable for triangulation purposes. However, several factors precluded their use as the primary method. Firstly, the hierarchical nature of forensic mental health settings meant that power dynamics within focus groups could inhibit open discussion, particularly if junior and senior staff were mixed. The risk of self-censorship or conformity to perceived organisational expectations was judged higher in group settings than individual interviews. Secondly, the sensitive nature of some topics (such as criticism of institutional practices or discussion of professional limitations) might be difficult to explore adequately in group settings alone where participants might feel exposed or professionally vulnerable. Thirdly, practical constraints around staff availability and operational demands made it difficult to consistently gather appropriate groups across all sites. The cancellation of planned focus groups at The State Hospital due to operational pressures illustrated these practical limitations.

Quantitative survey approaches were considered but discounted for this exploratory research. Existing coproduction scales (such as the Patient Participation Scale (Phillips et al., 2016; Song & Kim, 2023) or Service User Involvement measures (Bee et al., 2016; Morrow et al., 2010) were developed for very different healthcare

contexts and lack validation in secure forensic settings. Creating new scales for this project would have required extensive preliminary qualitative work to identify relevant items - essentially requiring the same research approach ultimately adopted.

Moreover, survey methods would not capture the nuanced understanding of how security constraints shape collaborative practice, nor would they illuminate the complex decision-making processes that staff navigate in balancing therapeutic relationships with safety requirements. The research questions required the illumination of meaning and process rather than the measurement of outcomes or attitudes.

Direct observation of staff-patient interactions was proposed initially as it would provide naturalistic data on coproduction in practice. However, this approach was rejected by all research ethics committees because of the following concerns:

- Observing interactions would require patient consent, raising issues about capacity to consent, potential coercion in secure settings, and the impact of observation on therapeutic relationships.
- Clinical interactions often involve sensitive personal information that could not ethically be accessed by researchers.
- The presence of observers might fundamentally alter the nature of staff-patient interactions, compromising both research validity and therapeutic effectiveness.
- A researcher observing in clinical areas could pose security risks or interfere with emergency responses.

Semi-structured interviews emerged as the optimal primary method because they offered the flexibility essential for exploratory research whilst maintaining sufficient structure for systematic analysis across multiple sites. The approach supported a deeper exploration of individual perspectives whilst preserving the contextual sensitivity required for understanding coproduction in such specialised environments.

The decision to complement interviews with focus groups using vignettes represented a methodological compromise that intended to address the limitations of each individual method. Interviews provided private space for honest reflection on professional practice, whilst focus groups offered insight into collective meaning-making processes and professional negotiation of complex situations. The methodological approach aligns with the study's interpretivist paradigm by prioritising participant meaning making whilst providing sufficient structure to generate transferable insights about coproduction across different secure forensic contexts. The combination of methods enables both idiographic understanding of individual experiences and nomothetic insights about patterns across the professional workforce.

The chosen methodological approach incorporates several features designed to enhance research quality and rigour. Firstly, triangulation through multiple methods (interviews and focus groups) and multiple sites, supporting cross-verification of findings. Secondly, contextual sensitivity by using semi-structured interviews, which allow adaptation to different professional roles and organisational contexts whilst preserving analytical focus. Thirdly, the systematic analysis employs structured analytical frameworks to ensure consistent treatment of data while remaining open to emergent themes. Finally, reflexive practice involving ongoing reflection on

methodological decisions and researcher positioning, which enhances transparency and reduces bias.

This methodological foundation provides a robust platform for generating credible, transferable insights about coproduction in secure forensic mental health settings whilst remaining true to the interpretivist paradigm that guides the research.

4.6.2 Focus Group Discussions with Vignettes

The focus groups complemented the individual interviews by allowing me to observe how participants interacted with one another as they collectively explored and discussed coproduction. As the results below show, they illuminated the social nature of the barriers to coproduction and the team dynamics that influenced the behaviours of staff. As Braun and Clarke (2013) note, focus groups can surface unexpected or novel perceptions and experiences of a phenomena, adding additional colour to the individual interview data. The contrast between the public focus group discussions and the private individual interviews highlights commonalities and differences in the participant's perceptions of coproduction.

There were three focus groups in total, one at each site except The State Hospital, as discussed. The focus groups consisted of 6-8 participants and lasted approximately 90 minutes. The demands on staff at each site meant that it was not always possible to ensure that the interview and focus group contained the same participants. Where this was the case, availability sampling was used to fill gaps in the group. However, it was not possible to replicate the spread of professional representation from the interviews, with each group consisting exclusively of nurses. This presents a methodological limitation in the research approach.

In Medium Secure 2 (Scotland) and Dundrum Hospital, the focus groups participants were staff of similar seniority. At Medium Secure 1 (Scotland), however, a Senior Charge Nurse (ward manager) participated in the group, which may have constrained or magnified how other staff members responded.

The use of vignettes should allow the participants to unpick a theoretical case and to step back from their work context to consider issues as an independent observer (Given, 2008). They were also intended to enable the exploration of differences between what participants identify as typical responses and what their actual responses might be in practice.

Three vignettes in total were developed with guidance from key informants (see Appendix 2):

1. A 24-year-old male with history of violence, diagnosis of schizophrenia, and interests in football, fitness, and poker
2. A 34-year-old female with no living relatives, subject to treatment order after shoplifting, with interests in walking and knitting
3. An elderly institutionalised male stepping down from higher security who has struggled with transfers and has a physical health problem affecting his interest in playing football

The vignettes reflected the demographic reality of secure care (89% male in Scotland) (NHSScotland, 2019) while at the same time presenting a diversity in age, gender, clinical presentation, and possible institutional trajectory. Patient interests were included to provide connection points beyond clinical details and to encourage as wide as possible a discussion of the potential opportunities for coproduction.

Ten researcher prompts guided the discussion around areas such as risk assessment, boundary-setting, relationship building, and mechanisms to support coproduction (see Appendix 5). These prompts aimed to create as naturalistic an atmosphere as possible while ensuring that as many relevant aspects of coproduction were explored. This approach allowed the participants to interact with each other in discussions that resembled real clinical conversations, surfacing potential contradictions between their broad commitment to coproduction as a concept and the reality of managing complex presentation with peers (McMullen, 1999).

While vignette methodologies have been criticised for not presenting genuine real-world scenarios (Given, 2008), they are well-established in forensic mental health research (Grøndahl et al., 2012; Lapatin et al., 2012). Using them as part of a multi-method approach also helps to mitigate any methodological or data collection limitations by triangulating the data with individual interview data (Evans et al., 2015).

Vignettes are well-established in health research precisely because they enable discussion of complex ethical and practical dilemmas without the professional risks associated with critiquing actual patient care (Bachmann et al., 2008; Lapatin et al., 2012). However, in practice, the vignettes functioned differently than intended.

Rather than facilitating a detached theoretical exploration, they consistently prompted participants to draw on their experiences with actual patients, using the fictional scenarios as springboards to discuss real cases and concrete challenges in coproducing care. While this departure from the intended methodology initially appeared problematic, it revealed the deeply contextualised nature of coproduction practice in secure settings, where staff understanding is fundamentally grounded in lived experience rather than abstract principles. This unexpected outcome

highlighted both the limitations of vignette methodology in highly experiential professional contexts and provided valuable insights into how staff naturally conceptualise coproduction through the lens of their actual therapeutic relationships, suggesting that their understanding of collaborative practice is inseparable from the specific patients and situations they encounter daily.

4.6.3 Recording and Transcription

All interviews and focus groups were recorded using a Tascam DR-40 digital recorder with encrypted storage. For the focus groups, two additional external microphones were connected to the unit to supplement two onboard microphones, ensuring that all contributions were captured clearly. While this recording setup was initially noticeable to participants, they typically appeared to forget the equipment as the discussions progressed.

Recordings and transcripts were stored in an encrypted folder within The State Hospital's Home Office approved onsite secure data stores. The data was maintained within a server farm in a secondary secure compound sited near the entrance to the facility. Only the site's data security officer and I had access to this folder. The data security officer had the authority, should they wish, to access to all data kept within the system to ensure that data governance rules were being followed. They did not use that authority to examine the transcripts to my knowledge. This process allowed for secure collection and management of data (using the secure storage on the recorder) and secure storage (on Home Office approved secure servers) (Antonio et al., 2020).

Following MacQueen and Milstein's four-structure framework (MacQueen & Milstein, 1999), the *source data structure* captured participant demographics, professional roles, and institutional contexts for 33 staff members. *The primary object management* structure involved the systematic handling and organisation of raw data materials - specifically the interview and focus group recordings and their subsequent transcripts. This process began with the verbatim transcription of audio files into Microsoft Word documents, followed by the assignment of systematic alphanumeric identifiers (e.g., S1SN1: site 1, Staff Nurse 1) that linked participants to their respective sites whilst preserving anonymity. In presenting the findings, randomised pseudonyms were assigned to each contributor to humanise the data while maintaining their anonymity throughout the analysis and reporting phases.

As all primary data was stored in The State Hospital's Home Office-approved secure systems this data management system exceeded standard university requirements. The *secondary object structure* was managed through NVIVO 1.6.1, where codes, themes, and analytical memos were systematically linked to transcript segments. Codebooks documented the rationale and how the analysis process was applied to the data, ensuring consistency across the data collection period. *Coder data structure* included field notes and a combined field and reflective diary which tracked evolving interpretations, methodological decisions, and positionality considerations across different sites. I used the field journal to document my observations during the interviews and the focus groups, noting any non-verbal communication, group dynamics, and interruptions that occurred. I also used the diary to record my reflections on the research process, capturing any emerging insights and questions that would subsequently inform the data collection and analysis. This documentation was central to managing the insider/outsider dynamics at The State Hospital versus

external sites. Version control protocols ensured data integrity throughout the analytical process, whilst backup procedures protected against data loss.

4.7 Data Analysis

4.7.1 Methodological decisions

This project intends to understand the construction and interpretation of the patient and professional identity and how that influences the adoption of collaborative relationships that lead to the coproduction of outcomes for both parties using a multi-method approach for data collection (semi-structured interviews and focus groups). As such I have selected *thematic analysis* (TA) (Braun & Clarke, 2013) to analyse in-depth what meanings are inherent in the experience of the social actors in this particular environment (Weber, 1949). This section sets out my rationale for discounting alternative methods for analysis.

The phenomenon of coproduction has not yet been described in secure conditions, and as such lends itself to *smaller scale* qualitative approaches (Crouch & McKenzie, 2006). As elaborated previously, coproduction is a known phenomenon with a growing but disputed evidence base (Jo & Nabatchi, 2016).

In determining an interpretivist approach that would best shine a light on the experience of coproduction in secure settings I have discounted a pure application of Interpretative Phenomenological Analysis (IPA)(Smith JA 2013). IPA draws on the philosophical positions and debate between Husserl and Heidegger (Smith, 2003) but values Husserl's exploration of emergent meaning for common themes that are context free and can be applied to other cases. As described in 4.5.3, the data gathering tools are individualised and analysed using the double hermeneutic

process. Although created for use in psychology, this approach has been applied in a range of contexts with differing interviewing techniques in other disciplines (Fade, 2004; Jeong & Othman, 2016)

Whilst IPA is grounded in inherent meaning making and understanding - and Smith et al connect their theoretical frameworks to the phenomenology of Husserl (Draucker, 1999) and the hermeneutics of Heidegger (Smythe et al., 2008) - its emphasis on cognition is problematic in phenomenology (Tuffour, 2017). The literature on cognition, specifically cognitive interviewing (Willis, 2004; Willis & Artino Jr, 2013), highlights the influence that context can inadvertently have on both meaning making and the desire to give the interviewer the answer they think they are looking for (see *strategic accommodation* above). IPA is also a well described and detailed methodology for small sample sizes, with foundations in critical realism, rather than a method (Smith JA 2013). Thematic analysis (TA), in contrast can be applied across a spectrum of ontologies, without the bracketing required by Husserl, that favour qualitative techniques and can accommodate research questions about experience and perspectives (Braun & Clarke, 2006).

Coding and thematic analysis in TA begins with data familiarisation (Terry et al., 2017a) with subsequent coding across the entire dataset during the process of reading/re-reading transcripts or at the end of the process. IPA's process focusses on individual codes before drawing themes across the dataset. This results in a higher number of emergent themes. In practical terms this means that the method of IPA, whilst sharing ontology and epistemology with TA, is commonly used with smaller samples than the current study that intend to elicit ideographic experiences (op cit), whilst TA allows the researcher to focus on meaning making across a larger dataset (Braun & Clarke, 2013).

I have also discounted another qualitative approach, *grounded theory* (Glaser & Strauss, 1967). Grounded theory was ground-breaking in setting out the case for qualitative research and analysis by challenging the apriori basis of quantitative research, suggesting that properly bracketed researchers will allow theory to rise from the open coded data using '*systematic comparisons ...to engage the data and emerging theory actively throughout the research process*' (Given 2008:374). A more recent version, constructivist grounded theory, assumes that both the world and the process by which research is conducted are constructed but constrained by society and history (Bryant & Charmaz, 2007). However, grounded theory, of whatever type, produces substantial amounts of data posing challenges for this project primarily because it was undertaken part-time and over three sites with a total of 33 interviews and three focus groups. It would also necessitate abandoning the body of interdisciplinary work explored apriori to develop the current hypothesis on coproduction and the theory of games which has been the foundation of this research project. It would also provide a snapshot in time rather than thematic evidence that could potentially allow coproduction to be replicated in similar conditions. A purely interpretivist approach of that nature would provide an in-depth journey through the cognitive processes that idiosyncratically lead to theory building but may not advance our understanding of the collective experience of coproduction. Ultimately, thematic analysis emerged as the most appropriate analytical approach for this study's specific aims and constraints. Unlike IPA's focus on individual cognitive processes or grounded theory's requirement for theoretical bracketing, TA's flexibility allows for the systematic exploration of shared meanings across diverse professional roles and institutional contexts whilst remaining theoretically informed by Ostrom's framework of common pool resources (Braun & Clarke, 2006). The

method's capacity to accommodate the multi-site design and larger sample size supports the identification of patterns that transcend individual experiences, also supporting the development of transferable insights about coproduction in secure forensic settings. In addition, TA's compatibility with interpretivist paradigms aligns with this study's aim to understand both how existing theoretical concepts manifest in practice and what new understandings emerge from participants lived experiences (Terry et al., 2017b). This methodological choice therefore supports the research objectives of developing both contextually grounded and potentially generalisable knowledge about collaborative practice in highly regulated healthcare environments.

4.7.2 Approach to Thematic Analysis

The interview and focus group data were imported into NVIVO 1.6.1, a software package commonly used for qualitative data analysis (Braun & Clarke, 2013; Marshall & Rossman, 2011). The analytical process followed Braun and Clarke's systematic framework:

1. Familiarisation with the data: Given that data collection extended over 12 months across multiple sites, analysis began with immersion in the data by repeatedly reading the transcripts. Field notes and a reflective diary helped me to track developing interpretations while using it as a reminder to retain a critical distance (Biesta, 2007). As Braun and Clarke recommend, I aimed to '*read data as data*' (Braun and Clarke 2013:205). This meant approaching each transcript with an active, analytical mindset that went beyond understanding the narrative flow of participants' accounts to systematically interrogate the material for patterns, contradictions, and underlying meanings

relevant to coproduction in secure settings. Rather than passively consuming participants' stories, this analytical reading involved deliberately questioning what was being said, what was left unsaid, how concepts were being constructed, and how power dynamics might be influencing the accounts provided. Each reading cycle served a different analytical purpose: initial readings focused on familiarisation and noting preliminary observations, subsequent readings searched for patterns across the dataset, and later readings examined how emerging themes related to theoretical frameworks of coproduction, citizenship, and game theory. This systematic approach ensured that the analysis remained grounded in the data while maintaining the analytical distance necessary to identify significant patterns that might not be immediately apparent to participants themselves, particularly given their limited prior knowledge of coproduction as a concept.

2. Generating initial codes: Complete coding (assigning descriptive labels to segments of the data) was used to identify areas of interest relating to coproduction as defined in the literature review and to tag phrases and paragraphs that provided illustrations of the emerging themes, such as the distinctions between environments and the consistent appearance of minor, human interactions that framed relationships with patients. I maintained a separate codebook that documented the rationale and examples for each code to ensure they were applied consistently, while I captured emerging insights and connections between codes in an analytic memo book.
3. Searching for themes: In a second analytical pass, similar codes were collated under collective codes as a data reduction method, allowing larger patterns to be identified across the dataset. This process led to the creation of

meaningful themes or *central organising concepts* (Braun and Clarke, 2013:224) that captured key aspects of coproduction in secure settings. These were: the existence of the behavioural gateway, environmental affordances, the existence of a commons of peace and security and the emergence of staff archetypes.

4. Reviewing themes: The thematic structure was tested against the original data to ensure it accurately represented participants' accounts and captured meaningful patterns across the dataset. This circular process involved returning to data extracts to verify the coherence and distinctiveness of themes.
5. Defining and naming themes: Each theme (4.7.4) was defined to capture the essential meaning and its contribution to the understanding of coproduction in secure care. This process involved identifying the *story* each theme told and how it related to the overall research questions. For example, *environmental affordances* described the experience of the rules that formally governed different environments and the subsequent impact they had on behaviour, whether to comply or to subvert those rules directly, surreptitiously, either solo or with the collusion of others, including staff. That is, physical space shapes rule interpretation and application (See appendix 8).
6. Producing the report: The final analysis integrated illustrative extracts with an analytical narrative to present the complexity of coproduction in secure settings. Care was taken to move beyond description to interpretation, connecting findings to theoretical frameworks and the existing literature.

The analytical process for this study was developed iteratively from the 12-month data collection period to initial write up. The section below outlines the systematic

approach undertaken to develop a robust analytical framework capable of managing the complexity of multi-site, multi-method data whilst maintaining analytical rigour.

Analysis began during the early stages of data collection, following recommendations for concurrent data collection and analysis in qualitative research (Hashimov, 2015; Miles & Huberman, 1994). After completing the first four interviews at The State Hospital, preliminary coding was undertaken to develop an initial analytical framework. This early engagement with the data served two purposes: identifying emerging themes that could inform subsequent data collection and testing the practical application of Braun and Clarke's six-phase approach within the NVIVO software environment.

Following MacQueen and Milstein (1999), a structured codebook was developed to ensure consistency across the large dataset. The initial codebook contained operational definitions for each code, inclusion and exclusion criteria, and illustrative examples from the transcripts. This codebook was iteratively refined as analysis progressed, with all changes documented to maintain an audit trail. The codebook served as both an analytical tool and a method for ensuring inter-site consistency, particularly important given the extended data collection timeframe.

Data analysis followed a systematic yet flexible approach. Each transcript was initially coded independently before being compared with previously coded material to identify patterns and inconsistencies. Transcripts from different sites were deliberately interspersed during analysis to prevent site-specific bias from emerging. For example, after coding three interviews from Medium Secure 1, a transcript from Dundrum Hospital would be analysed to maintain analytical balance. This approach helped identify both site-specific variations and cross-cutting themes.

The analytical process incorporated systematic comparison at three levels: within-site analysis examining patterns across professional roles; between-site analysis exploring how security level and organisational context influenced findings; and method comparison, contrasting individual interview data with focus group discussions. Each level of analysis was documented separately before being integrated into the overall thematic framework, ensuring that comparative insights were grounded in systematic examination rather than impressionistic observations.

Throughout the analytical process, reflexive memos were maintained documenting emerging interpretations, methodological decisions, and researcher positioning. These memos were coded alongside interview transcripts, creating a meta-analytical layer that helped identify potential bias and track the evolution of analytical thinking.

Several strategies were employed to enhance analytical rigour. Negative case analysis was systematically pursued, with particular attention paid to instances where participants' accounts contradicted emerging themes. Additionally, the use of illustrative quotes in the final analysis was checked against original audio recordings to ensure accuracy and context preservation. This systematic yet flexible analytical approach enabled the identification of themes whilst remaining sensitive to the contextual variations that characterise coproduction across different secure forensic settings.

As Braun, Clarke, and Hayfield (2022:424) emphasise, this process was '*a starting point for [the] journey, not a map*', allowing the researcher to reflectively engage with the data rather than simply applying the procedures. The iterative nature of the analysis meant that earlier phases were revisited as my understanding developed.

4.7.3 Comparative Analysis

A comparative analysis was conducted at multiple levels. The interview and focus group data were compared to identify any consistencies and discrepancies between the collective private accounts and group discussions of coproduction. Data from the different professional groups represented in the interviews within each site were also compared to explore any variations in understanding and practice based on the professional role and perspective of participants. The analysis also compared patterns across the four sites to identify how the security level, organisational context, and national setting influenced approaches to coproduction.

This multi-level comparison highlights both the shared understanding of coproduction that transcended the particular contexts and any distinct features that emerged from particular security levels or organisational settings. For example, a recurrent theme across the interviews in all of the sites was the cultural barrier to sharing power with patients:

"There's no' many people left from the same time as me. People have been here eight or nine years eh they still like to keep it 'them and us'... but you cannae. You're in a community setting." (John, Healthcare Assistant, Medium Secure 2)

This contrasted with concerns about perceived impact on safety expressed in other interviews:

"A lot of the patients here exhibit extremely challenging behaviours, and you could say that's caused by staff not working with them and talking away."
(Bob, Charge Nurse, Medium Secure 1)

The comparative analysis allowed me to examine any tensions that became apparent between different perspectives on coproduction while identifying the common challenges and enablers across the gradients of security in the study.

4.7.4 Overview of the themes

As described in 4.6.1 I used Braun and Clarke's 6 stage to generate an understanding of the meaning they contained and allocated a descriptive code which were then grouped under initial themes to test their validity and adjust allocations to those themes before allocating final theme names.

A summary of the high-level codes and their descriptors can be found in the table below followed by a map connecting those themes to their subordinates.

The themes identified from the analysis fall into four sections:

Table 12 Themes from analysis

Theme	Short Code
1. The criteria patients must meet to access off-ward activities	Behavioural Gateway
2. What the physical and psychological environment enables to happen	Affordances
3. Patterns of staff behaviour in different contexts	Behavioural Archetypes
4. Factors shaping staff approaches to patients	Influences on Practice

Table 13 Overview of codes

High level code	Overview	Descriptor
Behavioural Gateway	The behavioural gateway allows access to off ward activities. To achieve the gateway patients, conform to behavioural and treatment norms such that the risk of violence or disruption off ward is minimised or mitigated. There is a distinction between the on ward behaviour of staff managing dynamic risk and off ward behaviour where that risk has been minimised sufficiently to allow relationship-based interactions.	The criteria for the behaviour gateway are individualised in high secure such that patients may not know what they need to do to achieve it. In lower security it is generalised because the patients are of a lower risk. Relationships on ward can be difficult because staff are managing a range of different individualised risks. Off ward staff can be confident that patients have met the behavioural criteria and are safe for the environment Achieving the behavioural gateway also means that relationships with staff can be a little more relaxed and can lead to a common desire to maintain peace and security

High level code	Overview	Descriptor
Affordances	Affordance describes what the physical and psychological environment enables to happen. For example, a busy ward environment affords higher degrees of control on movement and behaviour, which in turn defines the relationship with on ward staff. Off ward affords closer relationships because	On ward working is distinctively more difficult for staff and patients because of the risks of disruptive behaviour and the attraction of '<i>recreational rioting</i>' (Jarman & O'halloran, 2001). This appears to create limitations to the affordances on ward and the degree to which

	patients have passed their gateway and there is a greater focus on relationships and relational security.	relationships can be developed between staff and patients. The distinction between the two environments appears to be categorised by staff as difficult (on ward) and easy (off ward), where overt power and security is exercised on the ward, but off ward relies on relational security and the common purpose of maintaining peace and security

High level code	Overview	Descriptor
Behavioural Archetypes	Each location affords different staff behaviour: relationally close being predominantly off ward and custodian type behaviour predominantly on ward. An overt and unnecessary expression of power intended to create a reaction from a patient is labelled as malicious custodian in this typology	Relational work is highly complex and psychologically demanding but can also generate significant benefits to patients in terms of their progress through the system and staff in terms of safety and therapeutic effectiveness Relational work can happen on ward but it can be overwhelmed by physical and procedural security demands. Malicious custodian behaviour appears to be a feature of historic practices and the need for some staff to feel fully in control of the environment, which may reflect their insecurity on ward, or their distrust of relational work.
High level code	Overview	Descriptor
Influences on Archetypes	The appearance and longevity of the archetypes described are	Staff appear to positively select for on or off ward positions in high secure

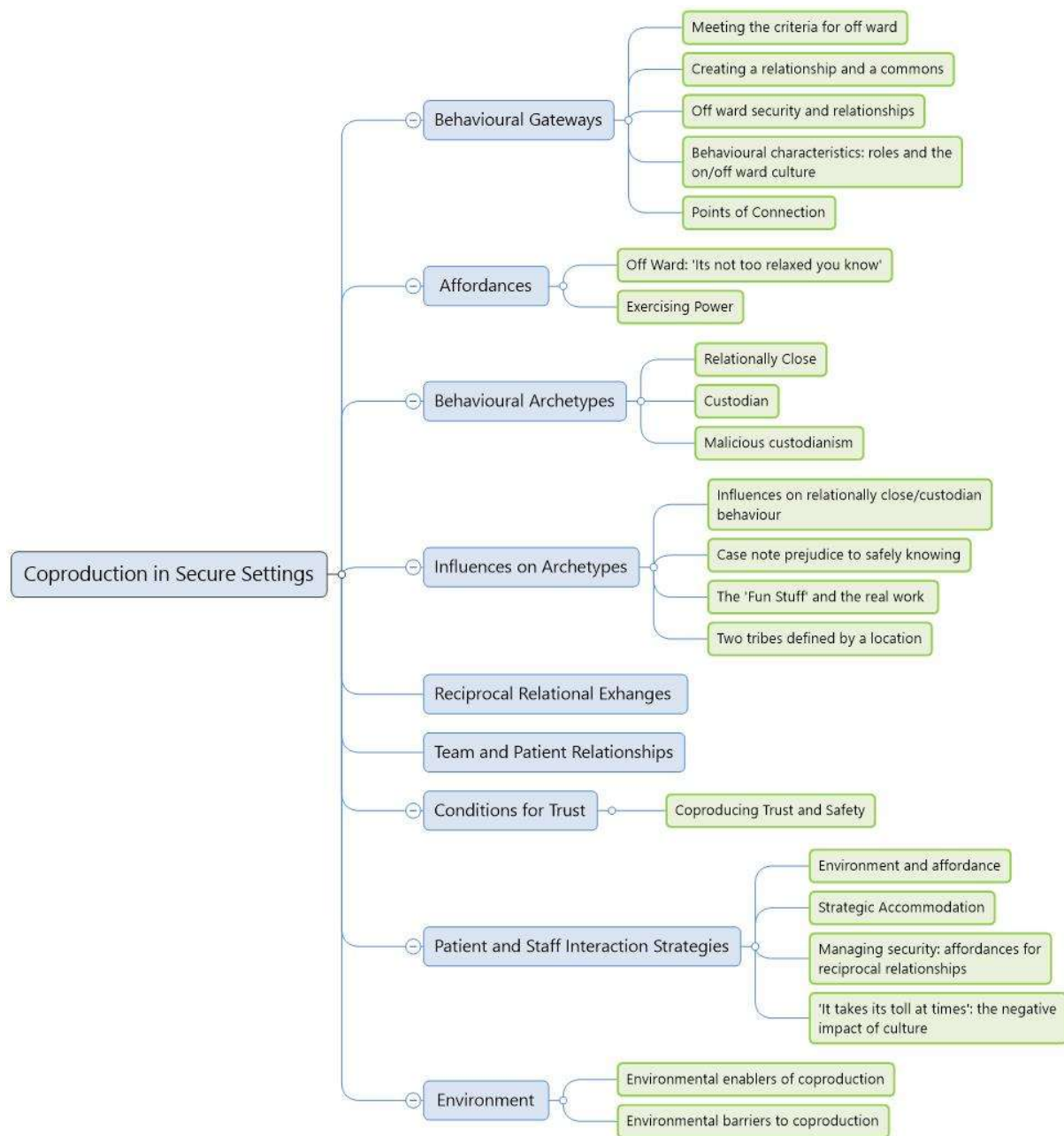
	influenced by the expectations and ethical basis of staff and how they are influenced by and recover from direct or vicarious experience of violence. On ward staff feel their work is of higher status than the 'fun stuff' created by visiting staff or off ward.	care depending on their archetypal orientation, and to volunteer for off ward work in lower security when it arises if they are relationally oriented.
Reciprocal Relational Exchanges	Staff who use the relationally close approach to supporting patients find means to share commonalities with patients safely to develop trust and a better therapeutic relationship	Reciprocal exchanges can occur on wards but they are at risk of disruption by other patients. The exchanges were most often described in off ward locations in high secure or on escorted leaves in lower levels of security.
Team and Patient Relationships	The connection and relationship that some staff have with patients can lead to division within the team where there is a clash between custodianism and relational working	The tenacity of relationally close working for some staff appears to occur when they have been exposed to community psychiatric work

High level code	Overview	Descriptor
Conditions for Trust	There are more fertile conditions for trust off than on ward. Primarily this is because patients have passed their behavioural gateway	The risk that a desired off ward activity could be lost appears to be a factor in self-management of patients that have passed their gateway. The staff in off ward projects or leave activities in lower security are at equal risk of losing a desired activity as their patient if something goes wrong. The central condition for trust then appears to be the establishment of a mutual commons - the activity-

		which both work to maintain.
Patient and Staff Interaction Strategies	Staff and patient interactions are influenced by the different spaces that they encounter one another.	Each space affords different behaviours and forms of connection dependent on the environmental affordances, the degree to which relationship reduce strategic accommodation and promote honesty, the willingness of staff to safely share something of themselves and the degree that culture supports or prevents such actions.
Environment	Different levels of physical and relational security afford distinctive degrees of coproduction: less likely in high secure and increasingly likely as we descend levels of security to discharge.	How risk is interpreted and understood by staff determines their response to different patients. Their behaviour is also determined by their history, their vicarious or direct experience of violence and the culture within each environment

The figure below presents a map of the themes relating to coproduction in secure settings.

Figure 8 Map of Codes



4.8 Ethical Considerations

Research within secure forensic mental health environments presents a unique set of ethical challenges (Keogh & Daly, 2009). This section provides an examination of the ethical considerations that shaped this study. I begin by setting out the ethical approval process for the multi-site design. I then discuss the approach to ensure voluntary participation and informed consent, followed by a description of the measures put in place to support participant anonymity and confidentiality. Next, I describe the steps taken to reduce potential harm to the participants in the study. This is followed by a critical reflection on my own positionality as both researcher and staff member, and the potential implications this held for the research process (Coffey, 2006). Finally, I acknowledge the ethical limitations of the study design and approach, particularly regarding representation and power.

4.8.1 Ethical Approval Process

This research required approval from multiple ethics committees due to its multi-site design and the secure forensic context. The project received approval from:

- University of Strathclyde's University Ethics Committee (UEC)
- The State Hospital (Scotland) Research Ethics Committee (TSHREC)
- The Forensic Network's West Research Ethics Committee (WREC) for access to the Scottish commercial and NHS medium secure sites
- The Dundrum Hospital (Ireland) Research Ethics Committee in Ireland (DHREC)

Each committee reviewed the research proposal and protocols, participant information materials (Appendix 1 and 2), and the data security arrangements.

An initial proposal for an observational study of staff interacting with patients was rejected by TSHREC, which was a position taken subsequently by the other REC's providing access to their sites. This required significant changes to the original method and data plan to focus instead on interviews and focus groups. This early feedback from THSREC was useful in that it led me to appreciate the ethical implications of observational methods in secure settings and the potential for inadvertent coercion of patients as vulnerable participants.

All subsequent changes to protocols, interview guides, or vignette structures were submitted to and approved by all relevant committees via email, ensuring ongoing ethical oversight throughout the research process. This multi-layered ethical review ensured comprehensive scrutiny of both the theoretical approach and practical ethical considerations. The different committees highlighted a variety of concerns based on their specific remits – for instance, TSHREC placed a particular emphasis on security, while the UEC focused on methodological rigour and general research ethics principles (Strathclyde University Ethic Committee, 2017) .

The UEC approval was subject to adherence with the Code of Practice of Human Investigations On Human Beings (Strathclyde University Ethic Committee, 2017). This code emphasises the importance of respect for autonomy, beneficence, non-maleficence, and justice – principles that guided the ethical approach throughout the study. Particular attention was paid to protecting participants against psychological and physical harm given the nature of the working environment, ensuring that

individual anonymity and confidentiality could be maintained, applying data protection.

One particularly challenging aspect of the ethical approval process was reconciling the often-competing requirements of different committees (Hammersley & Traianou, 2012). For example, TSHREC had specific requirements regarding data storage, dictated by the Home Office standards for the site, which were then applied to data from all of the sites, exceeding those of the UEC. Similarly, gaining access to different sites required navigating different institutional gatekeeping processes, each with their own ethical frameworks. These negotiations took place over a six-month period and required some revisions to the research materials, particularly the participant information sheet.

The ethical approval process also prompted an examination of the vulnerabilities associated with research in secure forensic environments (Guillemin & Gillam, 2004). These included heightened privacy concerns due to the sensitive nature of forensic work, the potential professional risks for staff discussing institutional and operational practices, and the complex power dynamics within hierarchical healthcare structures. The approval process required a comprehensive review with each ethics committee of how these issues would be addressed, except where WREC approval was accepted by both Medium 1 and 2, strengthening the robustness of the study design.

4.8.2 Voluntary Participation and Informed Consent

Ensuring voluntary participation and obtaining genuine informed consent were central ethical priorities throughout this research. These principles are of particular

importance in the context of secure forensic settings, where institutional hierarchies and professional obligations create complex power dynamics that could potentially undermine the voluntary nature of participation.

All participants received detailed written information about the study through participant information sheets (see Appendix 1 and 2). These materials were designed to be comprehensive without being unnecessarily complex, providing accessible explanations of the research questions and objectives; what committing to be a participant would involve in practical terms; the extent and limitations of anonymity; the rights to withdraw data without penalty; and the data storage and usage protocols. Particular care was taken to avoid technical jargon while still conveying the necessary information accurately.

I ensured that I obtained written informed consent from all participants prior to collecting data. The consent forms were structured to ensure participants explicitly agreed to each aspect of participation rather than providing a single blanket consent. This approach, sometimes called '*layered consent*' (Alderson & Morrow, 2020), allowed participants to agree to participation while potentially declining specific elements such as audio recording. No participant made use of this opt out.

Before each interview or focus group, I confirmed that participation was voluntary and that participants could withdraw at any time without consequences. This was particularly important given the potential for subtle coercion in workplace-based research, where participants might feel an implicit obligation to participate despite written assurances to the contrary (Miller & Bell, 2002). I was particularly mindful of the hierarchical nature of forensic mental health settings, where staff might feel institutional pressure to participate if requested by management. To mitigate this risk,

recruitment communications emphasised that participation decisions would not be disclosed to line managers or other superiors. Where possible, predominantly in the high security sites in Scotland and Ireland, I arranged direct contact with potential participants to discuss the project prior to interviews or focus group participation. However logistical and organisational constraints, such as rotations and workforce pressures, meant that recruitment was primarily through management channels for the two medium secure sites.

Attention was also paid to the possibility that junior staff might feel unable to decline participation in focus groups that included more senior colleagues. In the Medium Secure 1 site, for example, a Senior Charge Nurse participated alongside staff nurses. In these cases, I took particular care during the consent process to speak with junior staff individually and to emphasise the genuinely voluntary nature of participation. During the focus groups themselves, I used my professional training as an addiction counsellor to ensure that more junior voices were not overshadowed by senior colleagues. I also treated consent as an ongoing process rather than a one-time event, paying attention to signs of discomfort or reluctance during data collection. This *process consent* approach (Dewing, 2007, 2008), acknowledges that participants may reconsider their willingness to discuss certain topics as the research unfolds. On several occasions, I observed non-verbal cues suggesting discomfort with particular lines of questioning. In these instances, I offered participants the opportunity to pause, move to different topics, or conclude the session entirely. For example, during an interview at Medium Secure 2, a participant became noticeably uncomfortable when discussing challenges in implementing coproduction approaches. I acknowledged this discomfort directly and offered to move to a different topic, which the participant accepted with obvious relief.

I explicitly acknowledged with participants that discussing barriers to coproduction might highlight tensions between ideal and actual practice, with the potential to cause professional discomfort as participants reflected on limitations in current approaches. I framed my questions in terms of system constraints rather than individual practice limitations, emphasising that the research aimed to understand contextual barriers rather than evaluate individual performance. This framing appeared to reduce defensiveness and facilitated a more open discussion of implementation challenges.

The temporal limitations of informed consent in research involving professional practice were also considered. Participants consenting to discuss their work experiences may not fully anticipate how their perspectives might evolve after reflection, or how organisational changes might affect their comfort with previous disclosures. To address this, all participants were offered the opportunity to review their interview transcripts and withdraw or amend specific comments, although none chose to exercise the withdrawal option.

4.8.3 Anonymity and Confidentiality

Protecting participant anonymity and confidentiality presented particular challenges in this research context, given the specialised nature of forensic mental health services and the limited number of professionals in key roles (Saunders et al., 2015). A multi-layered approach to these issues was used, balancing the need for contextual richness with participant protection.

Participant confidentiality was ensured in a number of ways. All individual interviews were conducted in secure offices where conversations could not be overheard,

typically in administrative areas. These were situated adjacent to clinical spaces in the medium secure facilities but off ward for both high security sites. Focus groups were held off ward in dedicated meeting spaces to minimise interruptions and prevent patient or other staff observations of participation. All research data was stored securely with encryption in The State Hospital's Home Office approved secure storage systems, exceeding standard university data protection requirements, as previously noted.

All transcripts were anonymised using an alpha-numeric coding system that identified the site type and organisational position, but not specific individuals (e.g., S3SN3 for the third staff nurse participant from site 3). Additionally, any potentially identifying details within the data were systematically modified or removed from quotes. This included specific references to unique roles, distinctive career histories, or particular incidents that might make participants identifiable to colleagues. Where such details were essential to the analysis, they were generalised to preserve the substantive content while removing identifying specifics. In the two findings sections participants are allocated a random name to humanise the presentation of the data.

The decision was taken not to name the specific research sites, with the exception of the high secure sites in Ireland and Scotland. Their uniqueness meant that it was not possible to anonymise them to the same extent as the other sites. This was agreed with the DHREC and TSHREC. The medium to low secure sites, while also being unique, were less likely to be identified as they are part of a wider group of facilities across Scotland. While this level of anonymisation might seem nominal given the specialised nature of these institutions, it prevents immediate identification by casual readers and creates an additional layer of protection when combined with participant anonymisation.

Special care was taken to ensure that any specific views or experiences described could not be attributed to identifiable individuals, particularly for participants in more unique or senior roles. In some instances, this required omitting particularly distinctive examples or combining experiences from multiple participants to illustrate themes without compromising anonymity. While this approach occasionally reduced the idiographic richness of the data, it was deemed necessary to fulfil ethical obligations to participants (Kaiser, 2009).

I discussed these anonymity limitations openly with participants before obtaining consent, acknowledging that in small, specialised environments, complete anonymity could not be guaranteed despite my best efforts (Tolich, 2004). This transparency allowed participants to make informed decisions about what information they felt comfortable with sharing, within the realistic limits of the protection offered. Many self-censored particularly sensitive information or requested specific comments be treated as '*off the record*', a tacit acknowledgement of the anonymity limitations as they understood them.

During the focus groups, I established ground rules that emphasised confidentiality and requested that participants respect the privacy of their colleagues' contributions beyond the research setting. This included an explicit request not to attribute specific comments to individuals when discussing the research with non-participants. I also advised participants to exercise judgment regarding particularly sensitive disclosures in the group setting, acknowledging that confidentiality agreements between participants could not be enforced to the same degree as researcher-participant confidentiality.

The balance between anonymity and context presented ongoing challenges throughout the analysis and writing process. Forensic mental health services have distinct practices and structures that significantly influence coproduction approaches, making contextual details important for meaningful analysis. However, these same details potentially compromise anonymity in such specialised settings. This tension was navigated by providing sufficient contextual information for analytical purposes while systematically reviewing all site and participant descriptions to ensure they did not inadvertently reveal identities.

4.8.4 Reducing Risk of Harm

Research in forensic mental health settings carries potential risks of psychological distress for participants, particularly when discussing challenging aspects of practice or systemic limitations that may affect patient care. A range of measures were put in place to minimise these risks throughout the research process. I designed interview questions and vignettes to explore sensitive topics professionally rather than personally, focusing on practice conditions rather than individual performance. Questions were framed to normalise any implementation challenges, emphasising that barriers to coproduction are widely documented rather than unique failures of particular services or professionals. This framing aimed to reduce potential feelings of inadequacy or defensive responses when discussing limitations in current practice.

The vignettes used in the focus groups (detailed in Appendix 4) were carefully constructed to present realistic but depersonalised scenarios based on the literature and guidance from the key informants rather than specific cases from participating

sites. This approach intended to allow participants to discuss challenging situations without directly critiquing participants' own practices or those of their immediate colleagues. Preliminary versions of these vignettes were reviewed by the key informants and TSHREC, which included clinicians with forensic experience, to ensure they were realistic but not unnecessarily provocative or distressing.

Throughout data collection, I monitored participants for signs of discomfort, including non-verbal cues such as increased tension, decreased eye contact, or shifts in tone. When such signs were observed, I offered breaks, changed the subject, or checked whether participants wished to continue. For example, during a focus group at Medium Secure 1, I noticed a participant becoming increasingly withdrawn when discussion turned to resource limitations. I suggested a brief break, which provided an opportunity to check privately whether the participant wished to continue or to modify the discussion.

The timing and location of interviews were arranged to minimise disruption to participants' work routines and reduce potential stress. I offered flexibility in scheduling, including options for interviews during quieter periods identified by participants. Where possible, interviews were conducted in neutral spaces rather than managers' offices or other locations with power or hierarchy associations. This approach aimed to create psychological as well as physical safety for honest discussions.

I was mindful that discussing barriers to coproduction might highlight discrepancies between professional ideals and practical realities, potentially causing moral distress for the subject group. To mitigate this risk, discussions of barriers were balanced with an exploration of facilitators and successful approaches, acknowledging the

genuine constraints under which professionals in this unique field operate while recognising their commitment to high-quality care.

In the focus groups where hierarchical relationships existed (such as in Medium Secure 1 where a Senior Charge Nurse participated alongside staff nurses), I used my experience of facilitation techniques to minimise power differentials as far as was possible and to ensure all participants could contribute safely. These techniques included directing questions to quieter members, reinforcing diverse viewpoints, and careful management of dominant voices. While these hierarchical relationships were not ideal from a research perspective, they reflected the reality of multidisciplinary teamwork in these settings and provided valuable insights into how professional hierarchies influence approaches to coproduction (Karnieli-Miller et al., 2009).

After each interview or focus group, I allowed time for debriefing, giving participants the opportunity to raise concerns or reflect on the discussion experience (Dickson-Swift et al., 2008). I also provided information about support resources available through their institutions, including staff wellbeing services and clinical supervision. While no participants reported distress requiring formal support, several commented that the discussions had prompted useful reflections on their practice that they intended to explore further in supervision.

I was also aware of the potential for participation in the research to affect professional relationships or standing between participants. Comments made during individual interviews were never attributed to specific participants in subsequent interviews or focus groups, even when directly relevant to ongoing discussions. This was intended to minimise any professional consequences from honest participation while still allowing the themes to be explored across the dataset.

4.8.5 Research Positionality and Insider/Outsider Status

My dual position as both a researcher and a staff member at the State Hospital required ongoing ethical reflection. This insider-outsider status (Dwyer & Buckle, 2009; Merriam et al., 2001) carried both advantages and challenges for the research process, influencing access, relationships, data collection and storage, and interpretation. For participants at The State Hospital, I explicitly acknowledged my organisational role while emphasising that interviews were conducted in my researcher capacity rather than as a colleague or as a representative of management. This distinction was important but inevitably imperfect; participants' awareness of my institutional affiliation likely influenced their responses regardless of my attempt to ensure role separation. Some participants at this site demonstrated this awareness through references to shared knowledge ('*as you know...*') or hesitation before criticising institutional approaches.

At other sites, I predominantly occupied an outsider position, lacking knowledge specific to the institution but potentially benefiting from participants' willingness to explain their context more fully to someone they perceived as needing orientation to their setting. However, my State Hospital association might have created a perception of authority or expertise and potentially influenced their responses or created expectations that the research would inform practice at the highest security level. This was particularly evident in the Irish site where participants often assumed that The State Hospital had superior resources and practices.

This positioning has been explored as the '*insider/outsider phenomenon*' (Dwyer & Buckle, 2009) or '*outsider within*' (Collins, 1999). In The State Hospital, surface

legitimacy was given to me by senior managers supporting the research and the research ethics committee approving the proposal. In other locations, legitimacy came from senior management approval, my association with The State Hospital, and my university affiliation.

The insider position at The State Hospital created particular ethical challenges regarding confidentiality and potential conflicts of interest. I was careful to avoid scheduling interviews with staff with whom I had close working relationships, though the interconnected nature of the institution made complete separation impossible. I maintained strict confidentiality regarding participation and the content of interviews, never discussing research conversations in workplace contexts even when participants themselves referenced their involvement.

The contrast between the sites where I had '*performative knowledge*' (Geirbo, 2019) and those where I did not, allowed me to compare cultures and explore subcultures that might not have been evident from a pure insider perspective (Asselin, 2003). As Dwyer and Buckle note, people '*talk differently*' to those they perceive as sharing or not sharing their experience (Dwyer and Buckle 2009:59). I was aware that I did not speak like a nurse or a social worker, although I might have unconsciously adapted my communication to increase my acceptance by others.

My background in administration rather than clinical work also shaped the research approach in ways that have ethical implications. While this positioning provided a degree of objectivity regarding clinical approaches, it potentially limited my understanding of certain professional nuances or created an impression of naivety about clinical realities. I addressed this by researching the background of each institution and their approaches as much as was possible and by seeking clarification

when participants referenced unfamiliar practices, acknowledging the limitations of my perspective while using them as opportunities for deeper exploration of taken-for-granted practices.

My professional background in addictions services also influenced my perspective on therapeutic relationships and power-sharing. That experience oriented me toward valuing service users' inherent knowledge about their own lives and challenges, whether related to substance use itself or its socio-legal consequences. This positioning reflects what Freire (1970) terms '*critical pedagogy*': creating knowledge among equals rather than privileging professional expertise over lived experience. This orientation aligned with my interpretivist methodological approach and my theoretical interest in Ostrom's work on common pool resources.

Throughout the research, I maintained awareness of how my institutional position might influence data collection and interpretation. This reflective approach helped identify and address potential biases that I continually reflected upon (Berger, 2015). These included preconceptions that nurses, particularly healthcare assistants and nursing assistants, would spend more time with patients and therefore have more opportunities to develop coproductive relationships than other professional groups. I also assumed that professionals in forensic care experience a tension between caring and custodial responsibilities, potentially leading them to prioritise one aspect over maintaining a dynamic balance between them.

I also maintained field notes after each interview and focus group, including reflections on how my positioning might have influenced the interaction, which were reviewed during the analysis to consider potential positional effects. These reflections were documented in my field diary, which recorded how my

understanding evolved over time in my engagement with the participants. The diary served as a tool for sense-checking emerging interpretations and acknowledging the inevitable influence of my positioning on the research process.

My unique access to The State Hospital as both researcher and employee created an ethical dilemma that potentially influenced the depth of the critique of its institutional practices (Greene, 2014). While this access provided valuable research opportunities, it also carried risks of either undue criticism or excessive caution when analysing practices at my own place of work. I addressed this tension through regular supervision discussions focused explicitly on maintaining a critical distance while using my insider knowledge constructively, and through comparisons of findings across sites to situate The State Hospital practices within broader forensic approaches.

The research also required navigation of potential role conflicts when participants discussed practices or concerns that might normally warrant action in my administrative capacity. I clarified at the outset of each interaction that information shared with me would not inform my administrative work unless explicitly agreed, and that my primary duty was to participant confidentiality rather than institutional interests. This clarification was particularly important at The State Hospital, where participants might otherwise have assumed that criticisms or suggestions would be directly conveyed to management through my professional role.

As my fieldwork progressed, I gained a greater appreciation for the complexity of secure environments and the resilience of staff committed to supporting patients who are vulnerable both through their mental health conditions and their exclusion from mainstream society. This evolving understanding helped me maintain a balance

between critical analysis and appreciation of the challenging contexts within which forensic mental health professionals operate.

4.8.6 Ethical Limitations

Despite careful attention to ethical considerations, several limitations must be acknowledged in the approach taken. Transparency about these limitations is itself an ethical imperative, highlighting areas where ethical ideals were compromised by practical constraints or competing priorities.

A primary limitation concerns the institutional boundaries that shaped the research design and implementation. Access to research sites was contingent on accepting institutional requirements and limitations that had a potential to compromise ideal methodology. At The State Hospital, for example, focus groups were not authorised because of operational constraints, limiting the data collection to individual interviews despite the recognised value of group interactions for exploring shared understandings of coproduction. Similarly, at Dundrum Hospital, access to nursing staff was restricted to off ward staff selected by management, potentially biasing the sample toward more institutionally aligned perspectives.

These institutional constraints represent a form of ethical compromise (Swartz, 2011), where research access was balanced against methodological intentions. While these compromises were necessary for the research to proceed, they inevitably shaped the resulting data and must be acknowledged as limitations to both the ethical and methodological integrity of the study. Future research might explore alternative approaches to negotiating institutional access that better preserve methodological integrity while respecting legitimate institutional concerns.

A second significant limitation concerns representation and voice, particularly the absence of patient perspectives in the research (Hewitt, 2007). While the focus on staff perspectives was a practical methodological choice, it represents an important ethical limitation given that coproduction fundamentally concerns patient-professional collaboration. The exclusion of patient voices risks reproducing the very power imbalances that coproduction aims to address, privileging professional perspectives in defining what constitutes meaningful involvement.

This limitation was a conscious compromise based on several considerations: the additional ethical complexities of involving forensic patients as participants; the extended timeframes that would have been required for additional approvals; and the recognition that staff perspectives on implementation barriers represent an important first step in understanding coproduction in these settings. However, this compromise must be acknowledged as ethically problematic, particularly given the study's focus on approaches intended to elevate the patient voice and agency.

A third limitation concerns the inevitably partial anonymity possible in specialised forensic settings. Despite extensive efforts to protect participant identities, the small and interconnected nature of forensic mental health services in Scotland and Ireland means that complete anonymity cannot be guaranteed, particularly for those in unique or senior roles. While this limitation was explicitly discussed with participants before obtaining consent, it nonetheless represents a compromise to the ethical ideal of complete protection from identification.

Finally, the dual role I occupied as researcher and a State Hospital staff member created ethical tensions that could not be fully resolved (Smith, 2008). The insider knowledge and access this position afforded came with inevitable biases and

potential conflicts of interest that may have influenced data collection and interpretation despite my conscious efforts to maintain critical distance. While these tensions were actively managed through supervision and reflective practice, they represent a structural limitation to the ethical positioning of the research that should be acknowledged.

These limitations highlight the inevitably imperfect nature of ethical practice in complex research settings, where competing priorities and practical constraints result in compromises to ethical ideals. Rather than undermining the research, however, my transparent acknowledgment of these limitations strengthens its integrity by recognising the contextual realities within which ethical decisions were made and providing important context for interpreting the findings presented in subsequent chapters.

4.9 Chapter Summary

This chapter has outlined the methodological approach used to investigate coproduction in secure forensic mental health settings. The research is situated within an interpretivist paradigm, which recognises that reality is constructed and interpreted through experience and between people (Berger & Luckmann, 1966; Guba & Lincoln, 1994). This philosophical positioning acknowledges that understanding coproduction requires an engagement with the subjective meanings that staff attach to their interactions with patients.

The theoretical framework for this research draws on Elinor Ostrom's work on common pool resources (Ostrom, 1990), conceptualising peace and security as resources jointly produced through relationships characterised by trust, reciprocity,

and power-sharing. This lens provides an analytical framework for examining how staff strategically interpret their contribution to coproductive processes.

The research employed a multi-site, multi-method design, collecting data across four secure forensic mental health facilities representing different security levels, organisational contexts, and national settings. Data collection combined semi-structured interviews with focus group discussions using vignettes, providing complementary perspectives on individual and collective understandings of coproduction.

A total of 33 professionals participated in the study, predominantly nursing staff but also including psychologists, psychiatrists, advocates, and occupational therapists. Data were analysed using thematic analysis following Braun and Clarke's six-phase approach, with comparative analysis across methods, professional groups, and sites.

Ethical considerations included a multi-layered approval processes, informed consent procedures, and careful attention paid to confidentiality and anonymity. My positionality as both insider and outsider was acknowledged through reflective practice, recognising that my professional background and institutional affiliations might influence the research process.

The study's methodological limitations include its focus on staff perspectives without corresponding patient views, constraints on sample representation and site access, and potential influences from my dual role at The State Hospital.

The following chapters present the findings using this methodological approach, exploring how staff across different secure settings interpret coproduction, the factors they identify as enabling or inhibiting collaborative practice, and the

implications for understanding coproduction in environments where security concerns necessarily constrain autonomy.

Chapter 5. Findings: The Behavioural Gateway and Staff Archetypes in Secure Forensic Mental Health Settings

5.1 Introduction

This chapter presents the findings from interviews and focus groups undertaken with staff across the security gradient in secure forensic mental health care facilities. The findings encompass the emerging themes from the analysis that address the study's research questions:

1. How do rules-based environments in secure forensic mental health care affect forms of coproduction?
2. How do staff working across different levels of security conceptualise coproduction processes?
3. What factors enable or inhibit coproductive relationships in secure care environments?

To begin, this chapter describes the *behavioural gateway* as the key signifier of progress and stability for patients - becoming well enough and stable enough to access off ward activities. The chapter then describes an emerging understanding of the roles that staff take that are influenced by that signifier, dependent on the balance of relational and physical security required in the environment, and the cultural norms that support them. The chapter then proceeds to explore the relative emphasis on security or rehabilitation dependent on the approach that staff take, which is most apparent depending on whether they are working on or off ward. This can determine if the relationships and the sharing of information between staff and

patients are seen as a positive contribution to peace and security or a risk and, consequently, the influence of the environment on staff behaviour.

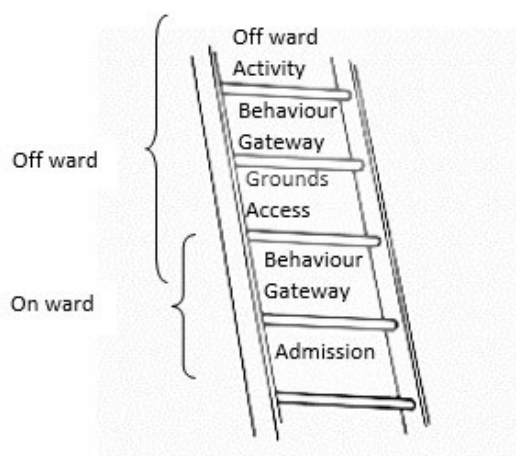
The analysis addresses the study's research questions through the lens of staff perspectives on coproduction processes, whilst acknowledging a fundamental limitation: the absence of patient and service user voices in this analysis. The study therefore examines staff conceptualisations of coproduction within institutional frameworks that inherently constrain patient autonomy and choice. The findings should be understood as exploring the possibilities and barriers to coproduction from the perspective of those who hold institutional power, rather than those who are subject to it.

5.2 The Behavioural Gateway: A Framework for Understanding Patient Progression

For the purposes of this study the *behavioural gateway* is defined as *the behavioural safety and symptom management thresholds that patients need to meet in order to access off ward activities* in all of the sites studied. Unlocking this behavioural gateway is one of the key indicators of progress for both patients and staff, signifying a reduction in assessed risk. This gateway passports patients to off-ward activities across the sites and can lead to off-campus escorted or unescorted leave in lower levels of security. Accessing the gateway is dependent on the patient's symptoms, behavioural compliance and the degree of instrumentality in their behaviour. That is, whether changes in their status are due to improvements in their conditions or the application of a strategic accommodation strategy. As Jim, a senior staff nurse in The State Hospital, describes it:

*'We usually get the patients when they've been assessed and **passed** by the clinical team...'* (Jim Staff Nurse, The State Hospital, emphasis added).

Figure 9 Behaviour gateways and accessing off ward



The gateway in high security marks a transition from predominantly physical restrictions and observation on the ward to predominantly relational security (DOH, 2010), but accessing the gateway is conditional and can be removed or withdrawn. It is a signifier of progress to patients and to off-ward staff of a significantly reduced risk because they are compliant with the rules which is: *'a testament to the work that they've done...'* (Susan CM Dundrum Hospital).

Forms of agonism as described by Rosanvallon and Goldhammer (2008), escape attempts as described by Cohen and Taylor (2003), or recreational rioting (Jarman & O'halloran, 2001) would exclude a patient from the gateway, with the path to legitimate protest exclusively through the independent advocacy projects provided as a human rights safeguard under the Mental Health (Care and Treatment) (Scotland) Act (2003), and to a limited degree under the Mental Health Act 2004 in Ireland. This constraint may contribute to instrumental strategic accommodation (Moore, 2009), that is accepting the rules and restrictions as a means to access off ward activity.

Distinguishing between instrumental accommodative and actual change appeared to be difficult for staff to determine objectively, even if that change represented a shift from non-compliance and resistance to demonstrating a level of self-control and motivation, influenced by the general stability on a ward. For example, the consultant psychiatrist from The State Hospital cautions:

'...there lies the danger because it comes with complications such as manipulation ... to gain for either primary gain or secondary gain. So that is to say sometimes, we hear about professionals breaching the boundaries because when you are in situation you know, and you are being manipulated sometimes you don't actually realise what they are doing. Sometimes it's for the secondary gains such as that you subvert security.' (Pete, Psychiatrist, The State Hospital)

This caution is also reflected elsewhere, as the Dundrum Hospital focus group contributor describes:

'This guy after 4 weeks just tells me he is doing ok, he's not assaultive, he's been out in the community, he's telling you what you want to hear. I mean 'you haven't really started anything'. ... You're not really getting anything here so your talking months, before..., years for some guys, before you have a meaningful relationship with them or certainly therapeutic relationship...' (Janice, Clinical Manager, Dundrum Hospital)

In lower security there is a distinction between patients stepping down from high secure restrictions and those referred directly from court or community services:

'the patient may be coming from [The State Hospital] will be going down the levels whereas court guys just coming, they've got different expectations

whereas maybe the ones that have come down from the higher secure, they know about activities and they know about like how they get the goodness out of activities whereas somebody coming from the jail might be like, activities, I'm not really up for that, they don't really understand the benefits the way a long term patient does' (Matt, staff nurse Medium 1)

In the Irish site there is a graduated process to access the gateway:

'They have a lot of little steps that they take, they don't take one big step...If they do well on this step then the next step has more to offer.' (FG Fergus Clinical Manager Dundrum Hospital).

And in the Medium 2 site, seeing others access that gateway is a behavioural compliance incentive:

'When they first come in, straight away they see patients going swimming, cinema, shopping, Glasgow, football, everything. The whole range of things that we do with them, so they see that as soon as they come in...' (FG Petra Nurse Medium 2)

The concept of the *behavioural gateway* represents the thresholds for behavioural safety and symptom management that patients must demonstrate to access a graduated system of off-ward privileges.

Staff across the sites described the challenges in distinguishing authentic therapeutic progress from instrumental compliance. The process for assessment and risk management may provide some certainty around the decisions about progressing to off ward activity, but ultimately it seems to rely on professional judgment - integrating standardised assessment tools with contextual knowledge (Mullen, 2000) - and consensus within the care team. The time required to reach that consensus may

paradoxically contribute to patient frustration. However, staff across security levels acknowledged that meaningful therapeutic relationships capable of distinguishing genuine recovery from strategic accommodation often require extended periods to develop -'*months, ... years for some guys*' (Peter, Charge Nurse, Medium 1). This dynamic is complicated by the institutional conditioning for patients stepping down from high security, and the expectations, or lack of engagement, of those entering directly from courts or community settings. Seeing others accessing benefits by achieving their behavioural gateway appears to function as both a motivator and a potential catalyst for instrumental compliance for patients, which present challenges for staff trying to establish therapeutic and real relationships to support them.

5.3 Behavioural Compliance as Progress Indicator

Procedural security measures (Crichton, 2009) such as locking doors or providing an escort for instance, is an unavoidable part of life within secure mental health services for patients and staff, although its prominence diminishes in medium and low secure facilities. However, there are two distinct groups of patients in the medium secure facilities who experience procedural security differently. There are the patients who are stepping down from higher security who see the reduced restriction in medium and low security as a reward for the work that they have done:

'[It]gives them hope from the minute they walk in that they know that they will not be sitting vegetating for months to get that wee step out of the door' (FG Jill Nurse Medium 2)

'We've cut down that kind of assessing period and progressing patients back into the community a lot quicker, in a controlled manner, but again I think the

patients recognise that we are very much working together with them.' (Paul Charge Nurse Medium 2)

Those who have been referred from prisons, in comparison, are in the facility for a shorter period of time before they return to the prison system. For them there is no reward other than a temporary relief before returning to closed conditions, which is reflected in behaviour and compliance which contrasts to patients on a progressive journey towards discharge:

'For the guys who are following high level security that's an easy enough connection to make. The guys who have maybe come from court who have maybe got a year in here that's maybe a hard thing to think about.' (FG George, Nurse, Medium 2).

On admission, when patients are most likely to be displaying significant symptoms, irrespective of the level of security, procedures provide safety for them, the staff and for more settled patients.

While the centrality of relational security is emphasised across settings, for example:

'If you do not have relational security... If you've not got a good relationship between your staff and your patients, your staff and your staff and your patients and patients, you're gonnae have a problematic unit.' (Mike Nurse Manager Medium 2),

in the highest level of security developing skills that support relational security take time to develop:

'...it's probably taking me all these years to get to a point of being no I can confidently do this and know that it's alright. Whereas if you had asked me 15

years ago, I might have been a wee bit more reserved then but it's just I am confident in myself, in my abilities and in my thinking that this is the right thing to do.' (FG/ John, Health Care Assistant Medium 2)

Being *reserved* reflects Daniel Kahneman's observation that in conditions of uncertainty, humans look for the rules and protocols that make them feel more secure (Kahneman, 2012). In secure care the protocols are procedural and physical security (Kahneman & Tversky, 2013).

As treatment progresses, and the risk of violence reduces, the restriction on movement similarly reduces such that patients get grounds access in high security, and medium security: the ability to walk around parts of the facility within pre-determined boundaries. In The State Hospital grounds access is a first step towards accessing the off-ward community and sports centre, and in Dundrum Hospital to the off-ward activity and education projects (the projects). High secure interviewees describe this progression as an opportunity for patients to safely test their mental health recovery, and for the clinical team to observe their decision making. That sense of progression is central to the mental health recovery process:

'.... after a period of time, [patients] need less structure and more decision making' (Tracy, Nurse Consultant, The State Hospital)

The alternative, permanent lockdown, is counterproductive in that it increases the likelihood of patient frustration and of violence against staff (Markham, 2021):

'You've got to at some point in time allow people the freedom to try and change because if they are always constantly in that kind of lock down situation they are going to react in a negative way because people don't like

that. It's not natural, it's not normal and people don't like being too strictly controlled' (Tracy, Nurse Consultant, The State Hospital)

Behavioural compliance also applies to staff as there are particular behaviours that are culturally valued that have become *rules in use* (Argyris, 1982; Ostrom, 2011); that is the distinction between rules as they are defined in guidance or directions (rules in form) and how they are adapted and adjusted to address a problem. A key rule in use is whether sharing personal information with patients is acceptable. The respondents in this sample who worked off ward appeared to be comfortable with idiosyncratic techniques they had developed with experience that allowed them to share information about themselves to create a relationship, without putting themselves or others at risk. This makes this group distinct from those who feel safer with exercising procedural security and the powers associated with being a 'screw' and those who use skills associated with relational security; building relationships with patients that lead to a more honest conversation about their hopes and fears, coproduces safety and therefore influences more personalised treatment:

'Working in the admission ward especially because you were expected to follow this protocol. I found it difficult. I mean staff used to give me such a hard time because they expected me to be that "screw". It wasn't me and I found it disheartening.' (Jim Staff Nurse, The State hospital)

5.4 Gateway Differences Across Security Levels

In The State Hospital the physical manifestations of detention are very prominent: high fences, cameras, airlock, security on entry to wards, etc, normalising one

aspect of the architecture of confinement and the psychology of space over treatment and rehabilitation:

'Nothing says power and control better than having a big fence round the place saying you can't get out.' (FG John Staff Nurse Medium 1).

Moving from the procedural security dominated wards in high security to relational security requires meeting behavioural standards or the gateway which allows incremental access to freedoms as treatment progresses. Relational security is more prominent off ward across the sites but specifically in the medium/low security sites where being attuned to the relationship with a patient determines the actions that staff take:

'You know there are certain patients you could say something and other times you just wouldn't.' (FG Jill Nurse Medium 2).

It is equally important to relationally oriented staff to understand what their role is in this phase of a patient's recovery, when security becomes less prominent:

'[it's] not exactly my journey, it's the patient's journey so, and they have to be a part of it, and if they are not part of it then it's not their journey, it's mine.'
(FG Petra Nurse Medium 2)

The staff in this sample described creating relationships that superseded the physical manifestations of detention both on and off ward. Those staff reported beginning their careers on-ward and gave examples of creating relationships in those environments despite their reports of colleagues viewing this as less safe practice. This appeared more concretely in the descriptions of activities that blurred the distinctions between staff and patients, such as the off-ward sports department in The State Hospital or collective social activities in medium security:

'...almost like we became one of them or they became one of us so to speak'

(John, Staff Nurse, Medium 1).

In some respects, the activities suspend reality to allow the patient and member of staff to forget the physical manifestations of security for a brief period of time. There is evidence from this sample that the activities that develop relationships off ward or while on escorted leave also provide a distraction and distance from the experience of detention and the condition that led to it. It may also be the case that the relationship developing with staff allows patients and staff to collaborate on a mutual distraction which is valued by both and provides a safe mechanism for emotional regulation (Laws & Crewe, 2016). That is, managing and responding to emotions and feelings by using tools - such as distraction - to manage their variability and intensity.

Access to off-ward activity also creates the conditions for in-depth conversations with patients about the experience of being on the wards, analogous to *walk and talk* therapeutic interventions (Revell & McLeod, 2017). That is the distractions of a physical task facilitating an in-depth discussion. For example, when engaged in education in the Irish site:

'The strange thing is we get them talking about sometimes they are being bullied on the units and they actually discuss more with me just in a conversation- "how's your day?"- and it turns out that there's all sorts of issues going on like that.' (Bert Clinical Manager Dundrum Hospital)

Or patients, unasked, begin to take on additional responsibilities (organisational citizenship behaviour), either to manage the spaces they are in or to take on a valued social role (Rowe, 2015) to support other patients:

"They start initiating things, like for instance the opening of the container in the morning where all the tools are kept, you know. one of the guys has comes in to us to get the keys to open up. So, you know, it's kind of that trust thing."

(FG, Janice, Clinical Manager, Dundrum Hospital)

"..I have seen loads of them help each other out." (FG, Jim, Clinical Manager, Dundrum Hospital)

'We would have lawn mowers, and we would give them petrol for the lawnmower, but they will bring back to you because they know they are not supposed to leave it around... and actually they feel good about it when they bring it back... they feel, they are showing responsibility' (FG, Fiona, Clinical Manager, Dundrum Hospital)

In the sites with lower levels of security, off ward refers to escorted leave in the community, which similarly influences the relational dynamics and interactions between staff and patient:

'Relationship[s] change when patients go out with staff' (Peter, Charge Nurse, Medium 2).

The reality of detention remains but the physical space has changed reflecting the normal life the patients aspire to return to. It also means that both staff and patients can escape:

'...all the difficulties that happen on the ward' (Mary, Psychiatrist, Medium 2).

Here Mary is referring to busyness on ward, suggestive of underlying threat and disruption from new admissions as they settle into the rhythm of the ward.

In this section I have described the concept of the behavioural gateway as the conditions that patients need to meet before accessing off-ward activities. The gateway is perceived differently by patients stepping down security levels, both from on-ward to off ward and to medium security facilities, and those who are temporarily receiving treatment before returning to prison. This can present a challenge to staff as they try to distinguish genuine from instrumental compliance. Experience of instrumental behaviour by staff may reinforce the primacy of procedural and physical security over relational security. Staff with greater experience and who are relationally oriented appear to have greater confidence in applying relational security. Those staff tend to work in off-ward environments where patients have successfully navigated their behavioural gateway, and their risks have reduced significantly. Off-ward environments appear to support more relational connection and working as a result.

In the next section I will present the evidence for two staff archetypes that support the applications of strict rules (the custodian), or the dynamic application of rules to support relational security (relationally close).

5.5 Staff Archetypes in Secure Settings

5.5.1. The Relationally Close Practitioner: Connection as Therapy

In high security these are staff who are predominantly - but not always – visitors to wards or supply a service off-ward in an environment that is distinct from the ward. These staff will have boundaried time to spend with patients and, when that time has ended, and they are off ward staff, they have similarly boundaried time for professional reflection, planning or to spend with the next group of patients on

another ward. For example, in The State Hospital I noted that senior staff such as psychologists and psychiatrists, but also OTs and social workers, had shared off ward offices (field notes, 2015). Unlike ward nurses, they had a withdrawal space distinct from the ward to write up notes and plan sessions. Nurses on high and medium secure wards could withdraw to a small office within the ward area for similar tasks but were likely to be interrupted by patients and other staff.

In the Irish high secure site, I observed similar arrangements with senior nursing, medical and specialist staff housed off ward and a restricted withdrawal space for staff to update records on the ward/unit (Field notes 2015). Those withdrawal spaces were similarly subject to interruption.

There appears then to be a distinction between off ward staff who have time and space to process their interactions with patients whilst on-ward staff are consistently monitoring patients and the environment for potential risks, perhaps increasing the psychological load on those staff. This is a significant barrier to effective reflective practice and the development of relational skills (Scaife, 2014). It may as a result have an impact on innovation and may stimulate relationally close staff to select out for environments where they can practice as they wish. Jim in The State Hospital describes this well:

'I used to go home and tell my girlfriend at the time I've had enough, I can't do this. Went and did my [conversion from nurse assistant to nurse] training, came back and was very fortunate to be asked to go to the sports for a short period of time' (Jim Staff Nurse The State Hospital).

This may also be the experience reflected in Janice's reflection (Clinical Manager Dundrum):

'I would have experience from working in the admission units, basically most of my time here in Dundrum would have been working in the admissions and then I got the opportunity to work in the garden and absolutely it feels different...'

Relationally close staff are confident in applying relational security skills and dynamic risk assessments to determine whether to apply strict rules for safety or to be more flexible in order to create a different relationship with patients for therapeutic purposes (Morgan et al., 2013; Thornton, 2002). As Jim describes it, the ward is a challenging place to work, because of the focus on consistent processes for safety and security rather than developing relationships. In the Dundrum Hospital site the challenge to relationships is inconsistency:

'...the reality is you get moved from unit to unit so you could develop a very close relationship, or you could develop an idea on the male admission unit and you're there maybe for four weeks and the next thing you're put into the female admission unit.' (Ger, Clinical Manager Dundrum)

The importance of consistency, and reciprocity, is reflected in the approach in Medium 2 where the psychiatrist notes:

'For me, what's needed is to develop my favourite word is 'authentic' relationships.' (Mary, Psychiatrist Medium 2)

For the Irish site, off-ward is also seen as a reward for progress (or good behaviour) for patients, reinforcing relationships. When speaking of the garden's project, Jane mentions a campus maxim: *'we're here to grow people and if the garden grows well that's a bonus.'* (Jane, Clinical Manager, Dundrum). At this point patients choose or have been socialised to act within the rules set for off-ward activities, although

perhaps another view would be that they have been re-educated and conditioned. They can, of course, choose to not cooperate.

The relationally close workers in this environment appear able to pay attention to a wider range of signals beyond physical and procedural safety that may be more subtle indicators of risk and allow for earlier intervention by clinical staff to support recovery. Whilst this adds to the psychological load on the worker, it also appears to be more supportive of reciprocity and coproduction. However, Susan in Dundrum Hospital describes the additional load as being taxing:

'... there's so much other needs of the patients in a forensic mental health hospital between the system that you organise within it takes a lot of effort if you are going to kind of bring a skill or bring something of yourself' (Susan, Clinical Manager, Dundrum)

This collaborative approach is also evident in other settings:

'I think it's probably because we're working side by side... and our project is based on goals that both parties need to be clear on choice ... we all need to be agreeable on [everyone's] ideas and their opinions matter.' (George, Nurse, The State Hospital).

In The State Hospital Paula, the Occupational Therapist (OT), describes the difference between the ward staff approach and her own relational security focussed approach:

'I think they are very security conscious as we all are but it's maybe less evidenced within [the occupational therapy] sessions because of the approach taken.' (Paula, OT, The State Hospital)

Paula is making a distinction between the security that is required to ensure safety across the hospital because ‘...*we all are...*’ security conscious, but that the way that power and control are exercised is more obvious in the actions of ward staff and less so in OT sessions: ‘...*because of the approach taken*’.

In this case, she was describing security being managed through relationships rather than physical and procedural security (Royal College of Psychiatrists Centre for Quality Improvement, 2023). The normalisation of dynamic risk management was also a feature of off-ward projects in the Irish site:

‘Then in the background obviously staff are, you know, observing them as well, but we mightn’t probably be as obvious because we’re chatting and being normal with them, I suppose. It’s more of a, it’s, ahm, normal’ (Janice, Clinical Manager, Dundrum).

The behaviours and interactions that Paula describes are closer to that which would be experienced as ‘normal’ outside of the hospital. This in turn suggests that the experience on the ward is not *normal* and is distinct from that experienced off ward. Janice is also suggesting that the experience of relational security feels closer to normal where there are more freedoms such as grounds access or leaves in lower security levels. They may also be describing a different relationship, role and shared responsibilities with staff supporting off ward activities where the patients are less constrained by the physical security restrictions and can perhaps be more genuine and reciprocal with staff, increasing the opportunities for coproduction. Susan (Clinical Manager, Dundrum) describes this relationship as:

‘They see me as nearly like an outsider and nearly like as a safety net that they can talk to ... although I feedback to the units’.

That is, despite acknowledging that there can be no absolute confidentiality, Susan is seen as genuine enough to share sensitive information with, in the expectation that she will act fairly to help resolve any problems. In contrast, her experience on the wards (described as units in the Irish Site) was:

'I was on the units for so long and it's a totally different relationship and you definitely have to not keep your distance, but you have to be more self-aware.'

Relational security and relationally close approaches appear to place a different psychological load on nursing staff in a lower threat environment than monitoring physical and procedural security alone with a higher degree of threat. To be safe and connected to their patients they are paying attention to a complex array of changing information such as a patient's responses to the environment, other patients, the impact of prior traumas and psychological triggers which may result in violent behaviour (Vaswani & Paul, 2019). As Susan (Clinical Manager, Dundrum) notes:

'On the unit I'd never, I'd never allow them to speak to me [like that], whereas on the unit it's like you have to have your dinner or you have to do this at this time and everybody does it together... On the unit...they much more aware of and focussed on risk'.

On busy wards, maintaining awareness of the relational cues plus maintaining physical and procedural security appears to overload ward staff who are juggling priorities, with tangible securities simpler and safer to maintain, while relational securities are complex and constantly changing. As Gill (Psychologist, Medium 2) describes it:

'I think on the ward is probably a lot more task orientated or you're getting the basics done and the basics are keeping everything safe, and you know tucked

away, you know where everybody is, not coming to any harm and you probably lose some of the interactions with patients to just sit down and talk’.

Off-ward staff will still scan their environment for risk, but this process is integrated into the task and reliant on conditional trust:

‘...there is an exchange of power there which I think is a good thing and trust, that they trust me enough and I’ll trust them enough’ (Susan, Clinical Manager Dundrum).

For the nurses in the medium secure sites the question of whether they are relational, or security focussed appears to be irrelevant:

‘I think for me it’s a strange question to ask. Because it’s natural for here. I can give loads of examples... Community leave is probably the main one that sticks out for me because the feedback that I get from the staff is that the patient’s presentation is different.’ (Paul, Charge Nurse, Medium 2)

However, there is still work to be done according to the Medium 2 consultant psychiatrist because although there are more opportunities for relational engagement, procedure that is dominated by the system is still apparent. They advocate for:

‘...relationships that are not solely patient centred and they are not staff centred but the idea that both of these have to take responsibility for the relationship that does or doesn’t develop.’ (Mary, Psychiatrist, Medium 2)

This is also reflected in Medium 1 where some nurses working in a relationally close environment feel less certain than they would with historical practice that focussed exclusively on medication:

'You know they'd rather sort of ... think, right! Meds! The short-term treatment. But in the long term, that treatment doesn't work. It does take a while to engage with someone.' (Pat, Staff Nurse Medium1)

In contrast patient behaviour is less certain on-ward, particularly in The State Hospital because of the additional uncertainty created by new admissions whose response to the environment and other people on the ward is unknown. That environment prioritises maintaining procedural and physical security because new admissions, who may be fearful and anxious, may also increase the likelihood of violence. This does suggest that the opportunities for relational and therefore coproductive opportunities in high secure settings are limited comparative to other levels of security, and that those limitations are most apparent in wards.

The on-ward environment is recognised by the respondents as suitable for a certain type of staff personality where rules are considered the mechanism for protection:

'I would struggle over there I'm not that type of staff.' (Jim, Staff Nurse, The State Hospital).

Similarly, the psychiatrist in Medium 2 suggests that the skills required for effective therapeutic care may be beyond the staff that feel safer with physical and procedural security:

'The more focused therapeutic environment, that's challenging for staff because it's more, they have to deal with a lot more uncertainties, a lot more going on and a lot more of the patient being out of their sight and out of their 'we're in control' sort of thing' (Mary Psychiatrist Medium 2)

The opposite is suggested for off-ward staff: that relationally close, but safe relationships have a positive impact on behaviour and on security. There is also a

sense from the interviewees in the high secure sample that staff are not getting to see the real patient in ward environments. Off-ward staff describe seeing more of their personality, where patients can suspend reality and begin to behave as they would if the restrictions did not exist. It appears that restrictions, rather than the individual needs of the patients, drive behaviour of staff and patients on the ward, particularly if the risk assessments and notes indicate historically challenging behaviours. If all staff respond the same way to risk, then it will be really challenging to be the member of the staff who looks at things differently:

'You have to give people a chance. And people can change. But if you believed [that people can change] and you were amongst lots of people who believed [the opposite] then it would be difficult to change ...' (Tracy, Nurse Consultant, The State Hospital)

This appears to be the primary cultural barrier to developing relationally close approaches on wards.

In lower security the NHS site was in transition from high levels of control to managing risk dynamically. For the psychiatrist in Medium 1 even the ban on smoking on NHS premises was a restriction too far:

'Personally, I don't think it's right. I think smoking is legal in the United Kingdom and if patients want to do something which is legal, even if it's harmful for their health, I don't think that we should be playing big brother and telling them that they can't do that. We should be making facilities available for them to smoke where other people are not harmed by the effects of the cigarettes that they smoke' (John, Psychiatrist, Medium 1)

And for Brian, a nurse working in Medium 1, it is an example of hypocrisy where relational security is promoted but coproduction and the sharing of power were not:

‘...under no circumstances is this co-production. This is a coming down from manage[ment]... Well they will be engaging in discussions with patients but only to tell them...’ (Brian, Staff Nurse, Medium 1)

While relationally close working is more common in lower levels of security it is still bound by the paternalistic nature of security and care. Nevertheless, being relationally close requires managing uncertainty, which may signal dangerous practice on-ward in higher security. The next archetype describes staff who seek safety through tangible security. As will be described this behaviour is also apparent in lower security but as an exception.

5.5.2. Custodian: security as a priority

The custodian’s primary focus is safety and security maintained through clear procedural and physical security in a busy environment that provides little time for reflection. This is an experience commonly described by staff in high secure settings (Oates et al., 2020), but is also described in medium secure settings:

‘...because you work in a closed environment, you work with difficult people, it takes its toll at times you know and it, at times, manifested ...in the shape of people just think silly things.’ (John, Psychiatrist, Medium 1).

That is, that monitoring and maintaining security is the most important function of the environment and staff.

Apart from the Irish site, the sites sampled for this study did not have admissions wards, with new patients admitted directly on to continuing care wards. In non-forensic mental health settings, staff in an acute or low secure admissions wards, typically receiving patients for assessment and triage (Cooke et al., 2003), support patients to adapt to - or comply with - the security conditions as they are being assessed prior to them being assigned to a continuing care ward. There is typically a higher staff to patient ratio in those admissions wards (Crichton, 2009) to account for collectively higher levels of activity (Kennedy, 2002) and elevated levels of burnout and turnover of staff (Johnson et al., 2018).

Without the induction and conditioning of an admissions ward, ward custodians' time is focussed on new admissions who can disrupt the ward routine. It may also increase the sense of threat to the commons of peace and security such that patients are perceived collectively as disruptive to that commons.

Custodian also describes the behaviour of ward staff who are wary of sharing anything of themselves or developing relationships with patients who are assessed as inherently dangerous, or believe that a relationship of any form could lead to problematic behaviours and consequences:

'Some [patients] are more malevolent and might actually deliberately try and get information that they can use for not such reasonable purposes. '(Jo, Staff Nurse, Medium 2),

Despite having an admissions unit in the Dundrum Hospital site, Tom identified the busyness of a unit rather than custodianism as being the primary barrier to creating relationships with patients:

‘So, they don’t get as much time, they wouldn’t sit, and they wouldn’t be necessarily sitting down and having a cup of coffee with them or tea with them because they wouldn’t have the time.’ (Tom, Nursing Officer, Dundrum)

There may then be a self-fulfilling cycle in wards that are busy across the security gradient. That is, where a lack of an admission’s ward contributes to a focus on physical security over relationships. However, and more importantly, when wards across the gradient are busy there is reasonable attention paid to security and safety. However, if the *busyness* of the ward does not change over time, then there is little resource to engage relational security, which in turn may contribute to the busyness of the ward. This appears to be the primary conundrum for coproduction in higher secure facilities: that the resources required to maintain peace and security are directed to physical containment with fewer resource available to engage in relationships, which reinforces the need for containment. This is also reflected periodically in lower security. For example, Mike, the Nurse Manager at Medium 2 describes the transition away from a culture dominated by The State Hospital in his medium secure unit:

‘We completely got the relational security wrong when I started here. We tried to kid on that it was right and it wasnae. There was a huge emphasis on the procedural security, environmental security and that was -- there was an imbalance.’

However, the interviews suggested that *containment* may not be a periodic occurrence. In high secure wards, and for some medium secure staff, the priority to maintain procedural and physical security and to create safe environments on the ward minimises the time for that care:

'...all [on ward staff] are doing is getting them up, medicating them, sending them out, giving them lunch, putting them to their bed, sending them to their placements, get them up, send them back to their room, medicate them... They might not get the same opportunity that we do up here because we will sit with them in whatever environment.' (Bert, Clinical Manager, Dundrum).

As Glenister suggests, mental health nursing *'exists in the moral grey zone between caring and controlling'* (Glenister 1997:50). The tasks for on-ward staff in the example are structured and functional with little time to spend *'with them in whatever environment'* to develop relationships that appear to be the focus off ward, *'up here'* in the projects, the term particular to the Irish site for off-ward activities. Ward staff are described here as custodians, prioritising the functions of being on the ward - medication and basic needs such as food - over relationships, custody over care.

Bert suggests that the practice of managing risk has an impact on relationships on wards and may, as a result, promote observing behaviour and maintaining boundaries over *'sitting down and having a cup of coffee'* which appears to normalise relationships:

'Like I was on the units for so long and it's a totally different relationship and you definitely have to, not keep your distance, but you have to be more self-aware.' (Bert, Clinical Manager, Dundrum)

Bert highlights a psychological barrier to connection for custodians in high secure wards which in part is protective: protecting both the member of staff and the patient from a future relational rupture should a restraint be necessary; protecting the member of staff from a relationship that could be interpreted by peers as too close and therefore at risk of manipulation; and protecting the authority of staff which might

be undermined by a closer relationship. In this case, the concern is about the knowledge that could be imparted to a patient inadvertently and used against the staff when, for example, that patient is unwell:

‘I have seen staff and there are staff here who we would all identify as based no doubt as being too close to the patients and the patients are their friend and it always goes pear shaped’ (Bert, Clinical Manager, Dundrum).

Unfortunately, the staff interviewed were reluctant to give examples of when it *‘goes pear shaped’*, although there are examples of what they meant in press articles highlighting inappropriate romantic and exploitative relationships between patients and staff in secure mental health facilities (Brady, 2022; Devine, 2011; Gordon, 2023).

Custodians may also be more likely to see and experience violent or unpredictable behaviour from patients who are most unwell at their admission to the facility, where the focus is on:

‘...keeping everything safe, and you know tucked away, you know where everybody is... not coming to any harm and you probably lose some of the interactions with patients to just sit down and talk’ (Kate, Psychologist, The State Hospital)

Consequently, on-ward staff may feel unsafe and insecure in dynamically managed off-ward environments despite knowing that patients who access this service have been assessed as compliant. This represents an exchange of the certainty of rules and procedures for relational cues and controls, which are reliant on judgement and may feel less certain.

The evidence for the ward custodian appears across the security levels in this sample but is more common on ward in high security. This is because of the nature of the security conditions in the environment and the predominance of unpredictable behaviour in the patient group, which makes this characterisation most common. This behaviour is also described in the low secure sites but appears less prominent than relationally close staff, and is associated with uncertainty in new roles or environments:

'When I think of it, it happens to all of us when you start working in forensics, I was very 'this is the rules, this is how you do it'. Do you know what I mean? that's the kind of thing which I think is natural when you are working in a new environment and you are getting used to the security and things that you are not used to before' (Chris, Staff Nurse, Medium1)

However, they do describe custodian-like behaviours in a small number of staff who may have found the transition to relational security more challenging than others, or may have been transferred from another unit and have not acclimatised or *grown* with this different environment:

'...newer nurses take over and take charge of shifts, they are the problems, you know, they are the issue... they have probably been allowed to grow that way.' (FG/Susan Nurse Medium1)

However, there **is** a need to temporarily focus on physical security for new admissions or when patients are acutely unwell. Chris describes this in reference to a case study of a patient with a history of violence:

'...we tend to observe them a bit more closely for the initial period to ensure they are bedded in kind of thing just to make sure to reduce the risk as much

as possible, especially for someone with that kind of history.' (FG/ Chris, Nurse, Medium 2)

Deliberately relying on this form of security when it is no longer necessary is described below as the malicious custodian.

5.5.3. Malicious custodian

Relationship building between staff and patients on-ward is limited by procedure. This is distinct from what could be described as a malicious custodian - the development of paternalistic custodian behaviour described by Eren (2014) and Fishwick et al. (2001). It may also be a manifestation of Cohen and Taylor's *escape attempts* (Cohen & Taylor, 2003): behaviours that are forms of agonism (Rosanvallon & Goldhammer, 2008) and resistance to relational security in favour of a more controlling approach. Malicious custodian behaviour is an unwarranted exercise of overt power that maintains the appearance of order while creating grievances which may affect future peace and security. These are actions that are described as *gunslinging* in the focus group by Bob, the Charge Nurse in Medium 1. That is staff that create deliberate provocations in order to stimulate a response from a patient that they can then respond to:

'...when I came here at first there was people, what I call gunslingers that were here, and they were people who would get into a situation with a patient and then expect someone else to come and dig them out of it. That wouldn't be tolerated here now, and that's to do with the leadership in the ward. That would not be tolerated.' (FG/Bob, Charge Nurse, Medium 1)

However, no matter how professionally trained and supervised staff are, psychological boundaries can be challenged by the offending history of a patient which may also influence the development of relationships and the potential for coproduction. For example, when Peter (Charge Nurse Medium 2) describes the difficulty staff find in supporting patients who have committed challenging offences:

We ... have had staff that have found it difficult to deal with patients who have committed sex crimes against children. But I think once you sit down on a supervision and you start to kind of give them research, you give them basically pointers and give them education...

The implications of not managing this challenge in the ways Peter describes below have been documented as leading to: *'callousness, suspicion, hypervigilance, and vulnerability'* (Grady and Strom-Gottfried 2011:20), sometimes leading to malicious acts (Maule, 2007), perhaps as a consequence of the experience of revulsion and horror generated by the acts that led to an admission (Houston, 2023).

'...you give them basically pointers and give them education, you give them basically the needs of the patient, the reasons why they're here, the reasons basically behind you looking to progress and move them forward.' (Peter, Charge Nurse, Medium2)

In the Medium 1 sample, custodian behaviour and gunslinging may also be a residual artefact of rapid culture change in their transition from a rural, rule dominant environment to a more relational security-oriented suburban site. Arguably, staff in transition are applying the tangible rules to maintain peace and security common to high secure sites while the service transitions to an emphasis on intangible and flexible relational security. Those staff may have become habituated to the

presentation of patients, are managing complex information whilst under resource pressures and may therefore be inadvertently at more risk of assault. This is because their attention is drawn to tasks other than monitoring the emotional indicators of assault, or in maintaining the relational connections that may be protective. Flannery and Flannery (2023) noted however that this is an under-researched area and as a result the existing studies follow quite different methodologies, with responsive interventions focussing on staff training on responding to violence, staff support post incident and anger management interventions for patients. This kind of response to an assault may reinforce the importance of physical over relational security for staff which paradoxically may increase the risk of assault because they become a palpable agent of control and may also contribute to the genesis of a gunslinger. In this framing, the gunslinger is afforded by the environment, and they manipulate that environment and the people within it to justify privileging physical and procedural over relational security. While there is no additional data from these sites to state this with confidence, there are examples of more extreme manipulation in physical health care. As Yardley and Wilson outline in their exploration of the '*Angel of Death*' phenomenon, this is an extreme form of attention seeking behaviour (Yardley & Wilson, 2016). There is no suggestion in the interviews that the behaviour described is intended to reach the extremes described by Yardley but the outcome: confirmation that the patient is more dangerous than the assessment suggests, and sympathy for the staff member subjected to an assault; may have similar foundations to fabricated or induced illness (FII) (Alcina et al., 2023), reflected in Bob's comment that they:

'...would get into a situation with a patient and then expect someone else to come and dig them out of it.' (FG/Bob, Charge Nurse, Medium1).

It is notable that the nurses in the focus group acknowledged that this has happened and that it *'wouldn't be acceptable'* (FG/Bob, Charge Nurse, Medium1). However, this was in a group that included Bob as their line manager which may have restricted their freedom to express themselves to the contrary, as described in the methods section above.

Bob described this form of behaviour as creating additional work for other staff. What is less clear is the distinction between the new culture that is being established where gunslinging will *'not be tolerated'* and the reality of the routine exercise of power to maintain peace and security. However Ostrom's description of community control of finite resources would suggest that the staff would act to remove excessive consumers of the commons, in this case peace and security, by taking action formally or informally to exclude those staff (Ostrom, 2003). There was no direct or indirect examples of this occurring from either the interviews or the focus groups however.

Within the lower secure sites, the distinction between off and on ward activities differs from that in the high secure sites. Therapeutic, occupational or leisure groups will occur on the wards led by staff who will also be assigned to escort patients with leave to visit the local town or other off-site facilities, such as the local leisure centre. Nevertheless, ward custodian behaviours were still described in Medium 1:

'Certainly you could have six say nurses on a shift and you could be doing a lot of work and you could, more sort of therapeutic, then you could ...have a nurse that's black and white: this is the boundaries you can't, someone is maybe near retirement, sort of like, no this is the way, it's got to be, you're a new start.' (Martha, Staff Nurse, Medium 2).

In this case Martha makes a distinction between therapeutic relational engagement and the nurse near retirement who understands safety and security through rules and imposes that view of the world upon inexperienced staff. The therapeutic relational approach is described by Martha as being more complex- '*a lot of work*'- such that a rules-based alternative which reduces that load may be more attractive to some staff:

'...the more focused therapeutic environment, that's challenging for staff because it's more, they have to deal with a lot more uncertainties, a lot more going on and a lot more of the patient being out of their sight and out of their "we're in control" sort of thing' (John, Psychiatrist, Medium 1).

However, well supported staff adjust their approach as uncertainty is replaced with greater certainty, and patients become acclimatised to their environment:

'I find it very black and white at the start and then once that's done the patients are quite relaxed because they know that they instinctively don't do things that they are not meant to do.' (FG/George, Clinical Manager, Dundrum)

And then it appears that they contribute their own resources to maintaining peace and security:

'...it doesn't have to carry on because they are all, they are watching each other, they help each other out' (FG/George, Clinical Manager, Dundrum)

Nevertheless, a rules dominated on ward environment for custodians creates certainty and predictability where the response to aggression and violence is to reinforce security conditions, and which in turn narrows the opportunity for coproduction. However, such a controlled environment may, as a result,

paradoxically replicate experiences that led to the admission of the patient and increase the likelihood of violence. For example, Vaswani and Paul (2019) describe the factors that may retraumatise prisoners as

‘...fear, anxiety and the threat of violence, often coupled with rapid withdrawal from substances can all potentially contribute to retriggering of trauma’
(Vaswani and Paul 2019:513).

There will be parallels for patients who may also be fearful in an unfamiliar and constricted environment, who may also be experiencing drug withdrawals and who may witness or be subject to restraint. Whilst the health and justice systems are delivered differently between Scotland and Ireland, it would be reasonable to assume that there are universal traumatising and retraumatising experiences for people admitted to secure psychiatric care, in confinement. It would also be reasonable to conclude that traumatisation is also experienced by staff which in turn may enable custodian type behaviours on wards (Morris et al., 2024). It is important to note here that whilst the identified risks for the patient will determine what level of security they are treated within, the experience of withdrawal from drugs and alcohol, and possible (re)traumatisation are common to each level of security.

The table below summarises the key aspects of the archetypes as described by location for ease:

Table 14 Archetypes in high and medium security

 Custodian Approach  On-Ward High Secure High - Variable predictability of patient behaviour influenced by admissions - Overt exercise of power to maintain peace and security Medium/Low Secure Medium/Low - Assumed unpredictable behaviour on admission, transitioning to more predictable after induction - Overt exercise of power to maintain peace and security


Off-Ward

High Secure High

- Patient:** Behaviour predictable due to passing a gateway. More open and playful with off-ward staff
- Staff:** Overt exercise of power discouraged by the environment. Discomfort because order is maintained through relationships which are viewed as exploitable on ward
- Staff select out of off-ward activity

Medium/Low Secure Medium/Low

- Predictable patient behaviour
- Staff select out of off-ward activity

5.6 Environmental Affordances and Their Impact on Practice

5.6.1 On-Ward vs. Off-Ward: Contrasting Spaces and Opportunities

The concept of *affordance* comes from architecture and design (Gibson, 1977), describing what the choices and actions that the environment and the objects within it offers to people using the objects or spaces. For example, a button invites or affords being pressed, a path affords or invites being followed. However, the designers' intended use can be overcome by the perceived affordance by the user. A typical example in physical infrastructure is when a paved path is circumvented by a more natural shortcut or wander path (figure below).

Figure 10 Planned vs actual affordances



In secure care physical and procedural security impose order and reduces the opportunity for similar variations in movement as well as placing limitations on the physical affordances that are possible. On wards, the visible limitations on movement and the potential unpredictable nature of patient behaviour affords

particular responses from both staff and patients. This limitation extends to the psychological inferences and meanings about relationships that are created in interactions between staff and patients, and what those relationships afford, which are '*both real and perceivable but are not properties of either the environment or the [patient]*' (Chemero 2018: 181, parenthesis added). That is, each location's physical make-up and psychological associations appears to afford particular strategies for the maintenance of peace and order, and particular strategies for the formation and maintenance of relationships.

The psychological affordances that exist that support relationally close working in high secure care appear to correlate with staff who are associated with a desirable activity (sports and recreation for example), and in an environment where the distinctions between staff and patients are, to some extent, suspended during an activity. However, there are inherent bounds to that affordance. Any psychological affordances are environmentally, normatively, and temporally contained. Breaches of those bounds result in greater restrictions which act as a behavioural compliance facilitator. As the manager of Dundrum Hospital's Wildwood woodworking project describes it:

'They've so much more invested in coming down and like I think they are less likely to do something that would scupper their chances of coming to Wildwood' (George, Clinical Manager, Dundrum).

This is a form of pareto equilibrium in game theory terms (Watson, 1994). That is, if a patient were to try to gain an advantage it would have a negative effect on patients and staff alike: all patients would have access restricted or denied and there would be a risk to the continuation of the Wildwood project. The interweaving of different

and desirable off ward relationships, a desirable resource and the risk that the resource could be jeopardised creates a complex dynamic with both staff and patients managing the bounds of their *real* and *therapeutic* relationship to both maintain order and access to the resource. The commons or CPR of peace and security is partly maintained through coproduction and cooperation between staff and patients who appear to use banter as a threat and consequence free mechanism to test the boundaries of the affordances within that environment. That banter is demonstrated in both the high and medium secure sites:

'...you've got to have a rapport, a laugh and a joke. Then people will maybe think you're having a laugh and a joke when this guy just did whatever but what do you do? Do you just ignore them, walk by, then there's an atmosphere and then you're just making matters worse.....' (FG/John, Medium 2)

'I better not swear while I'm here but if you tell someone to 'F Off' and you do it in such a way it's about banter and things like that or dismissive that's fine or you can use it in such a way that you're a bit angry and your so. When we're talking to the patients sometimes, we talk like that. Some people might overhear us and think that's terrible the way you speak to them but that's the way we've done it all these years ago. We're no being disrespectful it's just the way that we've known these guys for such a long time' (Peter, Staff Nurse, The State Hospital).

That commons is also managed by the implied threat of losing access to the facility should those boundaries be breached. For both staff and patients, the goal is a

positive relationship where trust is reciprocated and the power to remove the privilege of access to the facility is redundant:

'That's their reward for behaving themselves so to speak' (Jim, Staff Nurse, The State Hospital).

The Irish focus group participants describe the different relationship and stretched boundaries that exist off-ward as *garden privilege*. While patients are fully invested in the off ward projects to the extent that they undertake minor unmandated supportive tasks, the rules are less *mortifying* (Goffman, 1961) or infantilising, so that staff see more of their real selves:

"We do have what we call the garden privilege where you are allowed to say some things that won't be taken against you in a sense, you know what I mean." (FG/ Tom, Nursing Officer, Dundrum)

However, that privilege is not limitless: *'There is a limit.'* (FG/James Dundrum), *"You can't say 'fuck' all day."* (FG/ Ger, Dundrum).

There is a distinct difference between The State Hospital and Ireland in the application of incentives. In the Irish site the incentives are not solely access to off ward activities, but the additional social *events* that staff bring into the environment to create a sense of connection with the outside world and *normality*. For example, Bert when describing a garden party event that takes place annually:

'They look forward to that 'I'm not going to miss it' because during that day they get to meet patients from other units. There will be goodies being offered, there will be popcorn, there will be crisps, there will be chocolates, there will be fizzy drinks and other things like I offer to them on that day and there will be a stage.'

This is a literal reward for consistently engaging with therapeutic activities.

To be seen to be human, to be recognised (Anderson & Honneth, 2005; Honneth, 2004), also appears important for relationships in this environment, and the informality of humour as a means to convey it plays a significant role (Gildberg et al., 2016), especially in creating a form of temporary equality (Plester & Sayers, 2007) or a safe form of protest (Rodrigues & Collinson, 1995). It can also be a means to bring parts of a community together through the entertainment of banter:

'One of the domestic [indistinct] came in and sat down as well to listen to the banter. You know I think we maybe lose track of how sincere that can appear ... because you don't have any agenda' (FG/Bob, Charge Nurse, Medium 1).

'Yeah and have a laugh and to me if you've not got humour you would as well forget it. You've got to have a laugh, and that's what it's all about, and then they get more relaxed, and you get more out of them then, and I think you get more progress out of them, you know, because their levels go down' (FG/ Gerldine, Staff Nurse, Medium 2)

That is, the member of domestic staff has no defined clinical purpose in the interaction but by setting aside the time to enjoy the '*banter*', with tacit permission from the patients and the ward staff, they are participating in the normalisation of relationships in unusual circumstances.

These interactions demonstrate the relevance of Rowe's citizenship framework even within highly constrained institutional environments. As noted in Chapter 2, Rowe et al. (2012) conceptualised citizenship through five dimensions - rights, responsibilities, roles, resources, and relationships - with the relationships component proving particularly significant in secure settings where formal rights are

restricted. The '*garden privilege*' and off-ward activities described here create spaces where individuals can exercise meaningful roles and access relational resources despite legal detention.

As noted in Chapter 2, MacIntyre et al. (2019) position connection as fundamental to exercising citizenship. The temporary suspension of hierarchical distinctions during the activities described illustrates this principle in practice with '*collective citizenship*' (Quinn et al., 2020) demonstrating solidarity and shared responsibility. The collaborative dynamics described here - where both staff and patients jointly maintain the commons of peace and security – are examples of how collective citizenship can emerge even within institutions designed to limit individual autonomy.

Similarly in Medium Secure 1 banter with patients allows a testing of rules (Rodrigues & Collinson, 1995) to create a psychologically safe, or imaginary, space as described by John, Health Care Assistant, Medium 2:

'...it's just what as I say, when I am out with a younger patient, I tell them that they are looking after me [laughter]. They have actually done it'. (John, Health Care Assistant, Medium 2)

In that case the affordance is built around the age of the health care assistant and appears specific to them. They have given a signal that it is ok to respond in kind '*I tell them they are looking after me*'. Reciprocity - I am caring for you and you '*care*' in return - is part of that interaction, with the patient watching the response from a staff member to determine how much farther to stretch a rule (Plester & Sayers, 2007). At its most basic it is also a demonstration of shared humanity. Phillip describes that shared humanity in very different circumstances:

'We've got some new, young patients in [X ward] who actually seem to, well actually have more hobbies than some of the patients we have at the moment. So, some of them are really in to jigsaws, and they are on constants, and when they are on constants when you see them get agitated the easiest thing is, it's like a change, so you say, 'would you like to do a jigsaw?' And it's amazing how in just a couple of days actually you can build quite good rapport with somebody on a constant doing a jigsaw with them' (FG, Medium 2, Philip, Nurse)

The interaction, created to reduce the sense of constriction caused by close observation, develops a connection to such an extent that *'They don't get a sense that it's a therapy...'* (FG/ George Staff Nurse Medium 2), which has a reciprocal effect on the member of staff *'it doesn't feel the same as sitting outside somebody's room and staring at them.'* (FG/Gillian Nurse Medium 2).

5.6.2 How Environments Shape Staff-Patient Interactions

As noted previously, the interviewees in Dundrum Hospital describe an affordance that they call garden privilege, similar to the freedoms associated with sports interactions in The State Hospital. That is interactions allowed off-ward that might lead to a much more interrogative experience if it was to happen on-ward:

'Sometimes you might have to remind them you can't really, you know it might get a little bit inappropriate in their conversation like maybe just swear words but just to remind them that we're staff, and they are in the hospital. It's not too relaxed you know.' (George, Clinical Manager, Dundrum).

The off-ward prominence of relational security allows patients to relax, become less guarded and transactional, and to speak about their experiences. Therapeutic conversations can then occur without it being obvious therapy, which would have been the case on-ward (Revell & McLeod, 2017). It also allows patients to reciprocate in kind: making tea or opening up facilities.

The distinction between overt regulation and relational co-regulation, when

' ... people regulate their affect, thought, and action through ordinary yet affectively consequential conversations and shared activities' (Lakey and Orehek 2011: 482)

is the most obvious difference between the on and off ward experience for both patients and staff. Whilst regulation influenced by relationships may happen on the ward, it is dominated by the rules-based management of a range of patients with varying degrees of stability in a relatively small space, presenting a challenge to any staff who intend to coproduce.

'I think there is, not a certain type of patient you can have it with, but I think depending on the ward as a whole. I work on Arran; Arran is quite unsettled at the moment. It's not the worst it's been, but it is unsettled.' (FG/ Fiona, Nurse, Medium 2)

'The actual wards themselves are very small compared to the day rooms that they had in the old hospital, you know, and I think that it's quite enclosed when they've a lot of patients in together.' (FG/ Brian, Nurse, Medium 1)

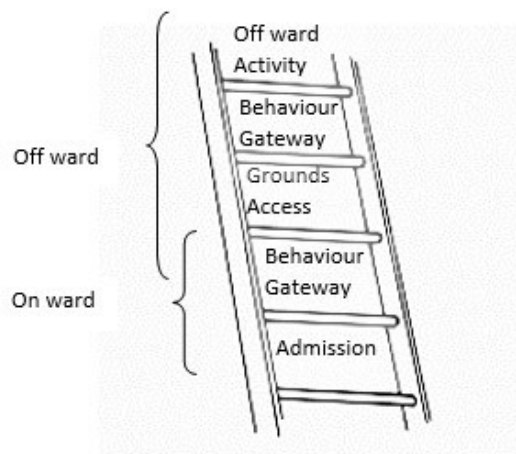
To add to the complexity, if staff do choose a relational approach, it may also be interpreted by patients within the ward context as a mechanism for control because of the environmental associations and affordances. Visiting off-ward staff may be

viewed differently precisely because their context is overtly relational, associated with a desirable activity and not embedded in the ward. This is therefore an inherent constraint on what appears to be possible for coproduction in highly regulated environments. That is, that the mechanisms to support coproduction, such as forms of autonomy and trust, are constrained such that they cannot be expressed or supported in an overt way in a ward environment where new admissions and variable behaviour of patients, who have not met the conditions for off ward activity, make managing the uncertainty of coproduction too challenging.

5.6.3 The Ladder of Freedoms: Progressive Environmental Access

There then appears to be a ladder of coproduction or freedoms, or more precisely, steps toward coproduction, in higher security settings.

Figure 11 Ladder of Coproduction of Freedoms



In this conceptualisation the coproduction of peace, security and progress are possible at all levels but are least likely on admission to high secure settings where physical and procedural security appear to take precedence. Proceeding through the

behavioural gateway increases the opportunity for coproduction but does not guarantee it because it is dependent on the patient investing in relationships with staff.

Note that the term '*grounds access*' is common across the forensic mental health system as a step before unescorted access to off ward activity (patients can access off ward up to that point if they are escorted). Once that activity has been completed successfully without any behaviour issues the patient can then progress to off-ward activity unescorted. A return to a previous step in that ladder would be undesirable such that it may act as a behaviour regulator.

In lower levels of security, it appears that the distinction between on-ward overt regulation (common for court referrals) and off-ward relational security (common for a step down in security) is also replicated but it is dependent on the referral route for patients. In contrast to the high security sites, neither Medium Secure 1 nor Medium Secure 2 have grounds for patients to access beyond small, enclosed communal outdoor areas. However, because the assessment of risk is lower in comparison to higher security, there appears to be more opportunities to engage relationally, to relationally regulate emotions and behaviour and therefore to build upon the trust, reciprocity and autonomy that are central to coproduction (Ostrom, 2003; Ostrom & Walker, 2003).

The affordances being described are dominated by the reality of significant power held by nurses. Choosing when to use that power has an impact on relationships, possibly temporarily, but also defines the affordances that are possible in each location.

The predominant power imbalance in high security is on ward. This is not reflected in the same way in low secure environments where the risk is lower overall, and rules dominated behaviour should be rarer. However, the transition of Medium Secure 2 from rural to a city centre environment appeared to have sustained that behaviour or approach for some:

'...some staff would make an assessment - a judgement on somebody who was watching the football ... When Georgia switched the telly off and basically nearly caused a riot, you know.' (FG/ Bob, Charge Nurse, Medium1)

It is possible that the history of the previously isolated institution had cemented a way of approaching security that relies on physical and procedural practice over relational engagement. It is equally possible that the move to new premises and new ways of working inadvertently created resistance as change created uncertainty. This is also reflected in the paternalistic approach described in Angela's description below:

'You know and I've heard stories em where patients have been told if you don't get your bedroom done your no getting out the day, if you don't get this done your no getting that. That's no right, that's wrong...We're here to encourage, prompt, advise, support, protect. We're no' here to... you know bully ...I suppose is the term' (Angela, Nurse Assistant, Medium 2).

Tversky and Kahneman's work demonstrated that judgement under uncertainty tends to create a bias towards previously certain behaviours, such as procedural security in this case (Tversky & Kahneman, 1974). It may also be the case that the consequences of an overt exercise of power have predictable consequences,

whereas relational, and by association, reciprocal power interchanges are less certain.

Procedural security is most prevalent on The State Hospital and Dundrum Hospital wards/units than off-ward, influenced by the different risk profile of patients who can access those facilities. An equal emphasis on relational security is slowly coming to prominence as new members of staff come on board who are either unaware of or are ignoring the history of The State Hospital or were trained as community nurses in Dundrum Hospital and are actively engaging in normalising conversations. Those normalising opportunities are risky, but they have potential benefits in that the patient may trust that member of staff to speak to about a problem they have been wrestling with:

'You need to see the person that is there, you know the risks, you know where your interventions going, you've made sure it's a safe and secure environment that you are providing so it means that you can see something else' (Paula, OT, The State Hospital).

That is, creating a sense of safety for staff and for patients also creates psychological space to see previously hidden factors in a patient's presentation that are central to their recovery, in the case below recovering from a restraint:

"And I said to her I said you are going to get restrained. You are aware of that; we are aware of that. We need to do something different to get you up off that floor faster. I said, so what was annoying you on that one. And she said it was a man talking to me and I said right that's something. We will have a female talk to you next time, she says aye, and she says, they didn't turn my music off. And I am sitting, how would we have even thought of that in the

middle of a restraint, we don't think we are going to turn her CD off just in case that makes her worse. She says no, you need to turn it off...' (John, Health Care Assistant, Medium 2)

Security limitations also limit the progressive delegation of power to patients in high security, a barrier to achieving Ostrom's triptych (trust, reciprocity and autonomy, Ostrom 2012). There are small delegations: by achieving and maintaining grounds access, and access to the community centre and sports facilities, for example. These freedoms are paradoxically often removed when a patient graduates to a lower security facility in order for them to be re-assessed by their new team. This can be conceptualised as a *procedural injustice* (Hucklesby, 2009; Tyler, 2006), that is the imposition of conditions for achieving and maintaining freedoms which appear to be based on a team's uncertainty about a patient as opposed to the reported progress in their previous institution. This form of injustice is the exercise of power without external validity: the imposition of conditions despite achieving behavioural gateways in other institutions. This is commented on by some respondents as the potential to frustrate the creation of relationships as patients progress through security levels. This was an unanticipated finding from the study.

Procedural justice theory, developed by Thibaut J (1975) and refined by Tyler (2006), argues that people's acceptance of outcomes depends on their perceptions of the fairness of the processes used to reach those decisions. Greenberg and Tyler (1987) further developed the concept, identifying four key components of procedural justice: voice (opportunity to present one's case), neutrality (unbiased decision-making), respect (dignified treatment), and trustworthiness (benevolent intentions of authorities).

In secure forensic settings, procedural justice illuminates the patients experience of significant constraints on their autonomy while simultaneously being asked to engage cooperatively with treatment and rehabilitation processes. The perceived fairness of these processes directly influences the *motivational postures* (Braithwaite, 2003) - whether individuals adopt cooperative, accommodating, or resistant stances toward authority.

The findings from this study shows that procedural justice has the potential to impact on the opportunity for coproduction. Participants across the sites described situations where patients were unaware of the criteria they needed to meet to access off-ward activities or progress to lower security levels. The mechanisms for progression then appear to be deliberately opaque, commonly in the highest level of security, with the overt intention to prevent manipulation. This opacity directly affects the *voice* component of procedural justice by preventing patients from meaningfully participating in decisions that affect their liberty. The data also suggests that rule interpretation and application vary dependent on the staff orientation (custodian versus relationally close) and the environmental factors (on-ward versus off-ward). This inconsistency risks undermining *neutrality* in procedural justice, leading patients to perceive the system as arbitrary or biased. In addition, the influence of historical information on current decision-making, '*case note prejudice*' (6.3.2), although not directly apparent to patients in the descriptions in this study, potentially undermine perceptions of fairness.

Tyler's research shows that when people perceive processes as fair, they are more likely to comply with rules and cooperate with authorities, even when outcomes are unfavourable (Tyler, 2006). This principle has implications for coproduction in secure settings, where cooperation is central to both safety and therapeutic progress. The

therapeutic management of violence and aggression (TMVA) approach described at Medium Secure 2 appears to address procedural justice by explicitly involving patients in designing de-escalation plans. This transparency provides patients with a voice in planning future interventions and demonstrated a respect for their capacity to understand and participate in safety planning. Conversely, when patients perceived processes as unfair or arbitrary, they were more likely to engage in what nurses termed *gaming* behaviours - strategic accommodation in this study - rather than genuine cooperation. The perception of procedural justice may then mediate the relationship between the environmental constraints at each level of security and the potential for coproduction.

Procedural justice adds an important nuance to understanding coproduction in constrained environments. Traditional coproduction definitions emphasise the importance of shared power and autonomous participation. However, procedural justice research suggests that when full autonomy is impossible, the perceived fairness of constrained processes can still support cooperative engagement and coproduction.

This insight helps explain why some forms of coproduction appear possible in secure settings despite significant constraints on patient choice. When security restrictions are applied transparently, consistently, and with appropriate consideration of patient input, they may not preclude coproductive relationships as completely as traditional theory, and Pilgrim (2018) might suggest.

The findings reveal fundamental tensions between the concept of coproduction and the realities of secure forensic care that require critical examination. Whilst staff described various collaborative practices, the question remains whether these

constitute genuine coproduction or represent what might be better understood as *strategic accommodation* within coercive arrangements.

The behavioural gateway system, whilst appearing to offer patient choice and progression opportunities, operates within parameters entirely controlled by the institution. Patients' *choices* are constrained to compliance with institutional expectations, raising questions about whether such arrangements can meaningfully be described as coproductive. The requirement for patients to demonstrate *appropriate* behaviour to access privileges reflects what Foucault (1977) described as disciplinary power - the production of docile subjects through systems of surveillance and normalisation.

The environmental differences between on-ward and off-ward settings suggest that the proximity to visible security apparatus constrains the possibility for authentic collaboration. Even in off-ward environments where staff reported more *normal* interactions, these relationships remain bounded by the threat of withdrawal of privileges and a return to more restrictive conditions. This creates what might be termed *contingent collaboration* - cooperation that exists only within institutional parameters and subject to continued demonstration of compliance.

5.7 Conclusion

This chapter has examined staff perspectives on collaborative practice within secure forensic mental health settings, revealing both possibilities and fundamental constraints on coproduction in coercive environments. The analysis identified the behavioural gateway as a central mechanism through which patients may access

greater freedoms, whilst highlighting how this system operates within institutional parameters that limit authentic choice and autonomy.

The staff archetypes revealed by this study reflect adaptive responses to the structural tensions between care and control that characterise secure settings. However, the analysis shows how institutional rules, and the environment, shape these approaches more significantly than individual preferences or personalities. The environmental analysis suggests how physical and psychological affordances can support different forms of relationship, with off-ward settings generally more conducive to relational approaches. Yet the prominence of custodian type approaches in high-security ward environments suggests that structural constraints may systematically limit opportunities for collaborative practice.

A critical limitation of this study is the absence of patient and service user perspectives. Without understanding how those subject to detention experience and evaluate staff approaches, claims about coproduction remain partial and potentially misleading. The findings represent staff aspirations and accounts rather than evidence of meaningful collaboration as experienced by service users.

The environmental analysis highlights how physical and psychological affordances create different possibilities for relationship development, with off-ward settings generally more conducive to relational approaches. However, this spatial segregation of coproductive practice raises questions about whether such arrangements represent genuine coproduction or rather the management of institutional tensions through the creation of bounded spaces of apparent normality.

Whilst staff described various forms of collaboration and shared decision-making, these occurred within frameworks where ultimate power remained institutionally held

and patient participation was contingent on continued compliance with institutional expectations. This raises important questions about whether secure settings can ever provide the conditions necessary for authentic coproduction, or whether alternative conceptual frameworks might better capture the nature of therapeutic relationships possible within such constraints.

Future research must prioritise service user perspectives on these dynamics and examine more critically whether the language of coproduction obscures rather than illuminates the nature of institutional relationships in secure care. The normative implications of these findings - particularly concerning patient rights, autonomy, and the ethics of claiming collaborative practice within coercive arrangements - require sustained critical attention from both practitioners and researchers.

Chapter 6 Findings: Relationship Development and Coproduction in High-Risk Settings

6.1 Introduction

The development of therapeutic relationships within secure forensic mental health settings presents unique challenges that fundamentally differ from those presented to community-based mental health services. In environments where security concerns must be balanced against therapeutic goals, the traditional models of coproduction - characterised by equal partnership and shared decision-making - require critical examination rather than simple adaptation.

This chapter examines how collaborative relationships between staff and patients emerge, develop, and are sustained within the constraints of high, medium, and low secure facilities, whilst acknowledging the fundamental tensions inherent in applying coproduction concepts to coercive settings. Drawing on interview and focus group data from the four sites, this analysis explores the complex dynamics that either facilitate or hinder collaborative approaches to care, recognising that what emerges may be better understood as forms of managed collaboration rather than true coproduction in its traditional sense.

The chapter addresses five key areas whilst maintaining a critical perspective on the possibilities and limitations of coproductive practice in secure environments. It examines the mechanisms through which trust develops under security constraints, recognising that such trust remains fundamentally asymmetrical; the various forms of reciprocity that emerge in therapeutic relationships, whilst questioning whether these represent genuine mutuality or strategic accommodation; the impact of institutional

culture and team dynamics on collaborative practice; the specific enablers and barriers to coproduction identified across different security levels; and the delicate balance required between risk management and therapeutic engagement.

The analysis draws upon Ostrom's common pool resource theory whilst acknowledging potential criticisms that this economic framework may depoliticise the inherent power dynamics in secure mental health settings. The conceptualisation of peace and security as common pool resources also requires careful justification, as it risks obscuring how these 'resources' may actually represent imposed institutional control rather than genuinely shared goods. Understanding how institutional rules emerge, persist, and change provides insight into both the possibilities and fundamental constraints for collaborative practice in secure settings.

6.2 Building Trust Under Constraints

The security and care dynamic influences relationships between patients and staff in complex ways that resist simple characterisation. External services such as advocacy, whose purpose is viewed positively by patients, appear to develop different relationship dynamics compared to ward staff across the security gradient, though this may reflect structural rather than interpersonal factors:

'...generally, you will find that we have a more kind of informal relationship with patients than what the staff do. I think it's again because of the role. It's easier for us to have that kind of relationship Frank simply because we don't ask anything of the patient. We are not telling the patient to do anything, you know? We are not expecting anything from the patient. But if you are a staff member it's completely different...' (Beth, Advocate, The State Hospital)

The apparent effectiveness of relational security in medium secure facilities, evidenced by the absence of escapes despite relatively low physical barriers, suggests explanations beyond simply successful trust-building. The proximity to discharge creates strong incentives for rule compliance that may be more significant than therapeutic relationships in maintaining security. As one participant noted:

'The more we interact with a patient the more we get to know them, the therapeutic relationship's built and you can reduce the risk, of all their risk and then you can progress to going outside, doing activities off-site, and then it goes on and they get their freedom.' (FG/ Angela Nurse, Assistant Medium 2)

However, this description may conflate correlation with causation, as the increased interaction appears to occur alongside a reduced assessment of risk rather than necessarily causing it.

Nevertheless, breaching security this close to discharge would lead to a return to higher security. Therefore, the incentive is to maintain rules. This explanation on its own is not sufficient, however. Relational security skills used by nursing staff, building, and maintaining connection, and recording observations of patients appears to play a key role in incentivising rule maintenance. For example, Tracy in The State Hospital indicates that:

'That relational element of... the relationship between the staff and the patient that has to build and forge before you can allow any greater decision-making powers by the patient because in effect people won't trust them to make the right decisions.' (Tracy, Nurse Consultant, The State Hospital).

However, disruption within the ward, whether that be in high or medium security, affects the ability to connect when there are other elements of security to monitor:

'I think there is, not a certain type of patient you can [connect] with, but I think depending on the ward as a whole.' (FG/ Paul, Nurse, Medium 2)

The arrangements described here reveal complex power dynamics. The sharing of responsibility for maintaining off-ward resources creates what appears to be collaborative governance, yet the fundamental power imbalance remains unchanged. As one participant noted:

'We've been giving them trust coming down, ensure they know that if anything goes wrong within the [off ward] project, even if they don't do it, it's going to reflect badly on everyone as a whole.' (George, Clinical Manager, Dundrum)

This approach reflects concerns raised in the '*dark side*' of coproduction literature about the transfer of risk and responsibility to service users. Whilst shared responsibility may function as a regulatory mechanism in secure environments, the consequences of failure are disproportionately borne by patients rather than staff. The language of '*giving trust*' reveals the conditional and revocable nature of these arrangements, suggesting that what appears as coproduction may be better understood as managed compliance within predetermined boundaries.

The apparent success of these arrangements should not obscure the fundamental question of whether genuine collaboration can exist within inherently coercive institutional structures, or whether such approaches represent more sophisticated forms of control that maintain the appearance of partnership whilst preserving institutional authority.

In lower security, the dynamic appears to be different because off-ward escorted and unescorted leaves are an inherent part of the testing out and rehabilitative process (Drennan & Alred, 2013). In those environments building trust creates opportunities

for staff to intervene earlier when patients show signs of distress. When staff invest that time and care, patients often respond with trust in kind, creating a positive cycle of connection. This relationship-centred approach allows problems to be addressed before they escalate into crises.:

'If you get the relationship right somebody won't self-harm in isolation they will come and tell you they're gonnae self-harm because something's bugging them' (Mike, Nurse Manager, Medium 2).

The staff member in turn can exercise key skills in the real and therapeutic relationship. In this regard there is a sense that the medium/low security environments afford a greater opportunity for nursing staff to use those therapeutic skills on the ward, whilst their higher security colleagues are focussed as much on security and behavioural management (Aiyegbusi & Clarke-Moore, 2009; Clarke et al., 2008). Coproduction then appears to be easier to facilitate, and possibly be more fulfilling, as security levels decrease.

From Ostrom's perspective, the development of trust in secure settings can be understood as a repeated game where both staff and patients learn the strategies that maintain access to common pool resources. The *behavioural gateway* functions as a screening mechanism in game theory - a way of identifying players who are committed to cooperative strategies rather than those who might defect from agreements about maintaining peace and security.

'The more we interact with a patient the more we get tae know them, the therapeutic relationship's built and you can reduce the risk, of all their risk and then you can progress to going outside, doing activities off-site, and then it goes on and they get their freedom.' (FG/ Angela Nurse, Assistant Medium 2)

Angela's description illustrates what Ostrom would recognise as the development of social capital through repeated interactions. Each positive interaction provides information about the other party's commitment to maintaining the commons, gradually building the trust necessary for expanded cooperation. The progression from ward-based activities to off-site privileges represents an escalating commitment game, where both parties have increasing stakes in maintaining cooperative relationships.

The absence of escapes or absconscions from medium secure facilities, despite relatively low physical barriers, demonstrates what game theory predicts: when players have strong incentives to maintain access to valued resources (in this case, progression through the system), they will choose cooperative strategies even when defection is technically possible.

Before proceeding with the analysis of relationship development, it is important to acknowledge how the researcher's position may have influenced both data collection and interpretation. As an external researcher entering sensitive institutional environments, participants may have presented idealised versions of their practice, particularly given the scrutiny that secure mental health services face. For instance, the tendency for staff to immediately personalise theoretical vignettes rather than engage with abstract scenarios may reflect not only how professional knowledge is constructed, but also a defensive response to external observation.

The researcher's background in mental health services, whilst providing valuable contextual understanding, may have led to assumptions about therapeutic relationships that influenced both questioning and interpretation. The absence of patient voices in this analysis also represents a key limitation. This methodological

choice, whilst necessitated by ethical and practical constraints, means the findings reflect professional perspectives on potential coproduction rather than evidence of genuine collaborative practice as experienced by those subject to detention.

6.3 Forms of Reciprocity in the Therapeutic Relationship

Nursing staff can also play a significant, and darker, role in maintaining a status quo in the patient's progression. In The State Hospital the OT and the psychiatrist describe some staff as potential barriers to the progressive development of trust and reciprocity over time:

'...there's maybe nursing staff that have seen a lot over the years and are a bit more susceptible to [resisting] change in terms of positive risk taking.'

(Paula OT The State Hospital).

'...you have to give people a chance and people can change, but if you believed that [that forensic patients will not change] and you were amongst lots of people who believed that then it would be difficult to change your thinking if that is what you believe.' (Pete, Psychiatrist, The State Hospital)

However, there is also a palpable risk for staff who will be held to account should anything untoward happen because of their judgement.

The darker role, referred to as *gunslinging* by Bob in Medium1 previously, appeared to be less common *now* than in the past in this sample. Restraints, for instance, are a common occurrence in secure forensic mental health (and were increasing during the data gathering period according to the media (Thomson, 2019)). During data collection Medium 2 were implementing a new approach to restraint using principles developed from advance statements (Scotland) or directives (England and Wales): a

person's statement about their wishes, including specific actions to take should they become unable to make decisions for themselves (Atkinson, 2007). In the case of restraint, the advance discussion was presented by staff in Medium 2 as a means to coproduce a positive outcome from the future negative experience of restraint:

'...it was my first day and [a patient] said to me, she said 'I don't like you'. And I said, 'that's fine, you don't need to like me'. She said, 'but I don't know what it is, I just don't', and I said totally fine, and I know when she is getting agitated or she is in a restraint then I am probably not the best person to be there...'

(FG/ Petra, Nurse Medium 2)

There may then be greater opportunities to coproduce safety and trust even in challenging circumstances using TMVA, despite the barriers inherent in high security. It appears that the approach being implemented in Medium 2 is facilitating reciprocation, even after a violent incident. For example:

"After 99.9% of restraints they will come up and apologise. They'll come up and say, 'can I talk to you'. And you'll come in and they'll sit and talk to them, and they'll go 'did I hurt you? I am really sorry'." (FG/ Liz, Nurse Medium2)

A form of reciprocation can also be seen when staff return from leave and are welcomed like a lost friend, or when a member of staff is threatened, and patients step in to protect them:

'Well, I came in this morning after being off a week it was like going in to see friends, they were coming up to shake ma hand, 'it's good to see you, blah blah blah'. That's nice, that's good. It's good for the patient, it's good for me.'

(FG/John, Health Care Assistant, Medium 2)

'I've had a patient hit another patient because a patient went for me' (FG/Jo, Staff Nurse, Medium 1).

In these quotes there is a recognition of the importance of human interactions beyond the roles that are allocated to the nurse and patient. The welcome back from holiday is a recognition of the value that a member of staff brings to the group on the ward, and perhaps a desire for new stories and vicarious participation in the experiences related from his time off. The second quote describes a complex relationship between some patients on the ward and those providing care: a connection that is protective of the staff member despite the powers that the nurse holds, and the potential consequences for their detention as a result of a performative form of reciprocity in defending the member of staff from another patient. This protective behaviour illustrates what Ostrom called *counter-sanctioning* - where community members protect those who contribute to maintaining common resources (Ostrom & Walker, 2003). The patient's willingness to incur personal costs to defend the staff member (potential disciplinary consequences) suggests they view this particular nurse as an essential contributor to maintaining the commons of safety and therapeutic environment, creating sufficient social capital that the reciprocal relationship becomes worth protecting.

The nurse referenced this incident as evidence of the strength of the relationship they had with the patient. There is a suggestion here that they were proud that the relationship was such that they would be defended by someone they were caring for. This dynamic reflects Ostrom's observation that successful common pool resource management requires mechanisms for monitoring and sanctioning behaviour. In secure forensic settings, these reciprocal relationships serve both functions, with staff and patients monitoring each other's commitment to maintaining peace and

security, while providing sanctions (such as withdrawal of trust or privileges) for those who violate the informal agreements that sustain therapeutic relationships.

6.3.1 Empathy as a Finite Resource for Connections

Identifying when to intervene empathetically - and determining whether you are trusted sufficiently to use it - is a crucial skill, developed through practice. This was described in the focus groups as one of the esoteric magical skills, based on having a good enough relationship with your team and being relationally close to patients to have robust enough information to interpret what you are observing:

'So, in terms of teaching people, you could maybe teach people who can't do it, but I don't know whether you can actually ...But then it becomes something esoteric, you can't nail down, that's floating about in the ether. I've got this mystical thing.... I don't think you can be professionally empathetic.' (FG/Bob, Charge Nurse, Medium 1).

In this case Bob is making the case for inherent interpersonal skills, especially empathy, being essential for effective relational care. He is also suggesting that creating training for empathetic work is not sufficient to create an empathetic workforce. That is, whilst the mechanics of empathy can be taught - how to use listening skills and reflection to develop and strengthen relationships (Petrucchi et al., 2016) - staff need to have innate empathy skills to begin with, as well as a working culture that supports and cultivates its expression.

While Petrucci et al. (2016) document that nursing tends to attract people with higher degrees of empathy than other professions, and Nembhard's systematic review of empathy research suggests that training can improve the skills that develop

empathetic responses (Nembhard et al., 2023), in this quote Bob cautions against lionising it as a *mystical* thing that only a special group of nurses will truly have, while at the same time advocating against the concept of 'professional empathy'. That is, where professionals:

'must economise emotional resources and consider appropriate responses to manage a full caseload of clients who require attention' (Ekman and Halpern 2015:635).

However, there is evidence that exposure to risk and assault can have a negative impact on the capacity for empathy (Grady & Strom-Gottfried, 2011). For patients this is apparent in staff whose experience was gained in environments where security dominated care:

'They know what staff have worked in the old institutions and after you've spent some time pick out which ones they were without knowing. They do have a very similar style of being quite hard actually.'(Lynn, Psychologist, Medium 2).

That is, empathy as an emotional resource for the staff member to understand and connect with patients is overwhelmed by the primary need for safety and security which is in turn challenged by the experience of violence and aggression. This phenomenon may be what we see being played out in the dominance of procedural and physical security over relational security systems on the ward: that defending and maintaining the commons of peace and security must come first before those staff feel able to engage with relational security. The paradox in this safety behaviour is that the dominance of these factors increases the likelihood of staff being seen as objects of detention rather than humans to connect with (Bernard et al., 2018),

increasing the potential of a violent reaction. Unlike the phenomenon of compassion fatigue, also described as vicarious trauma or the transfer of a trauma experience from one person to another (Canadian Medical Association, 2020), this does not appear to be a diminishing capacity for compassion rather than the dominance of a primary need for safety. That is, rather than Tversky and Kahneman's system 1 (trained automatic responses) or system 2 (real time assessment and judgment guiding responses) (Tversky & Kahneman, 2015), this is a fear response (Kahneman 2015: personal communication).

However, off ward, where the patient has achieved the behaviour gateway, there are greater opportunities to test out and create the opportunities for connection that develop empathy between patients and staff

'Now we would probably start something basic like, if the person was suitable you would go to the [garden poly] tunnels and so something like potting and you could chat with the patient... yeah and the staff are there observing and you don't necessarily have to be at arm's length from the patient, you could engage with that patient, to build a rapport with them.' (FG/ James, Clinical Manager, Dundrum)

Nevertheless, building empathy may be a challenge when a historical risk is prominent in the case notes available to staff.

6.3.2 Managing Case Information While Seeing the Person

In this section I examine the influence of the judgements of others through the records of patient behaviour in their notes. For some staff it presents a picture of the patient at a moment in time that is not reflected in the behaviour they have

witnessed, referred to here on in as *case note prejudice*. For others those records can highlight an ongoing threat which may provoke initial custodian like behaviours that reinforce physical and procedural over relational security. The advocates in this study do not have access to that information, or its influence, and see that as a benefit:

‘So, when a patient comes in, we only get to know where they’ve come from, what order they are on, right and that’s it. So, we don’t have any pre-conceived ideas and that’s important as well and I think that keeps us safe and makes it easier for us to do our job’ (Beth, Advocate, The State Hospital)

This study did not find evidence that case note prejudice or a conscious choice to focus on the current presentation resulted in either of the archetype behaviours described. However, the data does suggest that the judgement of others presented in case notes may help to reinforce existing tendencies toward custodianism.

For instance, while knowledge of the behaviour of a patient before admission is central to risk assessments, that knowledge can also be a barrier to creating relationships, especially if the offence that leads to admission is emotionally affecting. As the nurse consultant at The State Hospital identifies when asked if staff can separate the offence from the patient:

‘I think they try. I think they do, and I think some people try really hard. Others don’t in my opinion, but I think that most people, most people do, they try really hard to. Right, there’s a niggle at the back of your head, there’s sometimes just, they just can’t get rid of it and there are particulars you would imagine, there are particular groups of offenders that maybe niggle at people’ (Tracy, Nurse Consultant, The State Hospital).

This appears to occur irrespective of the professionalism of the member of staff in question and is dependent on the nature of the offence and how that psychologically affects the staff member. Similar challenges have been observed in volunteers supporting sex offenders (Höing et al., 2016), and vicarious traumatisation in professionals (Merhav et al., 2018):

'...we have had staff that have found it difficult to deal with patients who have committed sex crimes against children. But I think once you sit down on a supervision and you start to kind of give them research, you give them basically pointers and give them education' (Peter, Charge Nurse, Medium 1).

In this quote Peter acknowledges that professionalism on its own is not sufficient armour to ensure consistent approaches when staff may be triggered (a negative emotional reaction stemming from the emotions that knowledge of an offence stimulates) (Bonilla et al., 2025). And that additional support - 'education' and a refocus on the needs of the patient, the aetiology and dynamics of the offending behaviour and its relationship to their mental health - is required to help that member of staff provide the care the patient needs.

This may represent an availability and anchoring bias, as explored by Amos Tversky and Daniel Kahneman in prospect theory (Tversky & Kahneman, 1979). They describe the creation of systematic errors in decision making influenced by anchoring (how representativeness is defined) and availability biases (the prominence in recall of the most recent information read or heard) (Tversky and Kahneman 1974: 1128-1130). In this study the prominent anchoring bias appears to be public protection in the Scottish sites. This will affect how a patient's actions and that of the staff are perceived and would tend to weight staff decisions towards

minimising risk. It may also reinforce teamness (Glaser et al., 2004; Tilden et al., 2016), referred to as ingroup elsewhere (Tropp & Wright, 2001), and the existing culture. Availability bias would be represented in the case notes highlighting historical behaviour as the basis for a current risk assessment.

Despite the best intentions of staff, risk perception based on past patient history and the historical approaches to care in each facility can inadvertently dominate treatment decisions. For example, Martha in Medium Secure 2 comments on the lingering legacy of the unit being isolated prior to its move to a central location, and the influence that this has on the approach taken with patients:

'I think we've been too judgemental about mental illness and maybe what they've done' (Martha, Staff Nurse, Medium 2).

That barrier is not experienced in the same way by non-medical staff who may not require to know the reasons for the admission but will be aware of the orders that have been applied to patients. There may therefore be a distinction between the constraints on coproduction between qualified, and unqualified health and non-health staff. That is, the statutory duties of qualified health staff to monitor and manage risk and public protection may present barriers to the development and maintenance of the *real* relationship that is developed through reciprocation, and as a result presents barriers to be overcome to establish coproduction. Unqualified health staff and non-health staff, with the exception of social workers, do not carry those responsibilities and may then have greater opportunity to create the relationships that may result in coproduction of peace and security.

In common with other sites, one of The State Hospital nurses reported avoiding reading case notes - specifically the judgement of others - in advance of meeting a

patient so that they were not influenced by others' assessments. They gave an example of one occasion that their presumptions informed by the notes were challenged:

'...on the last course [of sports therapy] there was one guy I really had reservations about. I read his review case notes and I'm thinking I don't fancy this guy. It was great. I did raise my concerns. I was wrong.' (Jim, Staff Nurse, The State Hospital).

Jim, and John the Healthcare Assistant in Medium Secure 1 expressed similar views and seem to be recognising that there are inherent risks associated with all of the patients that they support:

'Well, we've got a patient in here took staff hostage and that. I suppose you need to know that obviously you don't want to be in a room with him but, but I think what you've got to look at is when that happened, was it last week or was it twenty year ago when he was unwell and now, he's a lot better and he has been free from any incidents for ten years' (John, Health Care Assistant, Medium 2).

They appear to be concerned that the specific concerns of others influence how they approach a first encounter with patients. From their perspective, this creates a barrier in the formative early contacts with the patient which in medium secure (John) and off ward in high secure (Jim) appear to be recoverable, but they seem to be saying it is best avoided. However, there is a significant caveat in that both members of staff were very experienced and as such will have practice wisdom (Samson, 2015), defined by Klein as an:

'integrating vehicle for combining the strengths and minimizing the limitations of both the "objective," or empirical, practice model and the "subjective," or intuitive' (Klein and Bloom, 1995: 799).

On-ward staff in the high secure sites in contrast view his approach as inherently dangerous:

'If you've got a patient whose been violent towards females you need to know that because obviously you wouldn't be putting them in the area or on a constant [with female staff] ...' (FG/ Ger, Clinical Manager, Dundrum)

This has implications for coproduction in this environment in that it may be the case that more experienced off ward staff, or staff in lower levels of security, can develop a relationship that is supportive of coproduction, independent of risk assessments and judgements of others, where new staff may have less confidence to take this approach.

6.3.3 Coproducing safe restraint

This section examines how staff and patients describe the co-production of the challenging but sometimes necessary practice of restraint in secure mental health settings, with a particular focus on safety and a swift conclusion as well as supporting swift post incident recovery. Drawing on the interview data from Medium 2, the analysis highlights collaborative approaches between staff and patients that appear to transform this coercive experience into an unusual opportunity for therapeutic engagement and recovery.

The interviews highlighted differences in approach to restraint between sites, particularly between the NHS and private sites. One senior staff nurse (Jo, Snr Staff

Nurse, Medium2) highlighted this contrast when comparing their current private facility with previous NHS experience. Jo describes how the NHS facilities appeared to have a different threshold for physical intervention:

'I think one of the main points you will find, and I've heard this from patients as well is that an IPCU they are quicker to lay hands on there. We'll do everything to avoid it, you know, we will do everything to verbally de-escalate a situation on a whole. Em rather than just pile them in.'

In this quote '*lay hands on*' is a euphemism for restraint, and IPCU refers to an intensive psychiatric care unit, equivalent to a physical care ICU (intensive care unit). In the quote she suggests that the co-production of restraint begins with what appears to be a nuanced approach to shared decision-making about whether restraint is necessary at all, with Jo indicating that in their current setting, staff prioritise verbal de-escalation before considering physical intervention.

Several interviewees in Medium 2 highlighted that the patient's contributions to the risk assessment could help prevent restraints. A staff nurse, Martha, described an incident where a failure to incorporate a patient's self-knowledge – Foucault's knowledge power (Foucault, 2020) - led to harm:

'One of the girls had recently been promoted to Band 4, above me. Less experience and stuff but she had been promoted and, em, talking about a particular patient. I'd been in the ward for about a year before her so I kinda knew the lassie [patient] well and knew she wisnae right. You could see through her facial expressions she wisnae herself and I says to her - she had escorted leave - and I said I don't think you should be going oot the day, maybe this afternoon. She went. Awe I just, burst into tears.'

Martha continued to explain that others team members also recognised that the patient was unwell, but the Band 4 nurse insisted on the patient going out, which concluded with self-harm. This example highlights that co-production of an intervention plan could have prevented harm by validating the patients' self-reported distress, incorporating the observations from staff with an established relationships with the patient, and supporting collaborative decision-making across the team rather than what is described as a unilateral decision.

Martha reflected on the patient's response after the incident:

'...when she same back that day she said but yous knew. That was meaning: you said it yourself, but you still let me go.'

This poignant statement highlights that patients also recognise when their own knowledge about their mental state is disregarded, potentially damaging trust and both the therapeutic and real relationships.

Several interviews on this site emphasised the importance of transparent communication in building the trust necessary for co-producing safe approaches to restraint. As Jo explained:

'I think in your one to ones you build up good trust with your patient and you ask to know what your triggers are for relapses, what is your risk. Is it drugs, is it alcohol, would you be able to come and tell me you're going to have a bad day rather than just going and absconding.'

This quote highlights that proactive conversations about triggers and warning signs can create a shared understanding between staff and patients, potentially reducing the number of situations where a restraint is necessary. Jo's emphasis on patients being able to communicate when they are *'going to have a bad day'* suggests that a

co-productive approach would be proactive and anticipatory where patients are active participants in risk management rather than passive recipients of intervention.

When restraint does become necessary, the manner in which it is conducted significantly impacts patient experience. One health care assistant, John, reflected on the differing and developing intuitions that can prevent a physical intervention before they are allowed to develop in Medium 2:

"You know if we've got somebody who is really upset and stressed or agitated sometimes you find it's better to step back and let that person have their space than it is to approach. You know, and that's something that you learn in this environment, that's something that you work on, you know."

John contrasts this approach with his experience elsewhere:

"I don't know, when I was in [NHS facility] IPCU, I'm no' saying I seen a lot of it but you know like for [a patient having in their possession] a thing like a staple, someone was restrained."

This comparison highlights that when staff work with patients to manage challenging situations, there is a potential to create an environment that encourages proportionate responses to behaviour. In this collaborative approach, staff become more attuned to recognising the circumstances where less restrictive alternatives to restraint would provide more therapeutic benefits.

The interviews contained less explicit discussions of post-restraint recovery processes, suggesting that this may be an underdeveloped area of TMVA and therefore of what may be the co-production of restraint. However, several quotes demonstrate the importance of maintaining therapeutic relationships, even when the

real relationship may have been affected by a restraint. Peter, a senior charge nurse, explained:

'We have to provide them with evidence to say yes that is the way that we are moving forward for you.' (Peter, Senior Charge Nurse, Medium1)

This suggests that how teams respond to incidents, including restraint, should be oriented toward recovery and progression rather than extended restrictions for safety that could equally be interpreted as a punishment. Peter's emphasis is on supporting patients to understand that even after difficult incidents, the focus remains on their recovery journey.

Several interviewees highlighted how organisational culture also impacts approaches to restraint. Mike, the Nurse Manager, described transforming a previously problematic ward:

'We didnae go in and take everything out the rooms. We didn't give everybody PRN [as needed] medication times 10. We didn't make the fences any higher. We made the ward environment nicer; we involved the patients; we gave them things we wouldn't have [normally] gave... you know big TVs... I don't know, a lovely dining room a beautiful garden. We gave people more than taking away and as a result [the] Ward is just not the same ward anymore.'

This description suggests that co-productive approaches to managing risk and reducing restraint involve creating therapeutic environments that reduce tension rather than reactively increasingly restrictive responses to challenging behaviour. Mike's emphasis on *'giving more than taking away'* suggests a different philosophical approach to risk management in comparison to historic practices - or current practice described by John above - that may reduce the need for restraint.

An important theme emerging from the interviews was that staff also need support following difficult incidents like restraints. Mike, Nurse Manager, articulated this clearly:

'The level of trauma and the level of challenging behaviours here has got to have an impact on our staff. If you also throw in an environment where people don't feel em, they don't feel valued, they em kinda..... they don't feel supported em they don't feel listened to....'

This perspective suggests that co-production of a culture where restraint is required less frequently and, where it does occur, is conducted safely, to a plan agreed with the patient and ended as soon as is safely possible, must address the wellbeing of staff as well as patients. Mike's perspective is radical:

'My strong belief is if you practice [mental health] recovery in the right way you could replace the patient with staff in any ethos of care that you've got.'

He implies that the imperative of reciprocity in co-production should apply equally to staff recovery following incidents, creating a therapeutic environment for all of the people within it.

The data suggests that Medium 2's approach to coproducing restraint and post-restraint recovery requires significant shifts in organisational culture, decision-making processes, and therapeutic relationships. The key elements include incorporating patient knowledge into risk assessment and management, prioritising verbal de-escalation and less restrictive alternatives, ensuring that there are proportionate responses to challenging behaviour, maintaining recovery-focused approaches even following difficult incidents and, finally, supporting staff wellbeing and recovery as essential components of therapeutic environments. While the interviews provide

limited explicit discussion of post-restraint recovery processes, they do suggest that maintaining therapeutic optimism and progression-focused care following any incident is essential to supporting the development and maintenance of co-productive practice.

The interview data from Medium 2 provides rich insights into how the therapeutic management of violence and aggression operates within a medium to low secure setting. What emerges is not a one-size-fits-all approach, but rather a complex, nuanced combination of practices that require considerable skill and adaptability from staff. Staff consistently describe a need to tailor their approach to individual patients - personalisation - recognising that what works for one person may be entirely ineffective or even counterproductive for another. As Jo notes in the Medium 2 focus group,

"It's just about knowing them isn't it... there are certain patients you could say something and other times you just wouldn't."

This personalised approach extends to restraints, where staff have learned to modify their techniques based on patient feedback:

'She said it was a man talking to me... We will have a female talk to you next time.' (FG, John, Health Care Assistant, Medium 2)

The data highlights the challenges of maintaining the critical balance between consistency and flexibility. While clear boundaries and procedures are necessary in secure environments, the most effective staff demonstrate an ability to adapt within these frameworks. They can shift between professional distance and more personal forms of engagement, using humour and banter with some patients while maintaining more formal interactions with others.

When considering how this approach might translate across the gradient of secure care, a number of challenges become clear. In high secure settings, the dominance of physical and procedural security creates barriers to applying relational security as can be seen in the interview data. As security protocols become more rigid, the opportunities for spontaneous, normalising interactions diminishes. As Peter describes, contrasting his current setting with higher security environments:

'We've got patients that are going down to Morrisons shopping... medical appointments, dental appointments... ten pin bowling, fishing groups.' (Peter, Senior Charge Nurse, Medium 2)

These community-based activities provide valuable contexts for relationship building which are typically not available in higher security settings.

The interviews also reveal significant variations in staff attitudes, even within this facility. Some staff naturally adopt a more human approach, while others focus primarily on security procedures. As Mike, the Nurse Manager describes it:

'...you're either a warder or you're a nurse... the warders watch the doors to make sure you follow all the procedures.'

This division could be more pronounced in higher security settings, where risk management may dominate the institutional culture.

Higher security settings typically accommodate patients with more complex needs and higher risk profiles. This may affect the development of the therapeutic alliance, as patients may have experienced trauma in other institutions and as a result have a deeper distrust of authority. The data suggests that patients who have been *'through the system for years'* often become disengaged from therapeutic activities because *'they've been there, they've done it, they've ticked the boxes'* (Jo Senior Staff Nurse,

Medium 2). Despite these challenges, the core principles could be adapted across the spectrum of secure settings. High secure settings could benefit from creating spaces or time periods where security protocols are slightly relaxed (while maintaining appropriate risk management) to allow for more normalised interactions. The *talking group* mentioned by Kate (Psychologist) in High Secure (Scotland) - where patients and staff voluntarily attended during lunch hours with minimal structure - provides a model that could be adapted even within high security constraints.

The interview data suggests that the ability to maintain therapeutic relationships alongside security management is partly innate but can also be developed. Nurse Manager Mike described a process of:

'...relearning people to actually say they need to get people to work with you to be able to facilitate that change.'

Targeted training in mentalising⁸ (Luyten & Fonagy, 2014), trauma-informed care (Forkey et al., 2021), and reflective practice (Bulman & Schutz, 2013) were being piloted in this site, which if successful could help staff across all security levels develop these skills.

Medium and high secure settings could also adopt the collaborative approach to risk management described in the interviews. George, staff nurse in the focus group at Medium 2, explains how they involve patients in understanding restraint:

'I said to her... you are aware that you are going to get restrained because I can't let you hurt yourself.'

⁸ the ability to understand and interpret our own and others' thoughts, feelings, and intentions to make sense of behaviour

This transparency could be valuable across all security levels, potentially reducing resistance and fostering greater cooperation.

While high secure settings cannot offer the same community access described in the interviews, they could focus on creating internal communities that foster similar benefits. The sense of community described in the interviews - where '*patients do see at times if things are quite difficult*' (FG, Elaine, Nurse, Medium 2) and adjust their behaviour accordingly - suggests that cultivating mutual responsibility could be beneficial in any secure environment.

However, any attempt to scale this approach faces several challenges. Firstly, institutional pressures: higher security settings are exposed to greater external scrutiny and political sensitivity, potentially limiting the opportunity for innovation. Secondly, resource constraints: the person centred and tailored approach described requires adequate staffing levels and training opportunities that may not be available. Thirdly, risk-aversion: in higher security settings, the consequences of adverse incidents may encourage a more conservative, procedure-dominated approach. And lastly staff wellbeing: maintaining therapeutic relationships in challenging circumstances requires a substantial emotional labour from staff.

The data from Medium 2 suggests that despite these challenges, the core principles of therapeutic management - seeing the person not just their history, maintaining authentic relationships through difficult situations, and collaborating on risk management - have the potential to be applied across the spectrum of secure care. While the specific mechanisms may differ, the fundamental approach of balancing security needs with therapeutic relationships appears to be both effective and potentially transferable.

6.4 Institutional Culture and Team Dynamics

6.4.1 Two Tribes: On-Ward and Off-Ward Staff Relations

'...it has always been [nurses working in off-ward sports and recreation] "they bastards they want to run about in tracksuits all day or [indistinct] they're not real nurses, they've never seen a violent patient in their life, blah, blah, blah blah blah."' (Martin, Staff Nurse, The State Hospital)

In this quote Martin from the off-ward sports department in The State Hospital highlights the distinction he believes that ward staff see between what they judge as their more challenging and dangerous work on the ward and their perception that sports is a soft option for staff, requiring less skill. This was a distinction that was apparent in both The State Hospital and Dundrum Hospital. Dundrum Hospital participants appeared to be more circumspect in their comments about other colleague's practice and perceptions but, nevertheless, they did recognise that the environment - wards versus projects - influences how staff and patients were perceived. As a clinical manager describes it:

'...we are not working with numbers and statistics we're dealing with people and nurses are individuals or care givers on the ward, ...they are individuals, and they have different individual ideas about things and similarly your experience as a ward manager. When I was one my experiences will lend me to have certain views ...' (Bert, Clinical Manager, Dundrum)

Similar distinctions between ward and off-ward approaches are noted in other settings:

'You see on the wards you've got a lot of policy. There wouldn't be as much about policies when I came. There was a kind of ward [culture] and you were taught what was expected but now if you start here as a nurse, you would be handed a book of policies...' (George, Nurse, The State Hospital)

There is a sense in Bert's quote that recognition of this environmental influence only occurred when the clinical manager had moved on from the ward manager post.

This, for them, is the reason for a ward manager's *certain views*, which may also reflect the importance of certainty in ward environments, and the role related beliefs and traditions they have inherited. There is also a suggestion here that experiences on the ward are formative, and the use of the phrase *certain views* suggests that this interviewee believes that the views are distinct from those who work off ward.

Both quotes suggest that the concept of teamness (Glaser et al., 2004; Tilden et al., 2016), to connect to one another such that they can have absolute trust in one another in the event of an incident, plays a key role in maintaining the distinction between the cultures in these environments. That is, belonging to a team that works in a particular way and the maintenance of rules can make using a different mechanism such as relying on relationships and dynamic risk management appear to be an unnecessary risk. Teamness may then serve paradoxically to create a sense of safety and to restrict what is possible in interactions with patients because to practice in a way contrary to the team may lead to exclusion.

The distinction between on-ward and off-ward cultures can be understood through Ostrom's analysis of how different institutional arrangements create different incentive structures. Ward environments, with their emphasis on physical and procedural security, create what game theory calls *dominant strategy* situations -

where following security protocols provides the highest payoff regardless of what others do. Martin's description of the disparaging way that off ward staff are referred to by ward staff in the State Hospital above illustrates what Ostrom identified as *institutional competition* - where different rule systems create conflicting definitions of appropriate behaviour. Ward staff operate under rules that prioritise risk minimisation, while off-ward staff work within conditions that emphasise relationship-building and therapeutic engagement. These competing institutional logics create tensions that can fragment the collective approaches to therapeutic outcomes across the State Hospital's environment.

The historical escape from The State Hospital ('the 1976 escape') also functions as what Ostrom called a *critical juncture* - an event that fundamentally altered the institutional rules and created path-dependent effects that continue to influence behaviour decades later. The institutional memory of this event created strong incentives for risk-averse behaviour that may restrict opportunities for therapeutic relationship development.

6.4.2 The Impact of Historical Incidents on Present Practice

A consistent cultural dialectic in The State Hospital, and the wider forensic network that it influences, exists around an escape from the facility and subsequent murders in 1976. This motif influences a zero-sum game of rules over relationships. Those who prioritise rules point to the fact that the relationship forged between a staff nurse and the two escapees, and what they consider a lax regime, led to tragedy. When change is suggested, this case is presented as evidence for maintaining distant

relationships and a reliance on physical security (Field Notes 2015). This can be reinforced by dysregulated or disengaged patient behaviour on-ward, which can contrast with the behaviour experienced off-ward as noted and described here by The State Hospital psychiatrist:

“I’ve got a patient who does not interact on the ward, he does not speak to the staff, only speak to the staff when he needs, sometimes he acts strangely, if he wants to go out of his room he would stand up he will walk towards the door and then he will just stand and will wait for somebody to come and open the door. He’s not engaging, he’s not mentally unwell either so what’s happening and then that same patient acts completely different in the [community centre]. Much more engaging and much more in tune with the environment and the people.” (John, Psychiatrist, Medium 1).

Staff sickness rates are also indicative of the level of stress generated by hypervigilance this historical dominance of procedural and physical security has on nursing staff. To illustrate this, the Scottish NHS performance management target for workforce sickness is 4%, but The State Hospital it is consistently higher (6.58% in 21/22). This is not similarly reflected in off-ward, relatively autonomous staff groups, increasing the distinction between the two cultures:

‘..... you work with difficult people; it takes its toll at times you know.’ (John Psychiatrist, Medium 1, describing the impact of working on ward)

The ward in high security also hosts the highest number of rules. Activities led by off-ward staff within The State Hospital panopticon-like ward day room allow for some testing out, but:

'...you've not got much privacy, and they are quite noisy' (Pete, Psychiatrist, The State Hospital).

That is, the mechanisms for control that appear to be prominent on the ward are equally prominent in the ward day room activities. In addition, the perception of constant scrutiny pervades even this testing out in a ward population which includes unpredictable new admissions, an unpredictability paradoxically encouraged by the noise and hubbub of therapeutic activity. This description of the environment and the nurse and patient reaction to it, does suggest that on-ward coproduction is challenging if not almost impossible to achieve in The State Hospital.

In addition, the nurses available during on ward or day room activities tend to take a custodian type role (Field Notes 2015), watching the patients rather than engaging in them:

'I have a view that staff who have been here a very, very long time, some do stick to more of the...down the routes that are old....' (Gill, Psychologist, The State Hospital).

That is, the response to sensory overload for nurses is to focus on the areas that they can control such as physical security, particularly in response to a violent incident, which is then reinforced by culture and history within this particular environment. This appears to be the most prominent contrast with the practice described in the three other sites and appears to be a barrier to coproduction in The State Hospital wards. Although, it may also be a feature in lower levels of security if staff are not eased back into relational working in that environment in the aftermath of an assault (Sweeney et al., 2018).

Changes in ward practices in The State Hospital are slow where the mythology of escape and the need for distance and security is pervasive. The key cultural phrase:

'When you come in the gate make sure you go to the gate at night-time and make sure your colleagues go out the gate as well.' (Peter, Psychiatrist The State Hospital),

could also lead to a misuse of power by punishing patients for violence against staff or not *behaving* (Crossman & Hardesty, 2018). For example:

'I was in the admission ward and let's just say Dr X was in charge at the time type of thing so if they didn't do what they were told, well they were encouraged to do what they were told, and I found that extremely difficult because I'm not like that at all.' (Jim, Staff Nurse, The State Hospital).

This experience was also reflected in the Irish site, where Tom reflected on his many years of experience of change on the site:

'When I started here 32 years ago you would never. No patient was let near any tool or anything, near any garden project you wouldn't be allowed. Security was very, very heavy. Everything was about security and about control and about containment. You'd very seldom see a patient in the grounds' (Tom, Nursing Officer, Dundrum)

Whilst this is presented by Jim as history, and for Tom it is, these types of discussions appear to have been important in his decision to move from the ward environment to off ward activities where relational security and engagement are the norm.

It is important to note that the interviewees across the sample recognised that there was a different relationship between staff and patients on a ward, the staff who visit them there and, in the high secure sites, the staff in the off-ward community spaces such as the community centre in The State Hospital. The Medium Secure 2 staff usefully described the distinction as being between those who come in and do the fun stuff and the on-ward staff role to maintain security and safety:

'I think with the patients and OT staff, and staff like that, who are doing the fun stuff Because we have to set rules.' (Bob, Charge Nurse, Medium 1)

This quote suggests that there is an underlying power dynamic between on-ward and off-ward staff: that no matter what progress occurs, the final arbiters are the ward staff because that encounter is where *'we have to set the rules'*.

This was a common theme across all sites: the distinction between the persona of some staff as approachable and empathetic, and as keepers of security, safety and the gateways through which patients have to pass and to prove themselves before they can access the more engaging activities off ward. This categorisation, of the on ward environment being security focussed and off ward being much more engaging, is a reality when wards are busy and populated by complex patients with potentially competing needs. However, there is a distinction between the high and medium\low security sites. Both high secure sites had distinct areas within the hospital campus that were designated for off-ward activities. In the medium and low secure facilities off-ward would mean a *leave* allowing a patient to visit a local town or leisure facility, either escorted or unescorted. In this regard the less overtly clinical interventions designated as fun via leave were being facilitated by staff who are also on ward staff.

There is therefore evidence that staff with skills and capabilities that could support coproduction in high security are driven from the environment by the lack of opportunity to practice in that way and by both a culture and a system that favours other forms of security and control. Medium to low secure staff in contrast have more opportunities to practice coproductively if they choose, but they are also supporting people with very different risk profiles than their high secure colleagues

6.5 Enablers and Barriers to Coproduction

6.5.1 Conditions That Facilitate Collaborative Approaches

Working in secure conditions means working with restrictions on relationships, movement and access to desirable activities or locations. These limitations, suggests Pilgrim in 2.6.1, mean that coproduction is not possible (Pilgrim, 2018). However, creating the conditions for patient compliance testing - with boundaries - or testing the extent of their recovery, limited though it may be in high security, suspends the reality of detention for a period. It allows patients to experience limited freedoms and forms of coproduction of their own outcomes in their developing relationship with staff. This is a form of normality even in abnormal conditions. Which for patients and staff who have high degrees of motivation to succeed can result in psychological flow as they are immersed in mutually absorbing activities, further suspending reality and providing an intrinsic reward (Norsworthy et al., 2021), which many patients will want to repeat. The incentive of having reduced restrictions is also an enabler for coproduction, providing a reward for compliance, and once achieved, providing an incentive to maintain privileges: both through behaviour and working collaboratively with others to maintain peace and security. Accessing off ward activities may be the incentive, but once accessed the more relaxed, personalised security environment

more readily affords relationships, reciprocity, conditional trust and autonomy. This is the distinction between the undesirable *abnormal* detention spaces (on the ward) and the desirable *normalised* fun spaces (off ward). In the Irish site for example:

'So if you go into an office, going into a session with a psychologist, even a nurse, with your consultant, being in that office or that room you know straight away that you are being interviewed. So, you have got that but once you get down to where we are, you know, choirs and the band, you are out of that, so those boundaries aren't there, they become more relaxed'. (FG/ Bert Clinical Manager, Dundrum)

'You start to build a relationship with the patient because they don't feel restricted. You know they let themselves go a little bit like.' (FG/ Mel, Clinical Manager, Dundrum)

Low secure facilities are preparing people for discharge and as a consequence the rules and the environment focus is on developing skills and relationships:

'... in this service, like a stick of rock is the notion that this is a low secure facility that is intent on discharging people who come here [chuckling]. That is the discourse, that's why they are here. For the guys who are following high level security that's an easy enough connection to make.' (FG/Bob, Charge Nurse, Medium 1).

Although at least one nurse was suspicious of reciprocal activity and asks who it is to benefit:

'But I just wonder what [are] these timetables for? Is it to make the service and the staff look good or is it actually to benefit the patients...' (Chris, Health Care Assistant, Medium 2)

Higher security requires levels of innovation to mimic normal conditions outside the hospital within the restrictions that are applied to patients *'when it is safe for [them] to do so'* (FG/Sean, Clinical Manager, Dundrum). Even then adaptations can be made to allow a patient on close observation, normally within arm's length of two to three members of staff, to experience off-ward activities:

'If the person was suitable you would go to the [garden project] and so something like potting and you could chat with the patient [all talking together], ... you could engage with that patient, to build a rapport with them. It would be limited enough until they wouldn't be under so much scrutiny I suppose.'
(FG/Janice Clinical Manager, Dundrum)

"...a lot of patients, especially in Wildwood I see the better ones will see someone and 'ah you can't do that', you know when holding a tool in a specific way because you are using a lathe." (FG James Clinical Manager)

Moving from the routine on the ward to off ward activity is attractive to patients. The off-ward experience is more relaxed and is more personalised:

'...we make it patient led so that when they are coming down, they know they are coming down to do something they want to do' (Sean, Clinical Manager, Dundrum).

There is then a distinction between the detention and control spaces, which in this case are the residential units or wards, and the spaces that patients desire to be in to be part of rehabilitative activities they wish to be involved in. However, in this example from the Irish site access to off ward, non-treatment-based therapeutic activity relies heavily on chance rather than choice: *'Some days it's the same patients, other days it's different'* (Sean, Clinical Manager, Dundrum). It may be that

the element of chance increases the desirability of that activity as it is effectively a rare commodity, requiring strategic gameplaying to determine the rules to access it. In this site in particular that rarity may in itself provide an additional regulatory mechanism for behaviour, ensuring behavioural compliance and valorising the support given by off ward staff within the activity, or confirming that behavioural compliance is no guarantee of reward, although there was no direct indication of this from the interviews. This is a phenomenon that was unique to this site at the time of the study which suggests that, whilst there are common core components to coproduction, there are also components that will be unique to each site that support cooperative and coproductive behaviours in patients, just as there may be historical and cultural barriers such as the notorious escape from The State Hospital in 1976 described above (Rose, 2013). This incident supported a cultural dialectic that influenced practice towards prioritising physical and procedural security over relational approaches

6.5.2 Patient and Staff Dynamics in Secure Mental Health Settings

Association with other patients is restricted on the ward in high secure locations more particularly on admission but it is evident to degrees across the sample. On ward activity is primarily passive leisure such as computer gaming or watching TV (Kim et al., 2019). However, attempts by the Irish sample to bring activities into the units were commonly challenged by security concerns:

'...no matter what you brought to a unit everything had a risk, every small piece of glue even if it was you know just normal kind of water-based glue to if

you had to bring a screwdriver and we just had to park it completely.' (Sean, Clinical Manager, Dundrum)

For ward custodians, innovations appear to be looked upon with suspicion and with elevated concerns about risk. Those in the sample who have driven innovations have had to develop a thick skin in order to deal with these challenges:

'There's always this thing that they are jealous. Not even are jealous but things you set up are going to be taken from you' (Bert, Clinical Manager, Dundrum).

Irrespective of the levels of security, the staff are constrained by rules just as much as the patients, creating a psychological barrier.

When an incident does occur despite the rules to keep everyone safe, there is a tendency for relationally oriented staff to take personal responsibility and to delve deeply into their practice:

'Because your instincts when you've been assaulted is what did I do wrong.'
(FG/Pat Staff Nurse Medium 1).

That is, to doubt the skills and capabilities they felt they had before the assault. It may also suggest an immediate disconnection of the automatic system 1 thinking (Tversky & Kahneman, 2015), described as the risk of '*habituation*' (Jacob & Holmes, 2011) that increased the risk of assault in experienced staff, for the more laborious thinking of system 2. There is then a risk that without effective support to understand the triggers to an assault that staff withdraw from skills that develop the intangible - relational safety - to paradoxically feel safer by focussing on tangible physical and procedural security which appears to increase the risk of assault.

On ward the experience of staff appears to be intense, with staff paying attention to a range of patient environmental and behavioural indicators:

'It's much more relaxed [off-ward] I would say. Also, on the units there's a lot of things that you have to look out for that we will secure, the kitchen is locked, dining room is locked, things are locked away. In the day room they can assess you know. When they are out there is less concerns because they are less risky' (Sean, Clinical Manager, Dundrum).

Patients on the ward use probing (testing the limits of their restrictions) and mirroring (of staff and other patients to conform) to help them determine what they need to do in order to access off ward activities and ultimately to be discharged. For example, in Medium 2 trying to find out more about the personal life of staff when there is a clear restriction on sharing that information:

'Sometimes they try to catch out by saying 'whereabouts in [local town] do you stay' and your like [area of local town], 'Oh my Aunty stays in [area of local town] whereabouts in [area of local town] are you' and that's you your scuppered and it's oh I need to go and you feel I've just like lied there.'

(Martha, Nurse, Medium 2)

These strategies will be affected by how unwell patients are and whether they are meeting the conditions particular to them that the clinical team have determined, but may not have shared to prevent manipulation, or reliance on extrinsic motivations.

These strategies are also affected by their relationship with other patients.

Being off ward is a hard-earned privilege for patients. Possibly because it is a privilege that can be taken away, there are very few off-ward incidents. The pay-off

for patients is the continuation of that privilege if they are able to maintain their behaviour, a form of operant conditioning (Rutherford, 2003).

Off ward environments offer more space, if it is within the unit's campus, or access to normality if off ward is escorted or unescorted leave:

'We've also had patients in the past that have you know met somebody in the town that they do know and said oh this is my friend you know instead of describing this is my escort or this is a member of staff from the hospital. This is my friend' (Liz, Nurse, Medium 2)

With fewer patients to look after off-ward staff can also give intensive, personalised support to patients and provide access to things like CDs: potentially a weapon that they would be denied on ward:

'Somebody might not be allowed to listen to music on the unit because they might break a CD or they've done it before, but when they are with me, they can do that because I am going to be, they're going to be totally in my remit for 40 minutes or 50 minutes or whatever' (Susan, Clinical Manager, Dundrum).

Off ward staff are still paying attention to physical and procedural security, but because any patients accessing their services are by definition stable and recovering, they can focus on developing the therapeutic and real relationship to maintain security.

For patients, off ward is a reward for managing their behaviour such that their basic interaction strategy is to maintain access through positive engagement. Unlike the ward environment where boredom is a factor in behaviour, the off ward environment affords interesting activities such as sports, woodworking, animal husbandry, or in

the case of lower security an opportunity to experience significant freedoms. It also affords a different relationship with staff where banter and physical interactions are encouraged rather than sanctioned.

The strategies that staff and patients use on, and off ward reflect the environmental and psychological affordances available in each location. On ward the staff focus is on safety, physical security and procedure with fewer opportunities to explore relational security except as indicators of potential recreational rioting. This strategy is affected by how unwell patients are and the relationships between patients.

These environmental differences in practice approaches are not simply individual adaptations but reflect collectively constructed understandings within professional teams about what is possible and appropriate in different settings. The ways in which staff make sense of these environmental constraints and opportunities - particularly the tension between security focused and relationally oriented approaches - emerged clearly through their collectively constructed narrative during focus group discussions using vignettes.

6.6 Collective Meaning-Making: Analysis of Vignette Responses

The focus group discussions using case vignettes provided insights into how staff collectively construct understanding of coproductive practice. Rather than responding to the theoretical scenarios as presented, participants consistently used the vignettes as launching points for discussing their actual experiences with patients, perhaps demonstrating how professional communities make sense of complex practice challenges through a shared narrative.

The first vignette presented a 24-year-old male with a history of violence, diagnosis of schizophrenia, and interests in football, fitness, and poker. Participants across the three focus group sites immediately connected this scenario to specific patients they had worked with, suggesting that the archetypal presentation resonated with common experiences across secure forensic settings.

'We've got someone exactly like that on the ward right now. The football thing... that's exactly how we got through to [patient name]. Same situation—wouldn't engage with anything else but mention football and suddenly you've got his attention.' (FG participant, Medium Secure 1)

This response shows that staff use shared interests as entry points for therapeutic engagement, viewing hobbies and personal interests as potential bridges across the institutional divide between care provider and patient. The immediate personalisation of the vignette suggests that staff appear to conceptualise coproduction in highly individualised terms rather than as a standardised practice.

The Irish site participants focused more heavily on the violence history, demonstrating how different institutional cultures shape the interpretation of risk:

'With someone with that history, you'd be looking at garden work maybe, but definitely not with tools initially. The football's good—that's something we could work with in the yard space, but it would need to be very structured.'
(FG participant, Dundrum)

This Dundrum quote shows that the same patient presentation generated different assessments of the potential for engagement based on their institutional risk tolerance and the available resources.

The second vignette, featuring a 34-year-old female with no living relatives and interests in walking and knitting, generated rich discussions about loneliness and the role of therapeutic relationships in addressing social isolation within institutional settings:

'She sounds like someone who's been let down by a lot of people. The knitting... we could definitely work with that. We've had good success with craft groups, especially for women who've had difficult relationships. It gives them something to focus on that's just theirs.' (FG participant, Medium Secure 2)

The focus group participants consistently interpreted this vignette through a trauma-informed lens, recognising that the absence of family relationships were likely indicators of historical trauma or relationship difficulties. The immediate focus on individual creative activities seen here appears to be a way to building self-efficacy before progressing to more challenging group-based activities.

The perception of this patient's isolation stimulated discussions about the artificial nature of institutional relationships and the challenges of creating authentic connection within professional boundaries:

'The thing is, we become like a substitute family for some of these people, but we have to be careful not to promise something we can't deliver. When they move on, we're not going to be there.' (FG participant, Medium Secure 2)

The third vignette, describing an elderly institutionalised male struggling with transfers to different institutions and physical health problems affecting his football interest, generated the most complex responses across all sites. Participants recognised this scenario as representing the most challenging aspect of secure care

- supporting individuals who have become institutionally dependent while managing the realities of ageing within secure environments.

All sites demonstrated similar concerns about *institutionalisation* (Verma et al., 2022)

- the psychological adaptation to long-term containment that can make community transition extremely challenging :

'This is the one that keeps you awake at night. You've got someone who's spent maybe twenty, thirty years in the system. The institution has become their world. How do you prepare someone like that for community living when the community has completely changed since they were last there?' (FG participant, Medium Secure 1)

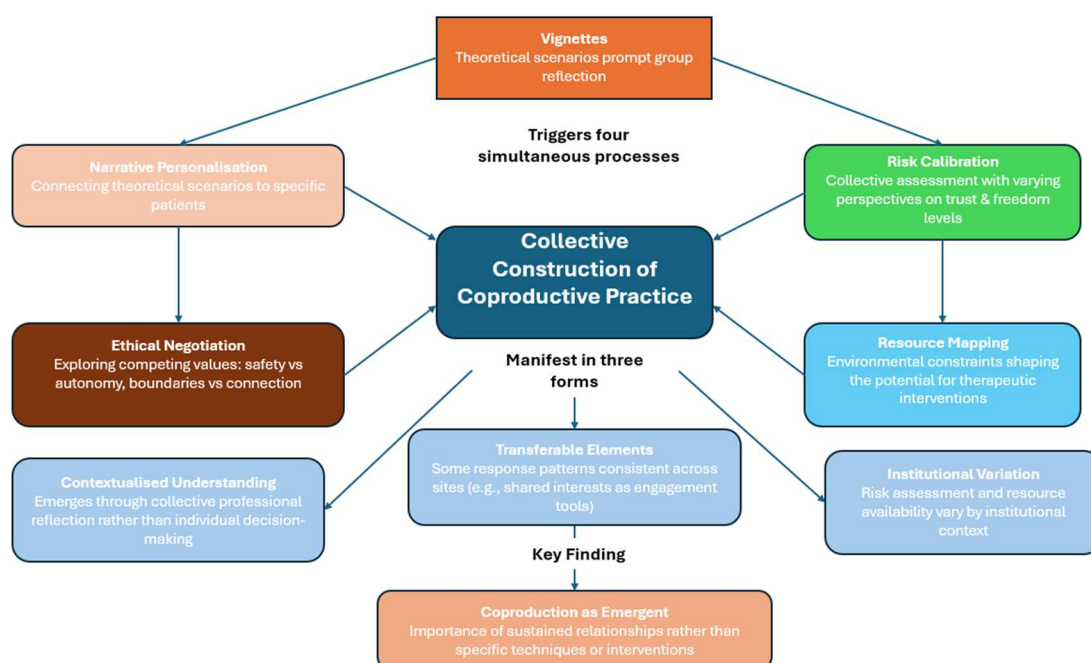
The participants struggled with the ethical implications of supporting community transition for individuals who may be more secure and comfortable within institutional settings, particularly when physical health problems limit their previous coping mechanisms.

The vignette discussions suggest several key processes through which staff collectively construct their understanding of coproductive practice. Staff immediately connected theoretical scenarios to specific patients (narrative personalisation)(Charon, 2001; Martin et al., 2025), suggesting that professional knowledge is stored and accessed through narrative examples rather than abstract principles. The groups actively engaged in collective risk assessment (risk calibration)(Connors & Large, 2023), with different participants offering varying perspectives on appropriate levels of trust and freedom. This process appeared to serve as an informal professional development opportunity, with less experienced staff learning from senior colleagues' risk interpretation. The discussions also

frequently evolved into explorations of competing professional values - safety versus autonomy, institutional security versus individual dignity, professional boundaries versus human connection (ethical negotiation)(Clay-Williams et al., 2018).

Participants also consistently discussed vignettes in terms of available institutional resources (garden space, craft facilities, community access), demonstrating how environmental constraints shape therapeutic imagination (resource mapping)(Sekhri Feachem et al., 2017).

Figure 12 From Vignettes to Understanding: Focus Group Processes in Constructing Knowledge of Coproduction



The focus groups response to the vignettes suggests that staff understanding of coproduction is highly contextualised and emerges through collective professional reflection rather than individual clinical decision-making. The immediate shift from theoretical scenarios to actual patient examples indicates that in this sample

coproductive practice is constructed through accumulated experience and shared professional narratives.

The consistency of the patterns across the sites (such as using shared interests as engagement tools) suggests that some aspects of coproductive practice may be transferable across different secure environments. However, the variations in risk assessment and available resource highlight the importance of the institutional context in shaping the possibilities for collaborative practice.

Most significantly, the vignette discussions demonstrated that staff conceptualise coproduction as an emergent property of sustained relationships rather than a specific set of techniques or interventions. This relational understanding aligns with Ostrom's emphasis on the importance of social capital and repeated interactions in successful collective action.

However, the vignette-based methodology has limitations. The immediate shift from discussing theoretical scenarios to actual cases may indicate a defensive professional response rather than authentic knowledge construction. The vignettes' brevity and archetypal nature may have prompted stereotypical rather than nuanced analysis in the group, whilst the focus group setting may have encouraged socially desirable answers that emphasise therapeutic optimism over realistic assessment of constraints.

The decision to present generic rather than institution-specific scenarios was intended to encourage broader reflection, but it may have limited the relevance of responses to actual practice contexts. These methodological limitations suggest that the findings should be interpreted as illustrations of professional discourse about coproduction.

With these limitations in mind, the emphasis on sustained individual relationships between staff and patients in this study creates a paradox within secure forensic settings. While these close therapeutic connections enable the trust and reciprocity necessary for coproduction, they can simultaneously generate tensions within professional teams. The very relationships that facilitate collaborative practice with patients may inadvertently compromise collaborative practice among staff members, as individual practitioners become invested in defending *their* patients against perceived criticism from colleagues.

6.7 Coproducing Safety and Recovery: Balancing Risk Management with Therapeutic Engagement

Inter-professional relationships are affected by relationships with patients and can lead to splitting and significant differences of opinion. That is; in creating connections to develop the therapeutic relationship, the member of staff inadvertently connects to the real relationship in such a way that they begin to see any negative analysis of the patient behaviour by other professionals as a slight upon them. This can create division between the clinical team - hence the term *splitting* (Green, 2018) - which can lead to inter-team conflict :

'One nurse's interpretation of a situation could be completely different to another and then you just go round in circles: 'well they're not like that, no they are like that, that's just his personality!' you know? It's kinda difficult and you can split the team with the care, like, 'I think he's got this and that or you could do this or no I'm really doing some good work with him, no you're too soft.'" (Matt, Staff Nurse, Medium 2).

Inter-staff relationships also appear to be based on longevity, such as the length of time an off-ward member of staff has been part of the environment, and the development of trust based on the shared experience of de-escalating a potentially violent incident. There is a sense here that all staff require to be *time served* an indeterminate time, after which they are *one of us*. This trust and understanding are not automatically transferred when a new member of staff comes on shift. This bond is a form of collective confidence, or a commons, which is protected in the same way that community resources are described by Ostrom: rules to exclude threats to the community in order to protect it (Ostrom et al., 1994). One of those potential threats is patients:

'People have been here eight or nine years eh they still like to keep it 'them and us'...' (Alice, Nursing Assistant, Medium 2)

However, the staff in the sample also recognise their professional responsibility:

"You need to be aware of your barriers. If you are building barriers, then you need to question [why]... Are you doing your job properly?" (FG/George, Nurse, Medium 2)

Respondents in this sample also recognise that staff can deliberately or unconsciously contribute to violent incidents by not providing the freedoms or responsibilities that patients believe they have earned and that signify progression. Placing additional conditions on achieving a goal that infantilises or mortifies the patient, increases the perception of procedural injustice and unfairness, the likelihood of an assault, and reduces the opportunity for coproduction (McLean & Wolfe, 2016). However, there is a balance to be struck between managing the systems that mitigate risk, which are not attuned to relational security, and managing

the impact of negative news on the patient's willingness to coproduce. This balance requires developing authentic relationships:

'We come and go with them as much as we can. There is a line they know we can't go above, and they don't push it to go above that line, whereas before they would constantly push to go above that line.' (FG Alex, Staff Nurse, Medium 1)

'I mean some of the guys that come down, they will want to use a saw that no-one else can have access to and they are well why can't they? So, you can't turn your back on them.' (FG Fergus, Clinical Manager, Dundrum)

This is the difference between being treated as a child (restricted) - or mortified (Goffman, 1961) - and as an adult (more freedoms and responsibility) (Pelto-Piri et al., 2013). The emotional reaction to being infantilised can lead to frustration or to a violent response if the tactics that a patient uses to try and make progress are frustrated by some staff (Marson & Powell, 2014; Salari & Rich, 2001). However, staff can interpret some patient behaviour as gaming the system (see Chapter 3) in order to access resources that they are not yet ready to receive (strategic accommodation, Moore 2009). This power dynamic is reinforced by the very visible manifestations of power, such as the existence of a fence and security procedures.

Relationally oriented staff circumvent those manifestations by creating points of connection with patients around an activity or an interest to create a relationship, which is incidentally protective of them and reinforces relational security. In the case below the activity is a distraction, an insight into the pre-hospital life of a patient and an opportunity for a more in-depth conversation, as previously noted:

'One day I was sitting in the day room, and I thought he's hit everybody but he's no hit me yet and I'm thinking, 'oh no!'. So, I didn't know him that well and I sat him down one day and I said look what kind of things do you like to do when you were outside. He said I liked to horses. I said I liked the horses as well, how about if we sit down when I'm in we'll look at the paper. We'll go through all the races; we'll try back winners. 3 [points] for a first, 2 for a second and 1 for a third and at the end of the week we'll add up the points and [win] a Mars bar. I never won, and he never hit me, and I thought there's more to it than them just bully stuff. there's more to it than that. And that's a lesson that I learned all these years ago when I first started at [The State Hospital] and it served me. '(Jim, Staff Nurse, The State Hospital)

While there were no similar examples presented by the staff in the Irish site Ger notes:

'...with me it's not, I'm not giving them any therapy so yes they do definitely see me very differently as part of their ward staff'

Jim sought an opportunity to see beyond the presenting behaviour, to find a mechanism which demonstrated to the patient that he was also a person with similar interests beyond the uniform and what it represented. That is, helping the patient to see him not as an object which was part of the system that was detaining him, but as a fellow human being, recognising the humanity in a patient with similar interests. In this example Jim hints at a form of reciprocation:

'I thought there's more to it than ... just bully stuff. There's more to it than that'
(Jim, Staff Nurse, The State Hospital)

That is, recognising and connecting to the humanity that Jim recognised in the patient. A simple act, following the horses, provided an opportunity to connect and was also protective. It is worth noting that this example occurred on the ward, facilitated by a member of staff who ultimately became part of the off-ward team. This is suggestive of a recurrent theme in the high secure sample, that relationally oriented staff self-select an exit from ward to off ward work. It is notable though that Jim found a way on ward to create this form of engagement where the culture and environmental limitations may have proved to be a barrier.

6.7. Conclusion

This chapter examined the development of relationships and possibilities for coproduction within secure forensic mental health settings, exploring how trust, reciprocity and collaborative approaches emerge despite significant constraints. The findings reveal that building therapeutic relationships under security restrictions requires balancing risk management with opportunities for meaningful engagement.

The vignette analysis also reinforces the key findings about the contextual and relational nature of coproduction in secure settings. Staff responses demonstrated sophisticated understanding of how to identify and build upon patient strengths and interests, while simultaneously navigating complex risk considerations and institutional constraints.

The immediate personalisation of theoretical scenarios suggests that effective coproductive practice emerges through accumulated professional experience and collective reflection rather than through standardised protocols. This finding has important implications for staff development and institutional approaches to

promoting collaborative practice. In addition, the collective meaning-making processes observed in the vignette discussions point to the importance of creating formal and informal spaces for professional reflection and peer consultation in developing coproductive practice skills.

The findings also suggest that the development of trust follows distinct patterns across different security levels and environments. In high security, particularly on wards, trust is carefully controlled and conditional, with staff vigilant about potential manipulation. The behavioural gateway serves both as an incentive and a frustration for patients on the ward: an incentive in that they can see others gaining access to valued off ward resources, and a frustration in that the mechanisms to access the gateway are not made explicit to patients. In off-ward settings and lower security environments, trust and access to activities through the gateway develop more fluidly, facilitated by normalised activities and a reduced emphasis on visible security measures.

Reciprocity also manifests in various ways, from patients protecting staff during incidents to mutual engagement in shared activities. *Garden privilege* in the Irish site and similar affordances in other settings allow for more authentic interactions between staff and patients where hierarchical roles are temporarily suspended. Both humour and *banter* emerge as important mechanisms for testing boundaries safely and acknowledging shared humanity beyond institutional roles.

Staff empathy also appears as a finite resource that can be depleted through exposure to risk, violence, and the emotional impact of working with patients who have committed serious offences. While empathy is crucial for therapeutic engagement, staff described the challenge of maintaining it in environments

dominated by security concerns, particularly when information about historical risks creates psychological barriers to connection.

Finally, the cultural distinction between on-ward and off-ward staff describes a division which suggests that there are challenges in creating integrated approaches to care specifically in high secure settings, with historical incidents (particularly in the Scottish high secure site) continuing to influence practice. That particular mythology reinforced what was apparent as a risk-averse culture that has the potential to impede innovation and therapeutic risk-taking.

Despite these challenges, several enabling factors for coproduction emerge. Off-ward environments that approximate normality, the development of authentic relationships that balance honesty with appropriate boundaries, and the creation of psychologically safe spaces all facilitated limited forms of collaborative working. The ladder of freedoms also provides a framework for understanding how opportunities for coproduction increase as patients progress through security levels.

Of note is the importance of inter-professional relationships which significantly impact the potential for coproduction, with the potential for splitting and perceptions of poor boundary management presenting ongoing challenges. The professional navigation between consistency and personalisation requires key skills, particularly when delivering difficult news or managing setbacks in a patient's progress.

Contrary to the suggestion by Pilgrim (2018) that coproduction is not possible in secure settings, the evidence from this study demonstrates that meaningful forms of collaboration that build towards and result in coproduction do exist (see chapter 2), particularly as patients progress through security levels. While constrained by necessary risk management frameworks, spaces for reciprocity, conditional trust,

and shared responsibility emerge that allow patients to participate more fully in maintaining peace and security and in their recovery journey.

These findings suggest that coproduction in secure settings must be understood differently from community contexts, recognising the legitimate limitations imposed by risk management while identifying spaces where collaboration and then coproduction through repeated exposure between patients and staff can safely flourish. The progression from highly controlled environments towards increasing freedoms represents a desirable pathway through which approaches to coproduction can gradually develop, supported by staff skilled in balancing security requirements with therapeutic engagement.

In both findings' chapters, I have presented the evidence from high and medium/low secure forensic interviews and focus groups. It describes a material difference between the experience of being a member of staff on ward and the opportunities for relational work with patients off ward. The former relies on the objective data that procedural and physical security provides to manage the environment. The latter relies much more on subjective judgement and qualitative data gathered from the formation and maintenance of relationships.

The findings chapters highlight the environmental constraints that are common across the sample, particularly the influence of admissions in all of the sites or of court referrals in medium security. These influences determine the affordances that are present in each site for coproduction and the opportunities for relationally closer work with patients. It also highlights that relationally closer staff were most likely to select out for off ward positions in higher security and to volunteer to provide escorts for leaves in medium security.

These chapters also explored the importance of the behavioural gateway in providing access to environments with more affordances for co-production of both peace and security and mental health recovery. The study participants seem to be suggesting that coproduction on ward in high security is often too challenging to establish and that the priority to maintain the commons of peace and security through physical and procedural security alone makes on ward coproduction difficult, but not impossible.

The medium secure data also suggests that banter is an important part of the development of affordances for coproduction where the interchange and safe testing of boundaries develop a commons from which relationships can be safely developed. Those relationships appear to require space for professional and personal reflection in order to ensure that they remain within safe and secure boundaries.

The chapters also highlight that the sites were all in some form of transition, either physically or culturally, which has meant that there were descriptions of resistance by staff in the form of malicious custodian behaviour and gunslinging. The transitioning services increasingly referred to that behaviour as being unacceptable whilst making the distinction between their priority to enforce the rules and the off-ward staff who provide the fun activities for patients.

It does appear that coproduction exists by degrees as a natural part of the progression of patients from admission, where trust, reciprocity and power are withheld, through to the behaviour gateway where these factors are more readily available. There appear to be more opportunities to develop reciprocation in the medium/low secure facilities where the proximity to release is an incentive to comply

with the rules and the risks of losing an opportunity for liberty are higher. There is therefore an interaction between the affordances for relationship-based practice and compliance to behavioural norms set by the forensic system. The implication for coproduction is that, even in those constrained conditions, partial forms can and do exist and can be drawn upon to develop a patient's recovery and rehabilitation.

Chapter 7. Discussion

7.1 Chapter overview

The aim of this study is to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction. The study used semi structured interviews and vignette guided focus groups in secure forensic mental health facilities in Scotland and Ireland to explore how the concept was understood and elicited practical examples from off ward staff in the highest levels of security and staff who performed off and on ward roles in lower levels of security. While there were comparators for the low and medium sites in Scotland, the Irish site was chosen to provide a practical high security comparator to Scotland's only high secure facility.

In order to meet the aim of the study it asks three research questions which explore staff understandings of coproductive processes and the practical bounds of its application in secure settings:

- 1. How is coproduction conceptualised by staff in high, medium, and lower secure forensic mental health care facilities in Scotland and the Republic of Ireland?*
- 2. What are the enablers and constraints for coproduction in these circumstances?*
- 3. What does coproduction in secure settings add to the classical definitions of coproduction?*

There were several key findings of significance: that there are two key stereotypical staff behaviours - the custodian and the relationally close; that there is evidence of individual coproduction (Bovaird & Loeffler, 2012; Bovaird et al., 2016) even in the highest levels of security; and that there is evidence of reciprocity analogous to an expression of citizenship as described by Rowe (2015) and MacIntyre et al. (2022) across all of the sites. This chapter will explore the implications of these findings.

The chapter begins by setting out the insights and gaps in research to date. It then addresses how the analysis of the data responds to the research questions. The chapter then explores the theoretical contributions to the practice of coproduction within these restrictions and the contribution the chosen method adds to the study of coproduction in medium and high levels of security in mental health care. The final sections explore implications for policy and practice to support coproduction in secure care. The chapter concludes with recommendations for future research.

The literature review in Chapter 2 highlighted the evidence for coproduction benefits in community mental health settings, demonstrating improved outcomes, enhanced service user satisfaction, and more effective use of resources (Batalden et al., 2016; Realpe & Wallace, 2010). However, a significant gap exists regarding coproduction's application to forensic secure conditions, whether it can exist across increasing levels of security, and its potential contribution to maintaining peace and security.

Knowledge about coproduction in secure forensic mental health settings remains limited and contested. Pilgrim (2018) argued that genuine coproduction is impossible in coercive environments due to constrained citizenship rights, inherent power imbalances and security constraints, while others have suggested that collaborative

and coproductive approaches might be adapted for secure contexts (McKeown, Jones, Wright, et al., 2016; Simpson & Penney, 2011). The forensic mental health literature has traditionally focused on risk management, therapeutic interventions, and staff safety rather than collaborative practice (Bowers, 2011; Dickens et al., 2013). While some research demonstrates the importance of therapeutic relationships for patient outcomes in secure settings (Bressington et al., 2011; Gunasekara et al., 2017; Gunasekara et al., 2014), there is insufficient understanding of how these relationships might incorporate elements of coproduction or enable meaningful collaboration within security constraints.

Related research from prison contexts suggests more promising possibilities. Weaver's (2013, 2019, 2022) work demonstrates that coproductive initiatives and practice can positively impact individuals' identities, perceptions of citizenship, behaviour and institutional cultures under closed conditions. However, there is very little research in secure mental health services that similarly addresses desistance (Göbbels et al., 2016), with existing research focusing primarily on psychiatric condition-influenced behaviours that led to the offence rather than broader rehabilitative processes (Day & Halsey, 2022).

Critical gaps therefore exist in several areas: empirical research examining coproduction specifically within secure forensic mental health contexts; understanding of how environmental factors across different security levels enable or inhibit collaborative practice; staff perspectives on the possibilities and limitations of coproductive approaches; knowledge of how progression through security levels affects opportunities for collaborative engagement; and theoretical development of how coproduction might be reconceptualised for secure environments, balancing its therapeutic advantages within necessary safety measures.

This study addresses these gaps by providing empirical evidence of coproduction as it is understood by staff within secure settings, examining environmental and cultural factors that shape collaborative practice, and developing theoretical understanding of how coproduction manifests within the constraints of security, using game theory as a lens to understand the strategic decisions involved in collaborative practice.

Before examining the gaps that this study addresses, it is important to establish what existing research tells us about coproduction in mental health contexts and what lessons might be transferable to secure settings.

7.2 Coproduction Research: Insights and Gaps for Secure Forensic Settings

This literature review reveals coproduction as a complex and contested concept rooted in Michael Polanyi's theory of polycentricity and Elinor Ostrom's groundbreaking work on common pool resources (Ostrom, 1990; Polanyi, 2013). Ostrom's research established that successful coproduction depends on three relational elements: reciprocity, autonomy, and trust - what this study terms *Ostrom's triptych* (Ostrom et al., 2012). These components form the essential foundation for effective collaboration between *regular producers* (professionals) and *consumer producers* (service users) as conceptualised by Parks et al. (1981).

However, the literature reveals significant definitional challenges that permeate the field. As Brandsen and Honingh (2016:428) note, '*the research community studying coproduction has become more multidisciplinary over time, which has made the original formulations less suitable and, on some points, less clear.*' This has led to coproduction being described as a *magical concept* (Pollitt & Hupe, 2011) that holds multiple context-dependent meanings simultaneously, making it vulnerable to

becoming a meaningless buzzword applied to any form of public engagement. The definitional ambiguity creates risks where seemingly progressive approaches become what McKeown describes as '*a legitimating smokescreen for more unpalatable coercive practices*' (McKeown et al., 2019:8).

The review exposes fundamental tensions between coproduction's empowering rhetoric and its practical implementation by examining power dynamics. Empirical research by Alford (2016) reveals how shared responsibility in coproduction can systematically disadvantage vulnerable citizens through internalised blame for system failures. This creates what the literature identifies as a '*darker potential*' where coproduction becomes a mechanism for transferring responsibility for institutional failures to service users while maintaining existing power structures. Longitudinal research by Innes et al. (2019) tracking participants over five years challenges optimistic assumptions about empowerment, revealing how coproduction rhetoric often masks persistent institutional control. Similarly, research across European contexts demonstrates that public servants often bound coproduction within manageable parameters, prioritising operational stability over transformation (Radzik-Maruszak & Bátorová, 2015).

Contrary to assumptions about material incentives driving participation, research examining what motivates people to engage in coproduction reveals more complex dynamics. Vanleene et al. (2017) in their study of deprived neighbourhoods found that *solidary* with others in similar socio-economic positions and moral/ethical reasons were greater predictors of involvement than material rewards. This finding is supported by evolutionary biology research on reciprocal altruism (Trivers, 1971; Axelrod & Hamilton, 1981), suggesting that ongoing interactions naturally foster collaborative behaviour through reciprocity accounting mechanisms, while single-

encounter interactions, one-shot games in game theory, typically result in mutual defection.

The literature also reveals complex role identities in coproduction that challenge simple categorisations. Ewert's (2016) comparative analysis across European welfare systems demonstrates how participants navigate multiple, often contradictory role identities simultaneously rather than occupying single, stable positions. This dynamic character of role identity underscores the fluid, contextually variable nature of authentic coproductive processes. Research by Mayer and McKenzie (2017) on experts by experience shows how individuals develop multiple identities that remained dynamic and in flux as they transition from service recipients to service providers, though this transformation can also create new limitations by potentially fixing individuals within their expert by experience identity (Scior et al., 2020).

Within health contexts, coproduction has been positioned as transformative, moving from traditional provider-recipient dynamics to genuine partnership working.

However, significant barriers persist, including the dominance of deficit-based approaches that focus on improving health literacy among patients rather than making health systems more organisationally health literate (Farmanova et al., 2018; Annarumma & Palumbo, 2016). As Annarumma and Palumbo conclude, health systems consistently dismiss citizens who use social supports to effectively manage existing conditions, reinforcing practitioner-led models that cannot adapt to local support networks.

The relationship between austerity and coproduction suggests additional complexities. Following the 2008 fiscal crisis, coproduction in the UK became increasingly positioned as a solution to constrained resources, creating what

Kleinhans (2017) describes as decentralised super austerity where risk is devolved without adequate financial support. This reflects broader tensions between active citizenship and organisational efficiency that characterise contemporary debates about welfare systems, with coproduction being mobilised by both political left and right perspectives to argue for either smaller government or greater citizen empowerment. The citizenship model developed by Rowe et al. (2012) offers a further framework for understanding mental health coproduction as the exercise of citizenship through the '5 Rs' (rights, responsibilities, roles, resources, and relationships).

The literature review identifies several gaps, particularly in understanding how coproduction functions within secure forensic mental health environments. Despite extensive coproduction research in community contexts, there is minimal investigation of how these principles apply within settings where choice is constrained and risk management paramount. Building on the foundational work of McKeown et al. (2016, 2023), who have already demonstrated that meaningful coproduction is possible in secure settings through collaborative approaches to audit and the development of practical implementation frameworks like the SeQuIn tool, this study seeks to advance understanding through a game theory framework. McKeown's research established that collaborative and coproductive approaches could be adapted for secure contexts when supported by appropriate organisational structures and committed staff, challenging assumptions about the impossibility of power-sharing in coercive environments. However, while McKeown's work focused primarily on co-design and collaborative audit, there remains a gap in understanding how these coproductive processes operate across different security levels and how staff conceptualise the mechanisms that enable or constrain such approaches. The

current study builds upon McKeown's demonstrated feasibility of coproduction in secure settings by exploring the strategic and relational dimensions of these interactions through a game theory lens, thereby extending rather than establishing the potential for coproductive practice in forensic mental health care.

A critical gap exists in understanding how coproduction may function within environments where staff hold significant discretionary power similar to prison officers, including the authority to use control and restraint techniques (The State Hospitals NHS Board, 2014). While trust, reciprocity, and autonomy are posited as essential for coproduction, there is no research examining how these elements might be meaningfully established in contexts where security constrains individual freedom and choice. This represents a fundamental challenge to Ostrom's framework when applied to secure institutional settings.

The literature also lacks an exploration of how professionals in secure settings navigate the tension between security constraints and the power-sharing imperative inherent in coproduction. This represents a critical gap given the unique professional challenges in these environments, where concerns about boundary violations including transference, grooming, and splitting can create an understandable reticence among practitioners about embracing fully coproductive approaches (Chester et al., 2017). Aiyegbusi and Clarke-Moore (2009) document relationship risks but provides limited insight into how collaborative relationships and coproduction might be safely developed within these constraints.

There is also a limited understanding of how coproduction might influence both literal and figurative *escape attempts* in secure settings (Cohen & Taylor, 2003), and how relationships might be structured to channel these impulses constructively rather

than suppress them through increased control. Without safely managed relationships and connections, the literature suggests that secure environments risk encouraging the very escape attempts they seek to prevent, making the development of coproduction frameworks specifically adapted for secure settings both theoretically and practically important.

The absence of research examining staff conceptualisations of coproduction in secure environments represents another significant gap. A limited number of studies explore how professionals understand and implement coproductive approaches within challenging institutional contexts, despite evidence that frontline staff adaptation of formal rules - what Argyris and Ostrom term *rules in use* (Argyris, 1982; Ostrom et al., 2012) - critically shapes the outcome of service delivery.

These gaps highlight the need for research that can bridge the divide between coproduction's democratic aspirations and the realities of institutional control in secure settings. As Pilgrim (2018) argues, fundamental questions remain about whether authentic coproduction is even possible within environments characterised by compulsion, while McKeown et al. (2023) demonstrate that meaningful collaboration can occur when carefully structured within the bounds of security. The evidence suggests that understanding how rules-based environments in secure forensic mental health care affect forms of coproduction, and how staff across different security levels conceptualise and apply coproductive approaches within these challenging contexts, represents a key area for theoretical development and practical implementation of coproduction in mental health care.

This study directly responds to these identified gaps by providing a comprehensive examination of how staff across different security levels in forensic mental health

settings conceptualise and operationalise coproduction within the constraints of institutional control.

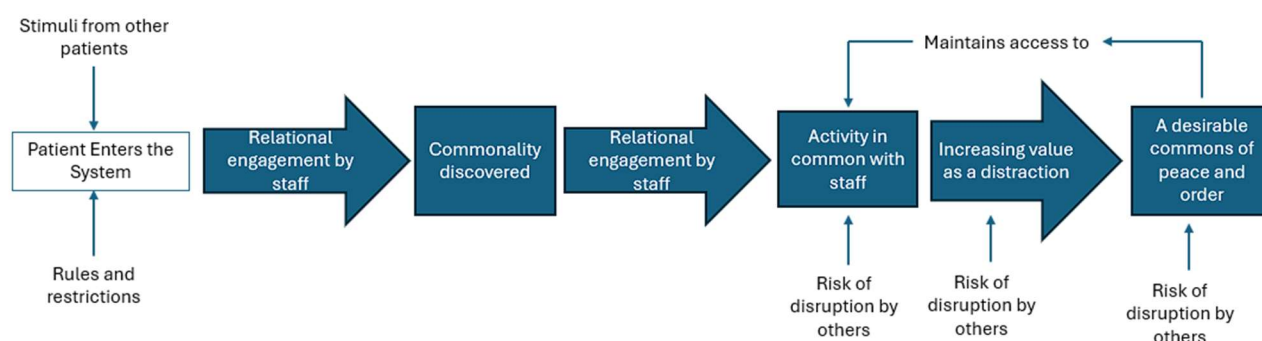
7.3 Summary of the key contribution to knowledge

A study's original contribution to knowledge is described by Baptista et al. (2015) as combining creativity and innovation '*which is not just novel but also meaningful*' (Baptista 2015:55). To this end this study analyses the unique application and understanding of coproduction in secure mental health settings in order to document the mechanisms that apply to staff and patient interactions that create the peace and security necessary to develop therapeutic relationships. In so doing, it was possible to differentiate between the attitudes and behaviours, related to roles, responsibilities, culture and environment of the procedurally dominant custodian position (5.5.2) and the relationally close position (5.5.1), ostensibly conditioned by their location, task and experience of threat or violence. The study presents a unique perspective of rules enforcers and caregivers in an environment that to date has been broadly elided by the coproduction literature, despite the significance given to coproduction and participation in health and mental health contexts (McKeown et al., 2023; McKeown, Jones, Wright, et al., 2016; Pilgrim, 2018). In particular, the ways that relationally oriented staff can create opportunities for coproduction and the maintenance of peace and security within particular spaces, and support the exercise of limited citizenship by patients (MacIntyre et al., 2022; Rowe, 2015), within the constraints of security. That is, the way that relationally oriented staff use spaces, skills and techniques to create opportunities for episodes of *normal* relationships. In those relationships the member of staff and the patient can experience one another as human beings sharing a common experience (Gelso &

Kline, 2019). That experience promotes the development of trust and a limited sharing of power and autonomy (Ostrom, 2005) that, in turn, encourages reciprocity in the creation of the commons of peace and security (Trivers, 1971), Ostrom's triptych, which makes coproduction more likely to occur (Ostrom & Walker, 2003). This commons, when created, forms a stable foundation from which to develop more coproductive relationships, which supports both peace and security, the real and therapeutic relationships, and the patient's recovery.

To illustrate this theoretically, consider the experience of entering a ward as a patient for the first time, experiencing symptoms of significant mental ill health and carrying a memory of the crimes committed when unwell. The ward will also house patients with similar conditions, some of whom will have been there for a while and are used to the conditions, and others who are still acclimatising. The patient is presented with a lot of new information and stimuli in a short period of time. Medications and their condition may make processing of that information difficult. Within that environment a relationally close nurse takes time to find a passion or an activity that they have in common with that patient, a foundation upon which to build a relationship (Couch, 1999; Megele, 2025). If the patient responds, what they have in common forms the basis for their banter, normalising the relationship (Marshall & Adams, 2018; Schafer & Peternelj-Taylor, 2003) and providing a constant in the ever-changing relational environment on the ward. Maintaining that relationship relies on the interdependent commons of peace and security between the worker, the patient and the rest of the ward community, which in turn is a requisite for achieving and maintaining access to a desirable activity. This sequence is illustrated below:

Figure 13 Influences on the creation of a commons



This study, then, recentres attention in coproduction to the process and the developing relationships as the primary output, irrespective of the outcomes (see Tritter and McCallum, 2.4.3 and 2.7). This is a key finding showing that there is value in supporting staff to gain and maintain dynamic relational skills that can both support coproduction and respond appropriately to patients. In this conceptualisation of coproduction in secure conditions, the relational dynamic between the patient and the member of staff is key to the coproduction of peace and security which in turn influences patient compliance.

Game theory (Dixit & Nalebuff, 2008; Von Neumann & Morgenstern, 1947) in this study illuminates the process of decision making between staff and patients in the creation of those normalising commonalities with staff, and the coproduction of peace and security. It provides the tools to understand and explain the motivations, incentives and strategic judgements that are being made by both patients and secure care staff when they choose whether to participate in coproductive exchanges. This lens can therefore shine a light on the decision making that supports or undermines coproductive processes. However, game theory's reliance on rational choice, in relation to a patient population whose rationality can be impaired (Janes et al., 2023) and in the context of a sample that only applied to staff,

on face value, appears to place a theoretical limitation on a pure application to the circumstances being described in the data.

However, we can discount that limitation because game theory describes a non-existent perfect world of perfect decision makers and, as described in 3.1., rational choice simplifies complex human decision making that is rarely rational in a scientific sense, in order to predict future behaviour. As Tversky and Kahneman demonstrate in prospect theory (Tversky, 1984; Tversky & Kahneman, 1974), behaviour in the general population is commonly complex and predictably non-rational. Similarly, forensic psychiatry patients are paradoxically, notwithstanding their rational strategies in an environment that they have little information, also predictably non-rational because of their condition, which is ordinarily managed by forensic care systems through risk assessments and routines that control that unpredictability, limiting movement and managing their interaction with others. A risk assessment anticipates patient behaviour in certain conditions and will determine at which point some of those limitations are lifted, reflecting the degree of predictability of that patient's behaviour. At the time of this study how that risk assessment was determined was not shared with the patient. In essence there are rules to obey to achieve freedoms that are understood by staff but hidden, unclear or not understood by patients. Commonly this leads to rules testing by patients to determine where the limits lie. This is overtly described by nursing staff as patients gaming, described by Bogg (1994) as acts which '*can be considered as moves in a series of games of varying lengths*' (Bogg 1994: 357), which may include recreational rioting (Tomlin et al., 2020) or manipulation (Green, 2018). Game theory can help us to understand patient motivations: to be under less scrutiny and to have more freedoms for example, and the psychological incentives that can encourage mental health

recovery. It can equally help us to understand the motivations of custodian staff; to be safe, to be connected to the team and to keep the public safe; and the relationally close: to be safe, to understand the patient, and to keep the public safe.

This novel application provides insight into the decision-making processes that can support coproduction in restrictive circumstances. For instance, a combination of the patient's positioning in a rules-based environment that is unknown to them and staff's competing roles as carer and enforcer serve to amplify the anchoring and availability biases in decision making - systematic errors in judgement identified by Tversky and Kahneman - which may in turn affect the relationships that are central to the creation of coproduction. That is, staff's prior knowledge of historical behaviour may influence how likely they view its recurrence (anchoring) or may lead them to prioritise preparation for irregular behaviour (availability bias) (Tversky and Kahneman, 1974). For example, a history of violence presented as a risk in medical notes, or a risk assessment, is a behavioural anchor against which staff judge patients. What is *anchored* is the perception that violence is likely from that patient, even if the last occurrence was a considerable time ago. This is similar to what Hudson (2003) describes as perceiving risks to be personal and likely when the reality is they are global and less likely. Availability bias would have a similar influence if the member of staff had recently been assaulted, increasing their sensitivity to possible threats, more graphic and personal but still similar to elevated anxiety about flying after news coverage about a plane crash. However, in secure conditions, particularly on high secure wards, the disconnection and alienation that Hudson (2003) describes in general society increases the tendency to eliminate risk rather than its management, which comes at the expense of connection and relationships, which are perceived to be inherently risky.

Despite these systematic errors (Tversky & Kahneman, 1979), it appears that the supports for and opportunities to coproduce peace and security on the ward in the highest level of security is limited comparative to lower levels of security, but it is possible. This study shows that despite the limitations of security and restricted liberty, which for Pilgrim (2018) and Carr (2015) are insurmountable barriers, there is evidence of individual and collective coproduction which increases as the security gradient decreases.

However, it is also apparent that the concept of coproduction was not common knowledge for those who took part in the study. This is understandable as the key components of mental health recovery – connection, hope, identity, meaning and empowerment (Leamy et al., 2011) – overlap with Ostrom's central triptych (trust, reciprocity and autonomy (Ostrom et al., 2012) and also with the Scottish model of citizenship : 'building relationships', 'autonomy and acceptance', 'access to services and supports', 'shared values and social roles' and 'civic rights and responsibilities' (MacIntyre et al., 2022) .

Table 15 Commonalities: Ostrom, Macintyre, Leamy

INTEGRATED THEME	CHIME (Leamy 2011)	OSTROM (Ostrom 2012)	SCOTTISH MODEL (MacIntyre 2022)
RELATIONAL FOUNDATION ★★★	Connection	Trust	Building relationships
Self-determination & agency ★★★	Empowerment	Autonomy	Autonomy & acceptance
Reciprocity & exchange ★★	—	Reciprocity	Civic rights & responsibilities
Future orientation ★	Hope	—	—
Identity & belonging ★	Identity	—	Shared values & social roles
Meaning & purpose ★	Meaning	—	—
Resources & access ★	—	—	Access to services & supports

★★★ = Strong alignment across all 3 frameworks | ★★ = Alignment across 2 frameworks | ★ = Framework-specific

However, despite their commonalities these concepts are distinct and are not currently understood to be interchangeable.

Coproduction has also been presented more recently as a key process that creates dialogue between professionals and patients in mental health recovery (Norton, 2024; Norton, 2021), although the retention of significant power in health settings more generally has been presented as a barrier to achieving both by lived experience researchers (Rose & Kalathil, 2019). While the literature review

highlighted Ostrom's triptych as necessary components for coproduction, in secure forensic settings sharing power alongside compulsion becomes particularly challenging. As McKeown (2013, 2023) argues, meaningful coproduction in secure conditions requires a fundamental democratisation of care and organisational structures to address the inherent tension between cooperation and coercion.

However, the conceptual overlap and confusion set out in table 15 also reflects the definitional challenges for coproduction and its application in health settings more broadly, explored in 2.4.3. That is, that coproduction is confused for therapy - the lowest rungs of the Arnstein (1969) ladder - where a professional reluctance to share power risks what Osborne describes as *value co-destruction* (Osborne et al., 2016). It also risks masking the meaningful adjustments and accommodations that are made by both staff and patients to coproduce peace and security because they are not recognised as being part of a coproductive process.

The next sections will address these issues by first describing the aim of the study and outlining how this study has addressed the research questions.

7.4 Aim of the Study

The aim of the study was to understand how rules-based environments in secure forensic mental health care affect forms of coproduction and how staff working across the different levels of security conceptualise the process that they understand to be coproduction. Chapter 2 identified a significant gap in existing knowledge: how coproduction can be applied alongside constraints that are commonly applied to patients being treated for forensic mental health conditions, and if it can, how that is manifest. Pilgrim (2018) in particular concludes that coproduction is not possible in

secure conditions. He compared the purposes of coproduction envisaged in the Care Act 2014 (NHS England, 2015):

'When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered' (The Care Act 2014 guidance: 2.14);

against the security restrictions common across secure care and determined that restrictions to liberty, and therefore of citizenship, as a consequence of detention mean that coproduction as defined in the Care Act (2014) was not possible in secure conditions, and that *'involvement and empowerment took place outside the secure setting'* (Carr 2015:3, cited by Pilgrim). That conclusion, however, is premised on a particular conception of coproduction as the co-design, delivery and development of services as outputs, rather than the process of human interactions that contribute to the coproduction of outcomes such as peace and security, and thus the relational space and environment identified in this study (NHS England Always Events, 2024; NHS England, 2015).

Tritter and McCallum explore this phenomena in their 2006 critique of Arnstein's *Ladder of Participation*, and the process of public participation in health care where they suggest that:

'User engagement and empowerment are complex phenomena through which individuals formulate meanings and actions that reflect their desired degree of participation in individual and societal decision-making processes' (Tritter and McCallum 2006:157).

This suggests that, for many, the process matters more than the output of coproduction. That is, in the context of secure care both Pilgrim and Carr's focus on

physical freedoms as a key tool in coproduction, obfuscates the complex human interactions that contribute, ultimately, to the literal liberation of the patient from some constraints on their freedom when they are well. The reality described by respondents in this study is of an iterative process of patients being incentivised to make conscious decisions to be accommodative to the rules and environment to access a desirable resource, supported by a developing therapeutic and real reciprocal relationship with staff that builds conditional trust. And once that access is achieved, maintaining access by coproducing the commons of peace and security with staff and other patients through self-regulation and the contingent regulation of others. In this *game* the initial accommodations as compliance are particular to the patient who is incentivised to seek opportunities to demonstrate their fit for the desirable resource, which is an opportunity for a positive relational contribution to peace and security for both patient and staff, or negative manipulation as determined by the risk perception of the ward staff. Once the resource is accessed the accommodations are complicated with and by communal regulation to maintain peace and access to a resource that can be removed. This is a positive incentive for organisational citizenship behaviour (OCB) to help others regulate their emotions and behaviour. Game theory therefore gives us the tools to understand the instrumental incentives in coproducing peace and security.

McKeown et al (2016, 2023) in contrast to Pilgrim used forms of coproduction to co-design a collaborative audit with forensic patients on the involvement and engagement strategies which promote mental health recovery, which incidentally improve and develop relationships and forms of organisational citizenship behaviour (OCB) between staff and patients (Ndoja & Malekar, 2020) . While McKeown's studies introduced coproduction as a collaborative mechanism in secure care, the

current study identified a gap in the literature describing the conditions that would support coproduction across all three levels of security in the UK and Irish forensic mental health systems.

This study also fills a gap in the forensic mental health literature by understanding coproduction as a product of cooperation and collaboration that is enabled by relational security. That is, that instrumental rationality or strategic accommodation by patients is the basis for initial, extrinsically motivated cooperation, that leads to collaboration, but that relationally close staff are able to apply personalised, dynamic rules within the bounds of procedural and physical security to create the conditions for the intrinsic motivation that leads to coproduction. It is this which contributes to the developing conditional relationships between staff and patients which provides an opportunity to develop organisational citizenship behaviour.

Pilgrim (2018) and Carr (2015) do not appear to consider OCB as an exercise of citizenship because their definition is functional. That is, to be a citizen means that you are at liberty to make independent decisions, obey laws, exercise freedoms and societal obligations, and to have an equal status with other citizens. Citizenship behaviour for patients in this context, in contrast, is analogous to that described by Macintyre et al's citizen defined citizenship (see 2.6.1),

"building relationships', 'autonomy and acceptance', 'access to services and supports', 'shared values and social roles' and 'civic rights and responsibilities" (Macintyre et al 2022: 695).

In secure contexts this *relational citizenship behaviour*, voluntary engagement and contributions to develop relationships beyond giving and receiving care, is part of the strategic game for liberation. That is, obeying the overt physical and procedural

security rules and testing the requirements to reduce their risks and the associated risk assessment to meet the behavioural gateway that is the first step towards discharge to lower security and ultimately to liberation. It is also a means to make the experience of detention easier to endure by exercising shared responsibilities for maintaining the commons of peace and security that allows access to the desirable off ward activities that will contribute to their discharge.

7.4.1 Conditions that support coproduction in secure mental health

As noted, Pilgrim's conclusion, that coproduction is not possible in secure conditions, is reliant on the NHS England (2024) definition which states that:

'Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.' (NHS England Always Events, no page).

In this definition it is the new or improved services that are valued, in the form of tangible outputs and outcomes, rather than the development of conditional relationships which support the creation of therapeutic and *real* relationships that are essential to the maintenance of peace and security, and mental health recovery. In this regard the results from this study provide a different perspective which identifies the environmental and psychological conditions, such as being off-ward and passing a behavioural gateway, that support a more intimate and personalised form of coproduction that has the potential to foster not just extrinsically motivated compliance or cooperation, but intrinsically motivated coproduction of peace and security. The mutual benefit for staff and patients makes coproduction an important

tool for staff in difficult social spaces. However, as this study suggests, the staff experience on ward is very different from that off ward. The ward *temperature* (an idiosyncratic forensic medicine means of describing the degree of threat) (Weltens et al., 2023), *teamness* needs and new admissions change the actual and perceived risk dynamic.

As Braithwaite (2003) outlines, these positions are also influenced by idiosyncratic and personal factors beyond the professional role and the hospital environment, such as existing beliefs, attitudes to the offence that led to a patient's detention, societal and local norms in relation to the patients and the emotions associated with particular patient's actions. These influences potentially magnify *case note prejudice* which may in turn contribute to a capitulation ('*passive acquiescence to authority*': Weaver et al 2020:435) to teamness as a strategy to feel safe in a threatening environment, or forms of defiant resistance described in the results as *gunslinging*.

For patients a motivational posture of compliance - which Braithwaite describes as demonstrating either positive acceptance of authority or submission - acts as a catch-22 dilemma. That is, do staff accept compliance as commitment, or perceive it as manipulation and instrumental behaviour to access a resource? It appears from this study that low trust environments encourage the perception of the latter over the former which in turn may affect how patients experience and evaluate their treatment within the system (Hucklesby, 2009; Tyler, 2006). This perception can influence patients' willingness to engage with treatment protocols and their overall relationship with the therapeutic process. Paradoxically, instrumental behaviour also demonstrates that a patient values a resource that they wish to access, as previously described. Off ward staff, in a marginally higher trust environment, take advantage of

that commitment as an opportunity for engagement and relationships with which to forge conditional trust, peace and security.

This disparity in trust levels can be understood within what Beck (1996) and Hudson (2003) describe as the risk society – an increasing alienation and perception of risk fuelled by news cycles that present global risks as personal. Within this societal context, ward staff in the highest level of security who experience or witness forms of violence most days become understandably sensitised to violence rather than focusing on relationship-building opportunities that the team may perceive as risky (see Chapter 6). This risk-averse stance further reinforces the compliance dilemma faced by patients.

Consequently, this study reveals that secure environments afford only situated and conditional trust. Trust off ward appears higher than on ward, primarily because patients have passed through a behavioural gateway. On-ward trust emerges as temporary and conditional upon the stability of the overall patient group, staff openness to relational proximity, and those particular staff being on shift. Similarly, off-ward trust relies on positive incentives for acceptable behaviour and the negative incentive of the loss of a resource for both patients and staff. Notably, unconditional trust was not described across any sites, even for low security patients with unescorted leave. The findings clearly demonstrate that graduated forms of trust exist across the security gradient, functioning as a dependent precursor for coproduction – a reality shaped by both the immediate clinical environment and broader societal factors around risk perception.

The codesign or the joint governance by professionals and consumers of a public service provider are the outcomes of coproduction identified in the NHS England

policy as noted above. These outcomes were not apparent in any of the settings participating in this study, congruent with Pilgrim (2018). In contrast Ostrom's triptych describes processes of interaction where power, trust and reciprocity in dynamic relationships result in the coproduction of a mutually beneficial *commons* such as peace and security. However, it is argued here that this does not necessarily mean that an unconditional form of coproduction was taking place in the environments in this study. This is an important consideration in understanding coproductive relationships in secure environments. The rights that are available to many citizens, such as the freedom of association and freedom of movement, are conditional on behaviour in secure care. It is also dependent on a patient's progression through to the *behaviour gateway* as an indicator of stability, wellness and safety. These conditions are interpreted by Pilgrim and Carr (ibid) as meaning that functional citizenship does not exist. However, that does not mean that citizenship as described by Macintyre et al (ibid) cannot be exercised and that coproduction cannot occur, which is Pilgrim and Carr's position (ibid). This study in contrast suggests that exercising citizenship is conditional on the spaces in which it occurs and the comparatively small but accumulative interactions that create a particular form of safe reciprocity reliant on the experience and skill of that practitioner to keep it safe. This is a key finding and contribution of this study, that being aware of and facilitating interactions which lead to a developing relationship, is an investment in the commons of peace and security. That an alternative form of coproduction can exist in secure care is an important finding. That is, reciprocity can occur within the bounds dictated by the environment and the patient's condition without exposing the members of staff to the potential for exploitation.

As the literature review (Chapter 2) shows, the classical definition of coproduction includes observations of reciprocation between coproduction partners (Ostrom, 2003; Ostrom et al., 2012). However, reciprocity in secure conditions is more transactional and contingent than in other settings and therefore carries an inherent risk. An exchange of power and the creation of trust similarly suggests an increasing risk of exploitation of staff by patients which staff working with dynamic risk management ordinarily overcome through relational security. However, the staff who rely primarily on physical and procedural security, and custodianism, present a barrier to coproduction. It is apparent from this study that an established custodian culture, inherent instability and the risk generated by receiving direct admissions, and a lack of retiral and reflective spaces for staff, reinforce these barriers. Re-establishing an admissions ward, increasing the staff to patient ratio and cycling staff off ward may provide opportunities to overcome these barriers.

It is important to note that in this study respondents described instances of reciprocity as a speculative risk that they took to create a relationship. In those circumstances the patient and the member of staff are using information particular to their relationship to reciprocate⁹. In these instances, while patients have very little power over their daily life, they do have the power to share or retain knowledge of themselves as they see fit. This is a form of Foucault's knowledge-power (Bevir, 1999), through which Foucault tries to transform society's relationship with power from:

'...something that represses by stressing how it also can act positively to produce and to define' (Bevir 1999:349).

⁹ Such as when Jim, Staff Nurse High Secure (Scotland), describes making a connection with a violent patient through their joint interest in horse racing (p207)

The judgement patients make in sharing or not sharing that knowledge may depend on the outcome of a strategic accommodation *game* (Moore, 2009). That is, partial compliance with rules or requests for information to satisfy someone in power to achieve another objective, for example greater freedoms (see figure above), described as tactical game playing by Braithwaite (2013).

Relationally close staff appear to use that strategic accommodation tactically to form commonality around the goal of greater freedoms and conditional trust which may prove protective as the staff member is seen as a fellow human, as opposed to an agent of detention. The connection is not a compulsory part of their treatment, so it lies within a patient's power to ignore it, a conditional form of autonomy. In using this connection to form a conditional relationship, staff contribute to a personal commons of peace and security between them and increase the likelihood that the commons could be expanded. A further key finding of this study is that fostering human connections in secure care (Kelley et al., 2014; Moudatsou et al., 2020; Taylor, 2022), however small, is a necessary condition for individual coproduction and is the foundation from which Bovaird's collective coproduction can grow (Bovaird et al., 2016).

Ethical approval restricted the sampling strategy in the highest level of security which excluded staff from the ward in the high secure sites. The evidence for coproduction in those spaces relies on the secondary historical reflections and current observations from off ward staff in high security. With that limitation, and there being no firsthand accounts from high secure on ward staff, the spaces where interviewees across the sites described positive interactions for both staff and for patients appear to occur most often off ward. This is where peace and security are most stable - patients have passed through a behavioural gateway and are perceived to be *safer* -

and where conditions that support trusting relationships are most evident. This suggests that the locations where interactions take place dictate the degrees of interpersonal interaction that are possible for custodian or relationally close staff and the degrees to which care and positive outcomes for patients can be coproduced. That is, staff who wish to coproduce must dynamically adapt their approaches to the physical context and the psychological associations that coproducers hold about that space, and the people within it. These interpersonal dynamics are not exclusive to high secure conditions as the findings illustrate. There is evidence of conditions at different levels of security, including the affordances or emotional connections to spaces, which contribute to or impede the coproduction of peace and security. Galvez-Pol et al. (2021) explored the connection between emotions and spaces, when the world was in lockdown because of the COVID -19 pandemic. Their key finding was:

'...that people's emotional representations of their environment are shaped by the naturalness of places, and by their affective state and interoceptive sensibility.' (Galvez-Pol et al 2021:1).

In lockdown, the natural environment was associated with happier times without confinement. More importantly, a person's emotional memory of what occurred physically or psychologically in particular spaces triggers a connected physical reaction. For example, thinking of a space where you desire to go may create anticipation and a sense of excitement, like butterflies in the stomach. Similarly, thinking of a space where you do not want to go may stimulate a similar physical reaction that is interpreted as anxiety or anticipation of threat. Analysis by Galvez-Pol et al. (2021) suggests that understanding the psychological and interoceptive in

spaces of confinement - a physical reaction to an external stimulus - is central to maintaining relational security, and in turn by creating the conditions, in the right spaces, for coproduction. For example, on the ward multiple sources of stimulation from other patients, the monitoring of procedural and physical security for staff and the common risk of being assaulted or being involved in a restraint increases the anticipation of threat that Galvez-Pol describes, creating a space with an ever-present risk of conflict. In contrast, in off ward contexts patients have passed through the behaviour gateway, reducing the perception of threat from others for staff and patients. In those locations the risk is primarily managed dynamically through relational security (Royal College of Psychiatrists Centre for Quality Improvement, 2023) rather than procedure and physical methods, and the motivational stance of the patient is *commitment*: to be compliant to maintain access to a desirable resource (Braithwaite, 2012).

The illustrations below present these points:

Figure 14 The Influence of the psychology of space on behaviour: being on-ward

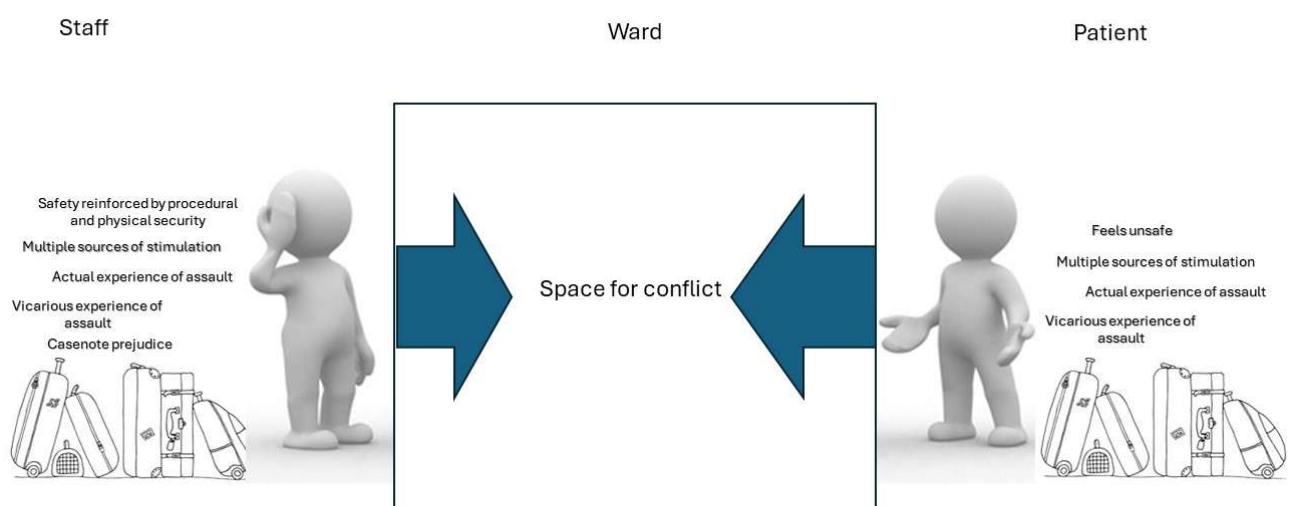
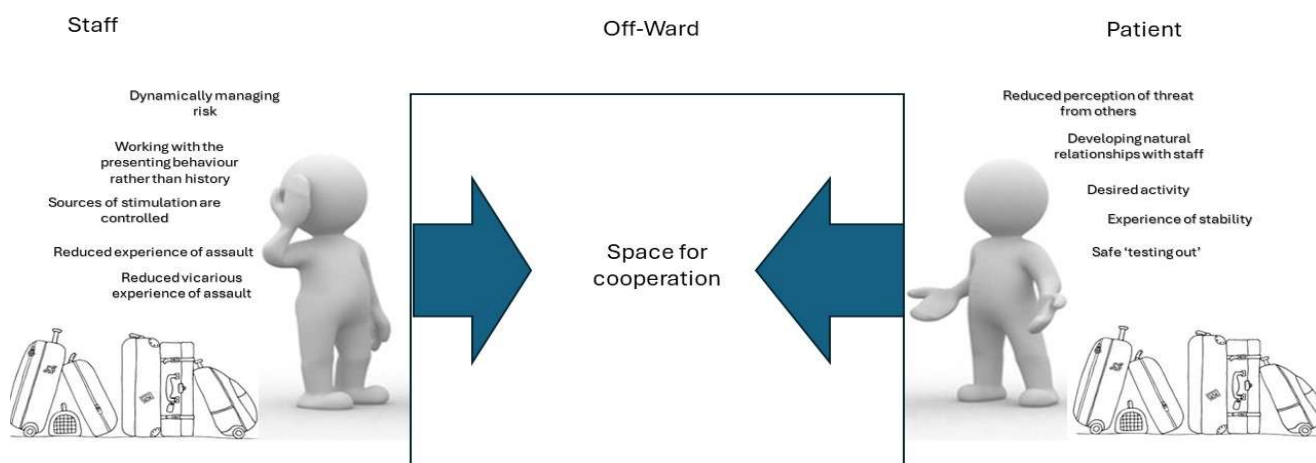


Figure 15 The Influence of the psychology of space on behaviour: being off-ward

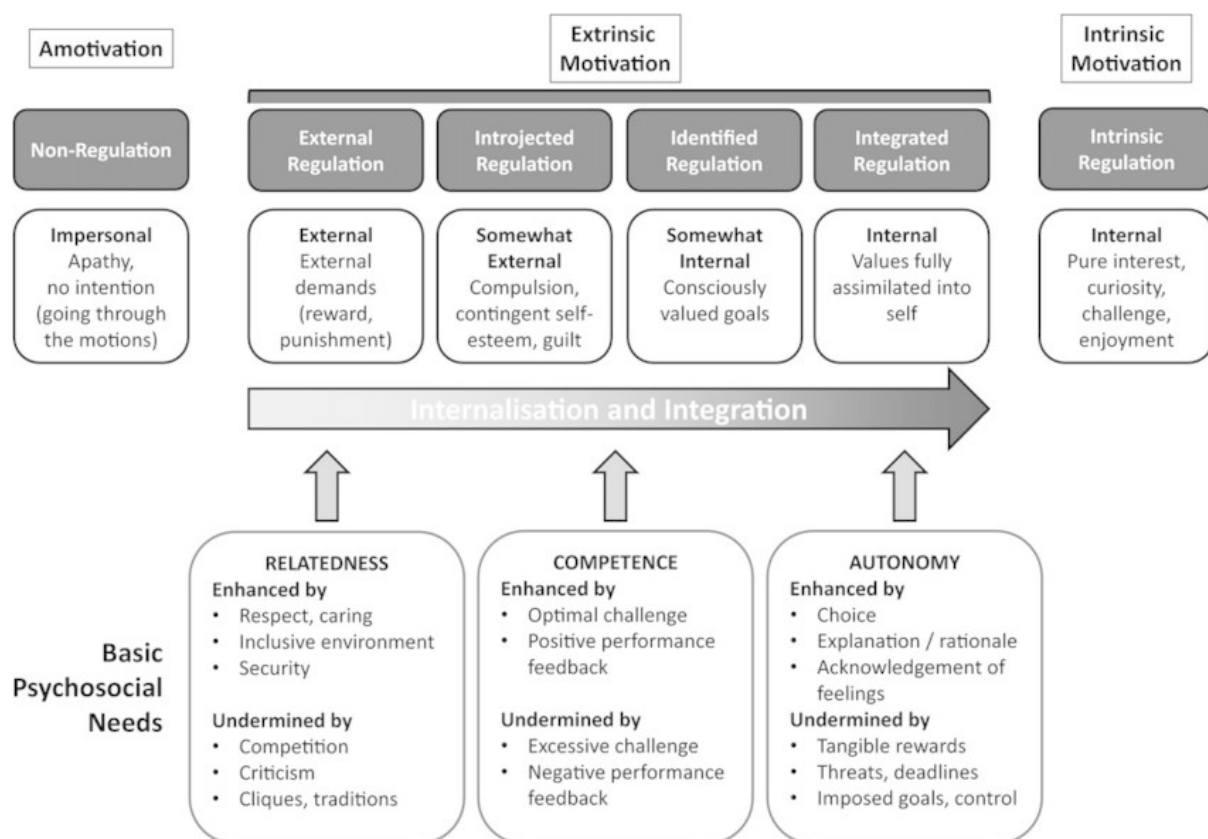


Compliance, however, remains a key feature of secure care: compliance with the rules and treatment indicates to staff that patients are recovering and is a requirement to pass through the behaviour gateway that in turn allows access to off ward. Compliance is an artefact of the environment and as such cannot be ignored. It is part of the process of compulsion inherent in secure care. The effect of coproduction is finding relational connections which make sense of the environment, and compulsion, to transform extrinsic motivations to comply to intrinsic motivations to maintain peace and access to the resource that make the compulsory nature of the environment irrelevant. Or at least less dominant.

As we have seen in the results, however, compliance is not a requirement for coproduction. For example, a patient may refuse medication with violence but have previously agreed a de-escalation procedure with staff in advance of a restraint as described in Medium 2. Nevertheless, compliance removes some barriers to the establishment of freedoms which in turn make the likelihood of violence unlikely.

There were also incentives for compliance across the sites in this study in low trust ward environments (Vanleene et al., 2017): negative extrinsic motivators. That is, institutional rules which, when broken, lead to a reduction in freedoms and privileges. Extrinsic motivations (see fig 17) (Deci et al., 1991; Ryan & Deci, 2000), for example performing tasks for a reward or to avoid a punishment, is the basis for the operant conditioning compliance model apparent in the sites studied (Skinner, 1988).

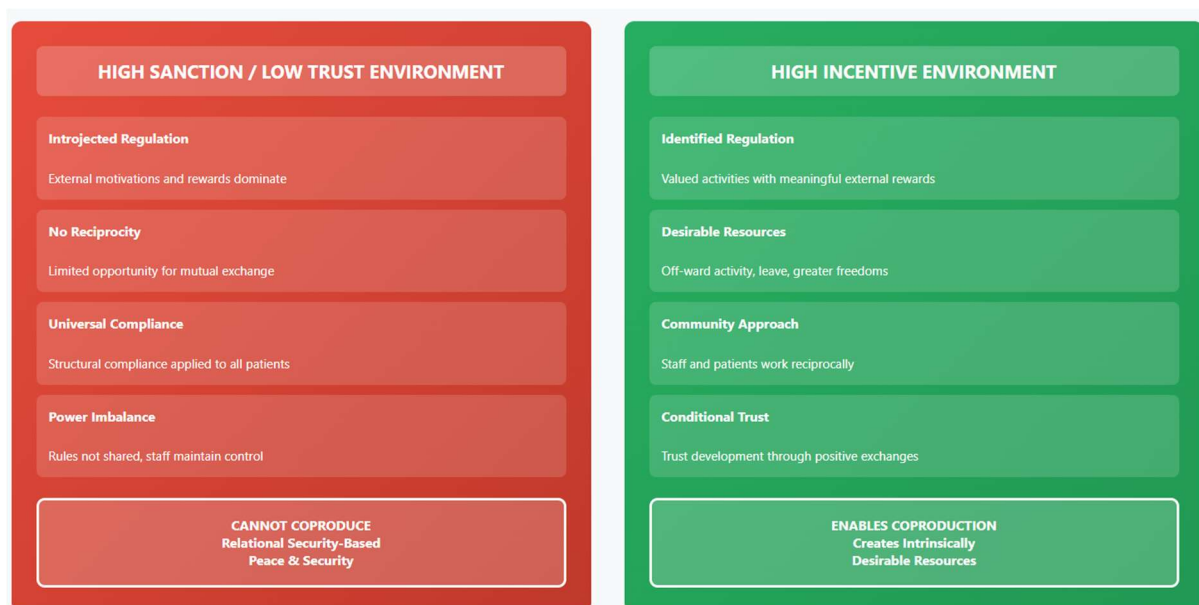
Figure 16 Self Determination Theory Deci and Ryan 2000



This is modelled reciprocally by patients. Evidence from this study, across all levels of security, suggests that some patients engage in a repeated strategic game to test the rules in the environment which results in staff adding more information, removing some restrictions, or responding with sanctions to modify behaviour: a well-tested tit-

for-tat strategy in game theory (Dacey & Pendegraft, 1988). Unlike traditional games which are time limited and include a rationale for exit, the threat of a modifying sanction, an extrinsic motivation, remains throughout a patient's experience from high to medium security, with the rules of the game in high security rarely shared with patients, maintaining the power imbalance between staff and patients (Reynolds et al., 2014). There is, then, an inherent tension in the data between extrinsically motivated and compelled structural compliance applied universally to maintain safety on a busy ward and the incentivised relational support for compliance represented by the behavioural gateway, described by Deci et al. (1991) as identified regulation. That is, a patient values a behaviour because the rewards are essential to attain the external goal of greater freedoms.

Figure 17 High Sanction/Low Trust vs High Incentive Environments



High sanction/low trust environments cannot coproduce relational security-based peace and security because regulation is introjected (external motivations and rewards) and there is no opportunity for reciprocity. However, high incentive environments, where the rewards for compliance are desirable (identified regulation:

a valued activity with external rewards), as described across the results, create an intrinsically desirable resource - off ward activity in high security or leave in lower secure settings for example - that the community of staff and patients work reciprocally, and with conditional trust, to attain and retain. That is, a transitional phase between intrinsic motivation to integrated regulation. Deci et al. (1991) describe the distinction between these two as: *'Intrinsic motivation is characterised by interest in the activity itself, whereas integrated regulation is characterised by the activity being personally important for a valued outcome'* (Deci et al 1991:330).

The exclusion of patient perspectives from this study represents a significant limitation that requires careful justification given the fundamental principle that authentic coproduction requires service user agency and involvement. This methodological decision was not taken lightly, particularly in light of McKeown's commitment to authentic service user involvement and the well-established principle that coproduction is fundamentally compromised when those most affected by services are absent from research about those services. However, several factors necessitated this approach in the current study context.

Firstly, the research focus on staff conceptualisations of coproduction was designed to understand how those wielding considerable institutional power understand and navigate the release and retention of that power within security constraints. Given that staff hold the authority to detain, medicate, and restrict patients, their conceptualisations fundamentally shape the possibilities for coproductive practice, regardless of patient willingness to engage. Secondly, significant ethical and security constraints across all participating sites prevented patient involvement, reflecting institutional risk assessments that prioritised safety over methodological comprehensiveness. While this creates an incomplete picture of coproductive

dynamics, it nonetheless provides essential insights into the institutional and cultural factors that enable or constrain collaborative practice.

This methodological limitation means that claims about coproduction in this study must be understood as staff interpretations of collaborative interactions rather than validated accounts of mutual engagement. The absence of patient voices prevents understanding whether staff-identified 'coproductive' moments are experienced as meaningful collaboration by patients or whether they represent more subtle forms of institutional control. Future research must prioritise patient perspectives to validate and challenge the staff accounts presented here, ensuring that theoretical developments in secure settings coproduction are grounded in the experiences of those most affected by these practices.

7.4.2 Environmental Conditions

The findings indicate that a lack of opportunity to disengage from the ward's intensity for staff presents a psychological and practical barrier to the planning for and the creation of activities that could contribute to coproduction. Patients in contrast could withdraw to their own personal spaces to escape. This was referred to in high security as '*early beds*' (Beth Adv S3), i.e. utilising the option to withdraw to their room and away from the ward. It is an opportunity to withdraw from sensory overload: '*secondary stimuli [that] cannot be cut out and permanently distract, irritate and disturb*' (Scheydt et al 2017:110, parentheses added).

This key finding highlights that central to supporting coproduction across all levels of security is the physical architecture and the presence of sufficient staff to create spaces to think, plan and decompress away from the sensory overload of the ward

(Scheydt et al., 2017). This is a novel finding in coproduction research in secure conditions: that to engage there also must be an option to disengage for participants.

In all of the sites studied there was a distinction between visiting staff, on-ward staff, and the availability of withdrawal spaces and therefore the intensity of interaction that the role requires. As the results show, those spaces were rarely made available for on-ward staff, and when they were, interruption to task was a regular experience. In those circumstances it is possible that availability and anchoring bias has an impact on the staff experience of threat and therefore perception of risk. However, the literature suggests that the relationship between interruption and risk perception is unclear (Kupor et al., 2018; Li et al., 2012; Nicholas & Cohen, 2016). Nevertheless, in an environment of heightened risk and demand it would be reasonable to expect coproduction with patients to be much more difficult.

As noted, over-stimulation and a lack of withdrawal spaces for both staff and patients negatively affect the opportunities for coproduction. This is most apparent in the highest level of security but is a factor across all levels of security. Mixing new and settled populations increases feelings of uncertainty which are manifested by staff in a greater focus on rules, and by patients by withdrawing where they can or contributing to recreational rioting (Jarman & O'halloran, 2001).

Conditions of uncertainty and disquiet in secure accommodation are therefore barriers to coproduction. This implies that the meaning of spaces is also a factor in coproduction. Environments where behaviour is uncertain are associated with threat for both staff and patients, provoking a controlling response from staff (Foucault, 2023). The space symbolically communicates mistrust and risk through rules and containment. Off ward environments symbolically communicate rehabilitation,

conditional trust and a sense of progression. Rehabilitative and therapeutic activities on wards by visiting staff are associated with a change in symbolic meaning in those spaces: from detention to *fun* (ibid). The desire to retain that experience incentivises reciprocity, the desire to be trusted, which is rewarded with trust and opportunities for autonomy, as reflected in *garden privilege* described in Dundrum Hospital. These are the relationships that custodian-oriented staff would see as a threat, but relationally close staff would see as an opportunity to build a different interaction.

Visiting staff, by virtue of their role, are unlikely to be involved in restraining patients, which affords them a different relationship with patients when developing coproduction. However, it is notable that psychologists in The State Hospital, who for logical therapeutic reasons had not participated in restraint, had during the period of this study started to do so, influenced by therapeutic restraint models in the Medium Secure 2 site (Field Notes 2015). As one psychologist described the change to a patient, if a restraint cannot be avoided, would it not be better that the person doing that was someone you trusted (Field Notes 2015)? This is described in the context of residential care for young people as *therapeutic containment* (Steckley, 2012). This challenges the evidence that restraint in and of itself has negative effects on the therapeutic relationship (Knowles et al., 2015; Moyles et al., 2023) and as a consequence coproduction. It rather focusses our attention on the nature of the relationship between staff and patients as a key feature of pre incident planning and post incident recovery as part of the coproduction process.

Visiting staff still hold power over the patient, but the specific power to restrain is ordinarily not apparent. For coproduction in the highest level of security this suggests that visiting staff, particularly if they are in those spaces that are associated with safety and fun, are more likely to be able to coproduce peace and security

successfully than their colleagues on-ward. However, the practice of therapeutic restraint (TMVA) described in Medium 2 (see 6.3.3) - the involvement of patients in designing de-escalation of violent incidents - suggests that forms of coproduction that were previously hidden may be possible even in unusual circumstances. Nevertheless, ward staff may find the development of protective interpersonal relationships a challenge to their interpretation of ethical working (Parker & Barrett, 2006) and the *practice wisdom* (Klein & Bloom, 1995) transmitted through *teamness* and culture (Tilden et al., 2016).

Being off ward for patients is a signifier of hard-won progress, and in lower levels of security it is a signifier of future freedoms to come. In both there are incentives to cooperate and comply to achieve freedoms. However, perceived fairness rather than enforcement has been documented as a significant factor in developing trust (Murphy, 2004). That perception of fairness by patients is affected by opaque processes and security assessments which are not ordinarily shared with patients, reflecting the power imbalance described in 6.3.1 (O'Dowd et al., 2022; Reynolds et al., 2014). This would appear to be an inherent barrier to coproduction as it is commonly understood. However, as this study shows, relationally oriented staff typically seek alternative means to develop trust through managed reciprocity. That is, finding a point of connection through shared interests or judiciously sharing something of themselves that does not expose them to risk. In lower levels of security in this study engaging patients in developing therapeutic approaches to restraint appears to make apparent the decision making and processes that staff will take when a physical intervention is necessary (see 6.3.3). This addresses the fairness test that Murphy (2004) describes - procedural justice (see 5.6.3) (Greenberg & Tyler, 1987) - and clarifies the power that the patient has to influence

the mechanisms that can lead to de-escalation. This process creates the opportunity for reciprocity, both of care and information, the establishment of trust and an expression of autonomy. In contrast to Pilgrim's assertion that coproduction is not possible in secure conditions, this finding suggests that within the bounded rationality of secure care, patients can proactively engage with staff to agree an advance directive that resolves a restraint quickly and as far as is possible, positively. They can also contribute their own knowledge power as a key participant in the exercise to achieve that outcome (Foucault & Rabinow, 1982), that will ultimately build a relationship with the care team supporting their recovery, despite the circumstances.

In lower levels of security trust is expressed with escorted and unescorted 'leaves': a palpable expression of conditional trust which, if done fairly, increases the potential for reciprocal trust in the staff member, for example by disclosing concerns about bullying that are hidden to ward staff. In fact, of all Ostrom's triptych - trust, reciprocity and autonomy (Ostrom et al., 2012) - trust appears to be the most important precursor to coproduction, and the most difficult to establish and maintain in higher levels of security. However, as the results suggest, there appear to be small instances of trust, such as patients making tea for nurses, even in those conditions, which relationally oriented staff capitalise upon to build stronger relationships.

7.4.3 The character of coproductive relationships in secure settings

The findings suggest that as trust and relationships develop, particularly in spaces that are associated with desirable activities and predictability, so too do intrinsic motivations to reciprocate (Ryan & Deci, 2000; Vanleene et al., 2017). Reciprocation is therefore a strategy to access and maintain enjoyable relationships, described as

hidden acts of citizenship by Hamer et al (2019:297), and a key aspect of citizenship described by Rowe (2015). The desirability of rehabilitative, as opposed to mandated, therapy groups and the stepping stone that they represent to progressing to off-ward activities equally act as an extrinsic motivator to comply and to cooperate (Ryan & Deci, 2000). There is therefore a distinction between spaces that are associated with unpredictability and those that are desirable for the activities that take place there. In the former it is extrinsic motivation: rules, restrictions and negative consequences, that predominate. In the latter desirability is also an extrinsic motivator to gain and maintain access, whilst the experience and contribution in that space is an intrinsic motivator, as patients are invested in the relationships their contribution helps to create.

In general, the ward is perceived as unpredictable in high security, a factor in both high secure sites in this study. However, it similarly promotes a form of reciprocal altruism (Hammond & Axelrod, 2006; House et al., 2013) - *I will help you as long as I am assured you will help me* - previously described by Trivers (1971) in the coproduction of security by birds, although it may more accurately be utility dependence: the utility or need satisfaction that I get is dependent on your needs satisfaction (Fontaine, 2012); or enlightened self-interest (Coker, 1990). It is altruistic in the sense that Derrida describes gift giving: that initiating the first gift risks not receiving a gift in return, but also places a psychological obligation on the gift receiver to reciprocate (Derrida, 1992). In the case of forensic patients, in order to retain the benefits of membership of the group (identified regulation) members are driven by intrinsic motivations (Van Eijk & Steen, 2016; Vanleene et al., 2018) to support one another to maintain order for fear of losing a desirable activity (a reward incentive) which marks progress towards freedom (a recognition incentive) (Kosfeld

et al., 2017). A similar utility dependence was described in the Irish secure site. This is distinct from strategic accommodation (Moore, 2009), simulated compliance which is employed to accelerate the removal of temporary restrictions. Trivers' contingent altruism (Trivers, 1971), in contrast to strategic accommodation, describes a testing of the system to determine the rules of engagement for coproduction. This testing occurs when the mechanisms for progression are deliberately opaque, commonly in the highest level of security, to prevent manipulation. This often leads to a typical Catch 22: trying to meet the conditions for off ward activities can be viewed as instrumental, which can lead to those activities being denied.

Ostrom describes contingencies regulating behaviours in her example of coproduced protection of oyster beds (Ostrom et al., 2012): excluding others from the resource, policing the actions of members and activating an arbiter in the event of a dispute. The distinction between the findings in this study and the earlier work of Ostrom are the overt symbols of power and exclusion that surround patients, but the mechanisms in both appear to be the same: a finite, desirable resources (peace and security) which can only be maintained through cooperation within a group. In this study, the sense of safety for staff relies on different factors, chief among them being their ability to rely on their colleagues for their physical safety. To paraphrase a common idiom across the sites, to make sure everyone who came in the gate, gets to go home. Teamness, to connect to one another such that they can have absolute trust when a violent incident occurs, is a protection that realises that idiom (Cooke et al., 2023). It may also act as a commons such that members act in the way that Ostrom describes, to deny unfamiliar team members access to that teamness, a barrier evident in the descriptions of some staff in the sample. The latter may be problematic for coproduction in secure conditions. For example, where the intrinsic

motivation is to minimise the risk predicted by past behaviours or conviction by prioritising procedural and physical security, over relational security. The tension between risk management and co-production highlights a fundamental paradox in secure environments: where institutional cultures prioritise procedural and physical security over relational approaches, they inadvertently reinforce the very risks they attempt to mitigate. This risk-averse stance, predicated on historical behaviours and convictions, creates barriers to meaningful coproduction and undermines the therapeutic alliance essential for sustainable change. The evidence from this study suggests that incorporating co-production principles may, in contrast, enhance the management of risk by encouraging patient engagement and shared responsibility. By reconceptualising risk as not merely something to be contained through rules and surveillance, but as a domain for coproduced problem-solving, institutions can move beyond the limitations of traditional security paradigms towards approaches that balance immediate safety concerns with long-term rehabilitation. For example, patients sharing even small amounts of knowledge power may challenge the overwhelming dependence on the anchoring and availability bias of recent incidents or historical events. In The State Hospital in particular attitudes towards security are anchored in sensitivity to close relationships and the risk of grooming. Similarly, being on a *busy* ward - an increased potential for violence - presents a proximity bias that patients are dangerous and that procedural and physical security are paramount. In this formulation, there is a risk that teamness supports staff to coproduce the means with one another to exclude team members who favour relational over procedural approaches to maintaining the commons of peace and security. This process may then mean that staff who are more custodian oriented are included and maintained on ward while the relationally oriented staff are excluded

and opt for off ward appointments, as evidenced in the data. It may also reflect the influence of teamness on the culturally acceptable means to maintain the commons of peace and security.

The influence of anchoring and availability bias in lower levels of security may be mediated on the ward because patients have already passed a behavioural gateway. They are progressing down security levels and are incentivised by impending greater freedoms to comply or are less unwell and therefore present fewer risks when admitted. This suggests that the environmental and relational conditions in lower security (the opportunity for leave and a lower threshold for the development of trust) are more conducive to establishing Ostrom's triptych of an exchange of trust, reciprocity and autonomy, and therefore are more overtly coproductive (Ostrom et al., 2012).

Patients who are progressing from high to lower security and discharge are likely to have tested and learned the rules of the game and may have experienced behavioural *conditioning* in the form of tit-for-tat (Skinner, 1988). They are likely to be aware that negative actions of others will not only disrupt the atmosphere on the ward but will also affect their own access to desirable activities, or identified regulation (Ryan & Deci, 2000). Maintaining the commons of peace and security is therefore an incentive in the strategic game to support other patients to learn the rules and to collaborate to coproduce the conditions that allow collective access to a desirable resource and integrated regulation (Deci et al., 1991). The conditions that support this kind of collaboration, relationally oriented staff and a low risk of a disruption to the commons of peace and security, will be more difficult to achieve in high security, where the risk of violence is considerably higher, than in low security.

In the next sections I present an analysis of how this study answered the research questions.

7.5 Research Question 1:

How is coproduction conceptualised by staff in high, medium and lower secure forensic mental health care facilities in Scotland and the Republic of Ireland?

This question is central to understanding if staff in forensic settings perceive coproduction as a process that contributes to peace and security, or as dangerous practice with inherent risks to peace and security which in turn is inherent to the setting. And, dependent on that conceptualisation, how they use their skills to implement or subvert strategies for coproduction. It is important to restate that, at the time of the study, coproduction was a novel concept that had not been explored in secure conditions, with the key exception of McKeown, Jones, Wright, et al. (2016) and, while interviewees were aware of the word from information circulated before the interview, it was an unknown concept to all of those who participated prior to the interview. However, in developing the proposal for this study I had spent time with staff and patients both on and off ward and I had observed that some staff used deliberate tactics in their interactions with patients, as described by Jim (staff nurse The State Hospital), to safely reciprocate, acknowledge the knowledge-power of patients and to establish temporal and defined instances of trust. Individual forms of coproduction seemed to exist in those interchanges but, nevertheless, coproduction was confused with mental health recovery concepts, particularly Leamy's CHIME mnemonic (Leamy et al., 2011). The confusion is understandable. Trust, reciprocity

and autonomy, Ostrom's triptych, can be seen in CHIME's empowerment, meaning and connection described in table 15 above. Philosophically both coproduction and recovery in these circumstances represent increasingly effective symptom management and personal change, commonly termed behaviour management by participants, and, ultimately, a pathway to psychological liberation as a form of self-actualisation (Freire, 1970). Off ward in the highest levels of security in this sample there are examples described in Ireland of how an environment supports patients to safely take on overt responsibilities for the maintenance of the off ward projects and support the behaviour of others, moving beyond compliance to growth for an intrinsic reward for their contribution

Within those limitations, it is apparent that seeking opportunities to reciprocate with patients, sharing of power, autonomy and establishing trust on the highest secure wards is socially and professionally unacceptable and perceived as a palpable risk, driving relationally close staff to off ward or to adopt a custodian stance if they remain. The concept of coproduction in those circumstances could be interpreted by other staff as contributing to very real escape attempts, rather than Cohen and Taylor's psychological version (Cohen & Taylor, 2003). This perception may also be reinforced when patients appear guarded or deliberately withhold information from staff, creating a sense of uncertainty about their true intentions or state of mind, even in the lowest levels of security. Even when a patient displays altruism it can be perceived as performative rather than genuine, depending on the stance of the staff member, acting as a barrier to reciprocity from staff, and by extension to coproduction. That is, behaviours that would be perceived as kind in other environments are initially perceived as potential manipulation - or an attempt to *split*

the clinical team (Green, 2018) - until such times as it is recognised as a consistent and *genuine* behaviour.

7.5.1 Influences on the Exercise of Citizenship by Patients

There is a notable distinction between the Scottish and Irish highest security sites when patients *go the extra mile* and exercise organisational citizenship behaviour (Wong et al., 2012). That is, by contributing to the task being undertaken by both patients and staff to a degree that would not normally be expected for someone being detained. These are actions and contributions in kind to the activity which in other circumstances would be interpreted as contributing to the common good (Etzioni, 2014), and an attempt to reciprocate for the care and support they have been given. Reciprocation here is a form of Derrida's gifting: it invites - or obligates - a further gift from the recipient (Derrida, 1992), which custodian oriented staff will recognise as a risk of manipulation. However if staff do not respond positively to the gift, by acknowledging a kindness for example (reciprocal altruism described by Trivers), they risk damaging a developing relationship and potentially retaliation (Trivers, 1971).

The distinction between The State Hospital (Scotland) and Dundrum Hospital (Ireland) appears to be the degree to which that reciprocation can be expressed. For example, in the Scottish system access to tools is highly controlled and monitored because there is a risk of them being used in an assault or to escape. The difference between the Irish and Scottish systems at the time data was collected, as noted, was that forensic patients with the highest risk of violence were treated in prison by

outreach teams rather than within a secure hospital (Cotter, 2015). In effect the Irish high security forensic care site was treating patients with a lower risk profile than those in the Scottish system, who by definition have not met the behavioural threshold for prison, such that reciprocity may then present a sufficient degree of reduced risk. As a result, reciprocity did appear to be presented less often by The State Hospital participants.

Coproduction in the two high secure sites therefore may be conceptualised very differently. In the Irish site the historical primacy of care and treatment (HSE Ireland, 2024) promotes reciprocity and Ostrom's triptych such that there are examples of coproduction as a natural consequence of staff and patient interactions. In The State Hospital the primacy of public protection, peace and security, and a less well patient population comparatively, creates a psychological and social barrier to adopting Ostrom's triptych on wards, although we know from the results that it does occur off ward in the Scottish sample. A further distinction between both sites appears to be the legitimacy that is afforded to more naturalistic relationships: more so in the Irish site as described than in high security in Scotland. The historical genesis of the two systems may be key to understanding this difference as well as the differences in their patient populations.

The most recent influence on the Irish site, as described above, was the banking crisis in 2008 which resulted in the allocation of community trained psychiatric nurses to Ireland's high security hospital (see 4.2.3). This signified a move away from the traditional training model where nursing staff were trained on-site and as a result were more likely to absorb the existing culture. This appears to have created a dynamic between the established risk averse culture with pre-existing staff and the new, community and relationally oriented staff, who were overwhelmingly

represented in senior positions in the off-ward sample interviewed. This dynamic was also reflected in Scottish high security but the consistent reference to history and the prominent physical reminders of security that were, in the main, absent in the Irish site, valorised custodian behaviour over relationally close. The historic pattern of recruitment and training was disrupted in Ireland and the system appears to have made an adjustment as a result. While the training of nursing staff in The State Hospital now takes place off-site, the culture has remained tenacious and has not received a similar workforce *shock* to stimulate radical change.

However, in both, the risks of failure are prominent. In the Irish site that risk for the off-ward projects appears to be existential – the off ward projects will close if there is an incident. However, that is balanced by the benefits of reciprocity for patients and staff as described - and coproduction - which appear to be protective of both in terms of the overall commons of safety and the exercise of reciprocal citizenship behaviour in coproducing the commons of peace and security by staff and patients. That is, the community of patients that access the off ward projects support one another to maintain peace and security in recognition that a disruption to that order would result in the loss of utility for them and the staff. These actions may fall between Deci et al's (1991) identified regulation where behaviour is valued but is driven by extrinsic motivations, and integrated regulation where the behaviours and rewards are a good in themselves.

In The State Hospital the on-ward risk of reciprocation for staff is personal: possible isolation from peers. That is, that the prevailing team culture considers reciprocation a risk to the commons of peace and security and responds by excluding the reciprocator from the group. However, there was evidence of organisational citizenship behaviour by staff on ward, such as the observation of the creation of a

simple throwing game on a secure ward. This implies that there may be more examples which were perceived as too trivial to mention during the interviews but that represented innovation, connection and the coproduction of a commons of *fun* that temporarily suspended some of the distinctions between staff and patients. Staff value what they are required to report and are measured against and yet the spontaneous creation of a trivial activity, which is not specified in care plans, served to reduce tension and create an opportunity for fun, peace, and security on the ward but had no clinical *value* and may not be repeated. This suggests that controlled and managed forms of trust, autonomy (the choice not to join in the game) and an exchange of (knowledge) power are present in the informalities of everyday life on a secure ward and are undertaken automatically by some staff because that is *their sort of nursing*.

Importantly, the rules and culture in high security wards appear to have crowded out, but not eliminated, explicit opportunities for the exercise of both coproduction and citizenship in the Scottish system where control is the primary tool for maintaining safety. Pilgrim (2018) argues that citizenship is *suspended* in secure forensic mental health care and therefore his functional definition of *citizenship* – the ability to exercise freedoms - cannot be exercised. This contrasts with MacIntyre's active description where citizenship is exercised in the relationship connections, the formation of identity and reciprocal responsibilities (MacIntyre & Stewart, 2018). A lack of formal citizenship rights does not preclude the exercise of citizenship behaviour to coproduce peace and security as described in both Ireland and Scotland.

As described in Chapter 2, the exercise of citizenship by marginalised groups, including former forensic patients, has been explored by Rowe and Pelletier (2012), Rowe (2015) and more recently in general mental health in American populations by Quinn et al. (2020) and in Scotland by MacIntyre et al. (2022). In his 2015 book Rowe outlines five key mechanisms (the 5 'R's') where excluded groups exercise citizenship beyond the traditional understandings of the citizen as described by Delanty:

'Citizenship implies membership of a political community and is internally defined by rights, duties, participation, and identity. It has traditionally been subordinate to nationality, which defines the territorial limits of citizenship'
(Delanty 1997:285)

Rowe's alternative citizenship relies upon: rights, roles, resources, responsibilities, relationships, and a sense of belonging (Rowe, 2015). In secure mental health the 5 R's appear to be limited by procedural and physical security, which limits legal and civil rights, and the imposition of limitations determined by the State through court procedures, placing restrictions on the types of valued social roles that can be undertaken, but does not eliminate them. However, patients still retain the autonomy to choose whether or not to cooperate, collaborate and coproduce valued social roles, alongside unconditional human rights, including the right to challenge decisions made about their detention. As we have seen across the sites sampled, medical and advocacy staff have described patient interactions that Rowe (2015), MacIntyre (2022) and Quinn (2020) would recognise as *valued social roles*. That is, an equivalent to organisational citizenship behaviour and going the extra mile: having a role and being recognised for it, contributing care and support to others that is above and beyond their traditional position of recipient of care and treatment.

Within the Irish context this was apparent in patient contributions to the maintenance of peace and security to preserve access to a desired resource: gaining trust to open the gardens tool container and preparing tea for the staff supporting them; building a connection. In so doing they were contributing to the collective effort as they take on some responsibility for maintaining peace, supporting others to do so and the relationships that are central to its effectiveness. In some regards this is similar to what Quinn et al. (2020) describe as *collective citizenship*, with the exception that patients are legally denied their liberty and, in the highest levels of security, are also denied rights to free association, and therefore that *collectivisation*. What is being demonstrated here is the exercise of citizenship behaviour by staff and patients not because

‘...the individual's involvement in collective efforts and “causes” in which rights embody collective goals’ (Quinn et al 2020:372),

but because of intrinsic motivation and a moral imperative: it is the right thing to do to reciprocate a kindness. Not to do so would risk the opprobrium of others should the access to the resource be denied as a consequence, in common with the reciprocal altruism concepts outlined by Trivers (1971). There therefore appears to be a relationship, indicated by the findings, between coproduction and citizenship, such that *citizenship* as described by MacIntyre (2022), provides the philosophical foundation for coproduction. The data may be suggesting that coproduction is how citizenship, not just mental health recovery (Quinn & Knifton, 2017), is realised in conditions of restricted liberty.

In lower levels of security there are more opportunities for testing out and off-site relationship building between staff and patients where valued roles are created

naturally, such as when a patient expresses care for the member of staff accompanying them on leave. This may represent the relatively short physical and psychological distance between most patients in lower security and freedom, and the tendency for off ward leaves to be with a single escort rather than a group. However, there was also evidence in the findings of forms of low-level collusion to protect a patient's identity: a patient describing their escort in an encounter in town as their friend and the nurse accepting that description.

For low security, reciprocation in the data focussed on developing relationships and forms of *banter* where boundaries were tested on the ward or when on escorted leave. There may then be a distinction between the conceptualisation of coproduction in high secure versus the other levels of security where the focus of the desirable activity is external, performative, and collective (high secure), or external and individual (medium and low security). This means that the tactics for the game of coproduction differ between high and medium/low security conditions: passing the behavioural gateway in both provides access to desirable activities, but in lower security the incentives and rewards are intrinsically linked to much closer discharge and restoration of full autonomy. For example, the purpose of banter in lower security, the development of a relationship with staff, and the common goal of coproducing discharge, is to confirm to staff that the patient is progressing to discharge. Whereas in higher security coproduction is manifest by patients in a performance to a larger audience who are scrutinising behaviour in a group.

It is useful to revisit Vanleene's analysis of the motivations to coproduce here to understand their influence on the conceptualisation of coproduction by staff. As described in Chapter 2 Vanleene suggests that there are five key incentives, presented in the table below:

Table 16 Incentives to Coproduce Vanleene 2017

Incentive	Example
Material Rewards	Token payment/in kind rewards
Immaterial rewards	Community or organisational status as a result of involvement
Immaterial sanctions	Social opprobrium for not taking part
Solidary	Personal, family and community interests coincide
Normative	Behaviour or actions that are acceptable or expected by communities

In the current study the material reward is progressing to lower levels of restriction and, ultimately, freedom. The immaterial rewards are associated with that progression such as the status conferred by grounds access in the highest security, or unescorted leaves in low security. Immaterial sanctions appear to be the potential impact on other patients of a valued activity being restricted because of behaviour, as described in the Dundrum Hospital Garden Project. Solidary is also reflected in that example when the nurses described patients working together to maintain order and their access to the project which is then accepted as normative. Vanleene also describes salience as a key driver for involvement, that is whether the purpose of the engagement meets a person's personal goals. In this case salience for patients is being off ward and avoiding boredom.

The level of activity on wards, particularly disruption, focusses staffs' attention on maintaining peace and security as their primary task. That is, the fundamental task that needs to be completed to perform the core function of a role (Rice, 1969). However, as Dartington (1998) suggests, it could equally be used '*...in a self-seeking way to emphasise the needs of one stakeholder over others*' (Dartington 1998:1478). The immaterial rewards for staff in high secure wards appear to be dominated by custodianism as the primary task, with a *self-seeking* emphasis on being seen to be part of the team. There may then be fewer opportunities to create the relationships that lead to relational security. It is worth recalling that staff self-select for on or off ward positions depending on their orientations, with immaterial rewards off ward being primarily in the relationships that are developed with patients that lead to more effective clinical interventions. Saliency is likely to be similar to that of patients, to avoid boredom, but in the case of staff it has a dual purpose: avoiding boredom in a shift but also ensuring that boredom in the patient population does not lead to '*recreational rioting*' (Jarman & O'halloran, 2001). These findings considered together confirm that the incentives to coproduce are as evident in secure care as they were in the communities described by Vanleene above.

7.5.2 Understandings of the concept at frontline

As previously noted most respondents gained more knowledge of coproduction from the interview process and focus groups, or would reasonably provide examples of what they interpreted as coproduction from their work in developing the therapeutic alliance (Hartley et al., 2020) or supporting mental health recovery (Davidson & Roe, 2007). This is an understandable confusion given that coproduction is not the primary task (Rice, 1969), and that the therapeutic alliance relies on reciprocation (a

coproduction component) in (co)producing (the process) an effective therapeutic and the real relationship (the product). The difficulty respondents had in understanding coproduction was compounded by the definitional confusion described previously by Bovaird (Bovaird and Loeffler 2003:316) but might equally meet the definition of emergence as described by Carroll (2017). However, Tversky and Kahneman's concepts of data anchoring and availability systematic errors (Tversky & Kahneman, 1974) can shed light on the developing understanding of respondents. These understandings were anchored in the form of mental health recovery promoted by NHS Education for Scotland (Brabban et al., 2006), NHS approaches to Patient and Public Involvement (PPI) (Markham, 2021) - replicated in the Republic of Ireland (Finnerty, 2018) - and the availability of tangible examples for staff in the sample that made sense of the coproduction concepts they were presented with, often with the response '*we have a group for that*'. This appears to be a rational-technical¹⁰ way (Marcuse, 1941) of managing the definitional uncertainty (Parton, 2000; Schön & Argyris, 1996). That is, the tangible provision of a group, and thus the intervention or outputs, rather than the complexity of dynamic relational interactions that keep its members safe and secure. Coproduction in health settings such as these exists within a context of adaptive rather than radical change over time where paternalism has been a predominant anchor (Kjellin & Nilstun, 1993; Peltó-Piri et al., 2013), and is '*dependent on the prevailing structures and processes of the service*' (Markham 2021: no page). Forensic mental health in the highest levels of security such as The State Hospital are also naturally inwardly focussed and avoidant of power sharing (Farmanova et al., 2018). However, the results indicated that there was evidence of

¹⁰ That is, focussing on tangible tasks that result in tangible outcomes over intangible relationships or a sense of security. In this study this manifests as custodianism

short term and conditional releases of power as the testing out process that forms part of the assessment that allowed grounds access and off ward projects.

Nevertheless, there did appear to be a stark distinction between the experience of temporary release to off ward projects, the autonomy that unescorted access represents and the return to the restrictions on the ward. This seemed to be represented in both high secure settings, where Osborne's consumer coproduction - the patient contributing to and benefiting from peace and security - occurs exclusively in off ward contexts.

The focus groups revealed the inherently social nature of both barriers and enablers to coproductive practice, exposing the team dynamics that significantly shape individual staff behaviour and patient experiences. Most notably, the focus groups highlighted the cultural tensions between different staff groups - particularly the '*two tribes*' phenomenon between on-ward and off-ward staff - and how these divisions create systemic obstacles to consistent coproductive approaches. The group discussions also uncovered informal policing mechanisms within teams, such as how problematic behaviours like '*gunslinging*' are collectively identified and managed, suggesting that sustainable change in coproductive practice requires team-level rather than just individual-level interventions. In addition, the focus groups provided insights into how teams negotiate competing priorities between security and therapeutic engagement in real-time, revealing the collective decision-making that determine whether coproductive opportunities are seized or constrained. The group format also supported staff to discuss sensitive topics about colleague relationships and professional boundaries that they may have been reluctant to address in individual interviews, providing a more complete picture of the interprofessional dynamics that either support or undermine collaborative working with patients.

While the understanding of the concept of coproduction was low across all four sites there was evidence of Pennington's subtractability or rationing of desirable activities for patients, or more specifically in Dundrum Hospital a lottery for access to off ward; and social capital reliant excludability in terms of the *teamness* described by interviewees on ward (Pennington, 2012). That is, that being part of the team requires the development and establishment of social capital with other team members over time. There is therefore evidence of the managing components of coproduction described by Ostrom in the sophisticated systems of relational security – specifically excludability - which is part of the rehabilitative systems that are promoted within each environment (Ostrom et al., 1994). Their existence suggests that even without direct knowledge of the concept there is latent potential in the actions of staff, often realised, that can lead to degrees of coproduction. This therefore suggests that the dual role of carer and maintainer of peace for staff in secure care contains the latent components for coproduction and co-destruction (Osborne et al., 2016). How staff respond to threat and violence, and the effectiveness of organisational support to recover from both, will determine whether coproduction or co-destruction (Osborne et al., 2016) is activated.

This section provides evidence of how staff conceptualise coproduction across the security gradient, despite most participants having limited prior understanding of the concept. Staff perceptions vary significantly based on their orientation (custodian versus relationally close) and setting (on-ward versus off-ward). In high-security settings, particularly in Scotland, staff on wards view reciprocity and power-sharing as professionally risky behaviours that might compromise security, while off-ward staff recognise their value in controlled reciprocal exchanges. The Irish high-security

system shows a greater acceptance of the naturalistic relationships that support coproduction.

In this sample staff often conflate coproduction with related concepts like mental health recovery and the therapeutic alliance, while its components are apparent in their descriptions of practice. This section reveals that staff implicitly understand key coproduction elements - recognising when patients exercise organisational citizenship behaviours, managing small exchanges of trust, and creating environments where mutual interests in maintaining peace and security emerge.

Staff conceptualisations are influenced by institutional cultures, risk perceptions, and environmental conditions, with those working in lower security settings or off-ward activities having more positive views of coproduction's potential within the constraints of secure care.

Coproduction in secure settings in this study challenges traditional definitions of the practice in other settings. It manifests as a process of human interaction for common purposes, rather than the production of tangible outputs or service design suggested by NHS England's definition. Evidence from this study also challenges Pilgrim's assertion that coproduction without the rights ascribed to a functional definition of citizenship is impossible in secure settings. This is because a different form of active citizenship, and a patient's intrinsic motivation to maintain and protect relationships, is being exercised, supported by conditional relationships and a mutual investment in safe and desirable spaces and activities.

Ostrom's triptych was apparent in the descriptions of relationally close working, but in modified and constricted forms as a consequence of security. Coproduction, and the triptych, therefore, exist in secure care but their combination and effect are

dependent on the orientation of staff and both the physical location and security level of the facility. Coproduction across the gradient of security also exists along a gradient where the range of opportunities to engage in it and to engage more aspects of Ostrom's triptych increase as the security levels decrease.

Evidence from this study suggest that, while coproduction does exist across levels of security, it is situational and conditional and more readily occurs in spaces that are safe and predictable. Typically, this describes off ward rather than on ward spaces.

7.6 Research Question 2:

What are the enablers and constraints for coproduction in these circumstances?

7.6.1 The enablers and constraints.

This section examines the barriers to coproduction across different security levels in forensic mental health settings. The tension between maintaining security and supporting therapeutic relationships means that coproducers must navigate procedural safety and good relational engagement. The way staff approach this task is influenced by institutional cultures, the environment, and psychological responses to perceived risk. Understanding these barriers provides insight into why coproduction remains challenging in secure environments, even when its potential benefits for both patients and staff are recognised. The interplay between custodian approaches and relational security demonstrates that coproduction is not impossible

in these settings but requires specific conditions and adaptations to flourish amid constraints inherent to secure care environments.

The barriers to coproduction are common across all levels of secure care.

Custodianism, as an expression of Osborne's public sector delivery logic¹¹ (Osborne, 2018), either as a consequence of embedded culture, a response to violence, threat or sensory overload, presents a psychological barrier to the creation of meaningful relationships, which in turn affects the ability to coproduce. That is, the certainty and reliability of custodianism versus the uncertainty of relational security. As established earlier, the primary task represents the fundamental function that must be completed to fulfil a role's core purpose (Rice, 1969). For ward staff in the highest level of security, working in *busy* wards, the primary task prioritises maintaining safety and security over therapeutic engagement. This is a natural consequence of unpredictable environments with the potential for violence, creating what Dartington (1998) described as a *self-seeking* emphasis that privileges one stakeholder's needs over others.

The data suggests that custodianism becomes entrenched when maintaining physical order is perceived as the primary task. This is particularly evident at the highest level of security where the heightened risk of a busy ward, or a reduction in available staff, shifts the primary task toward containment. That is, the tendency also documented by Kahneman and Tversky as systematic errors (Tversky & Kahneman, 2015), to manage psychological overload and the experience of high stress with a reliance on tangible rules and procedure. There is then a conflict between the custodial and therapeutic functions for on ward staff, resolved by focussing on the

¹¹ Traditional service delivery that is not coproduced

more concrete, measurable and therefore rational-technical aspects of their role - procedural and physical security. The psychological comfort provided by clear rules and procedures offers staff a sense of competence and control in managing their primary task, whereas the ambiguity inherent in relational approaches creates uncertainty. This dynamic explains why, even when relational security is acknowledged as ultimately more effective, staff revert to custodial approaches when under pressure. For coproduction to flourish, the definition of the primary task itself must expand beyond security maintenance to include relationship development as an equally essential function.

While this was an important finding from the high secure sites specifically, there was also evidence of the cultural resilience of and rational return to custodianism in both medium and low secure sites. This presents a barrier to coproduction across secure care environments. The rational-technical production of safety and security relies on universally applied procedure to create consistency. Coproduction of the same is dynamic, creates safety through interpersonal dynamics that exist within the relationship itself - staff and patients actively embody safety through their interactions with external protocols being secondary. This coproduced safety exists primarily in the ephemeral moment of interaction and develops through personalised inter-connections unique to each staff-patient relationship. This fundamental difference represents a significant barrier to implementing coproduction, as institutions naturally gravitate toward measurable, standardised approaches over the less tangible, relationship-based security that coproduction requires.

Beyond staff approaches, patient-specific factors create additional barriers to coproduction. Active mental illness, the effects of medication, and responses to trauma can affect a patient's ability to engage consistently in coproductive

relationships. In addition, institutional conditioning - where patients learn passive compliance rather than active participation, described by Goffman (1961) - can undermine authentic engagement, and coproduction. The *catch-22* identified in the findings, where a patient's motivation to cooperate may be interpreted as manipulation, creates a particularly challenging dynamic where patients' genuine attempts at coproduction may be systematically misinterpreted dependent on the levels of security, location and orientation of staff.

This is evidence of an interesting interaction between a realist, medical model reliant on protocol (Farre & Rapley, 2017), that views mental ill health primarily through a biomedical lens focusing on diagnosis, symptom reduction, and standardised treatment protocols (Double, 2006) - and the strengths based mental health recovery model referred to by participants (Leamy et al., 2011) and explored in Chapter 2. This may be a factor in the positions that staff take on and off ward. That is, the certainty and predictability of physical and procedural security which can be measured and monitored for compliance and remediation versus the relative uncertainty of relationships which will vary from one member of staff to another, dependent on their relational investment with the patient.

The cultural dominance of custodianism as a barrier to coproduction in higher security is reinforced by the uncertainty caused by direct admissions, the lack of withdrawal space for staff or the opportunity for uninterrupted reflective practice. The cultural importance of teamness in the highest level of security may also be a conditional barrier or a multiplier, if custodianism is also a predominant feature of that culture. This suggests that secure environments beyond forensic mental health care must also pay attention to the influence of teamness on the ability to coproduce peace and security. The importance of teamness in these circumstances is

reinforced by the cultural predominance of safety. In environments where constraining the actions of some for the safety of others predominates, and there is a latent and unpredictable risk to staff, reliance on others for safety means that individual innovation, and therefore a deviance from the expected norm, present personal risks. That is, the risk of alienation or expulsion from the group. The incentive is to act and perform as other staff do, and to exclude deviant behaviour, or to self-exclude by leaving that team.

Structural and resource constraints present further barriers to coproduction across all security levels. Staffing ratios set limits on the time available for relationship building beyond basic care and security functions, particularly in high security settings. Risk assessments, while necessary, prioritise administrative compliance and the tangible outputs over the less tangible, and perhaps less valued relational connections. These systemic constraints create conditions where coproduction becomes an *addon* rather than an integral part of care delivery.

There is evidence that relationally close staff self-select for off ward positions where they can engage therapeutic and coproduction supportive skills. This reinforces the presumption that the process of coproduction on wards is not possible and is an important barrier to the creation and maintenance of coproduction processes in rules dominated environments.

In lower security staff roles are a hybrid of custodian in response to risk or threat but relationally close when supporting a leave. In those environments it may not be possible to remain in one mode throughout a shift, which means that staff are exposed to coproduction supportive conditions more often than their high secure counterparts. The lower security model where staff follow their patients on their de-

escalating security journey may be a solution to retaining coproduction receptive staff in higher security.

The physical architecture of secure environments, designed primarily for observation and control rather than interaction, creates spatial barriers to coproduction. As evidenced in the findings, the lack of withdrawal spaces for both staff and patients impedes the psychological safety needed for authentic engagement. Moreover, the fundamental power imbalance inherent in compulsory treatment settings creates perhaps the most persistent barrier to coproduction. While relationally oriented staff may attempt to mitigate these power disparities through small exchanges of trust and control, the institutional authority to detain, medicate, and restrict remains an inescapable background condition that shapes all interactions. Any model of coproduction in secure settings must then acknowledge and work within these power realities rather than attempting to deny their existence.

Environments characterised by high levels of restriction, the dominance of rules, and extrinsic motivation inhibit the conditions necessary for coproduction. As Ryan and Deci (2000) demonstrate, extrinsically motivated compliance supports different behaviours than those arising from internal motivation. In highly restrictive settings, there is a risk that prominent restrictions encourage patients to primarily respond to external control rather than developing the intrinsic motivation that supports genuine reciprocity and relational security necessary for coproduction.

In contrast, less restrictive environments allow for the development of *identified regulation* - where patients recognise that specific behaviours will lead to valued outcomes - creating a pathway toward more internally motivated engagement (ibid). This progression from external to internal motivation becomes more resilient as

patients learn from boundary testing, as their compliance stems from understanding the value of the relationships that helps them to navigate an opaque system of personal and group controls rather than only the avoidance of punishment.

When environments become more restrictive in response to *busyness* or the disruption of new admissions, staff naturally gravitate toward *teamness* for psychological safety. While this provides immediate comfort and security for staff, it simultaneously reinforces custodian type approaches, particularly in high-security settings. This is a barrier to coproduction because, as Brody (2022) explains, our interpretation of information is heavily influenced by those in our immediate social environment, particularly colleagues. That is, staff give a disproportionate weight to perspectives shared by the team in uncertainty. Fairfield and Charman (2019) describe how these *Bayesian priors* - existing beliefs that influence probability judgments – create confirmation bias within teams, making custodian approaches difficult to dislodge once established. In practice, this means that staff in secure care, having witnessed or experienced violence, develop collective prior beliefs about risk that prioritise physical and procedural security despite evidence that relational approaches might better prevent violence (Royal College of Psychiatrists Centre for Quality Improvement, 2023). The potential of losing the safety and collegiality of the team prevents some staff from challenging these collective assumptions. This barrier highlights a paradox in secure care: that while rule-based custodianism provides an illusion of control through simple, standardised procedures, relationship-based approaches may ultimately create safer environments and more fulfilling professional experiences.

A summary of the enablers and constraints of coproduction identified in this study are presented below:

Table 17 Summary of Enablers and Constraints

Summary of Enablers and Constraints	
Constraints on Coproduction	Enablers of Coproduction
Custodial culture and overreliance on procedural security	Off-ward environments with lower perceived threat
Staff stress, sensory overload, and fear of violence	Passage through behavioural gateways that establish conditional trust
Cognitive biases reinforced through teamness	Relationally oriented staff willing to engage in reciprocal exchanges
Limited withdrawal spaces for reflection	Spaces associated with rehabilitation rather than containment
Environments that foster extrinsic rather than intrinsic motivation	Environmental conditions that support intrinsic motivation
Staff self-selection away from ward environments	Opportunities for staff to disengage temporarily from ward intensity

7.7 Research Question 3:

What does coproduction in secure settings add to the classical definitions of coproduction?

As Chapter 2 illustrated there are a plethora of definitions of coproduction. However, for the purposes of this study I have used Elinor Ostrom's framing of coproduction from 2012: *'Over time, the users have developed high levels of **trust** and **reciprocity** and have the **autonomy** to determine at least some of their own rules.'* (Ostrom et al 2012: 80 emphasis added).

In the most restrictive environments, procedural restrictions suggest that there is no autonomy for patients to set their own rules. Compliance is extrinsically motivated by rewards in degrees of liberty or access to desirable activities. Compliance represents just one of several possible motivational postures. When patients in secure settings

comply to gain access to greater freedoms or desirable activities, they are exhibiting what Braithwaite terms *capitulation* or *game-playing* rather than genuine commitment (Braithwaite, 2003). This reflects earlier discussions about strategic accommodation (Moore, 2009) and tactical game playing (Braithwaite, 2012) where patients partially comply with rules to satisfy those in power while pursuing their own objectives.

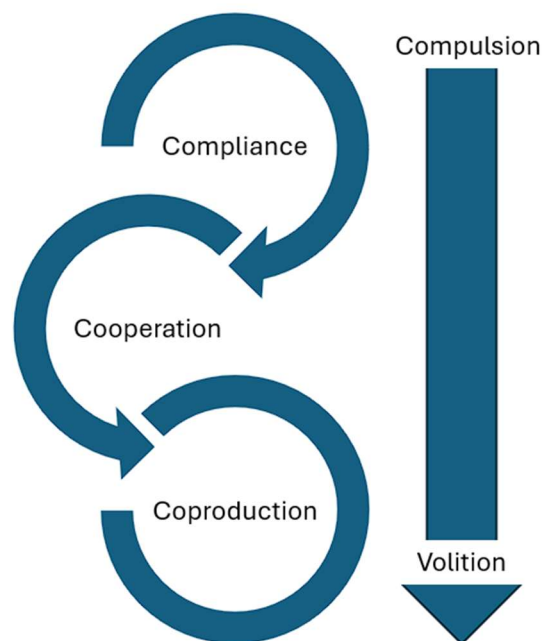
Braithwaite's framework helps to explain the catch-22 dilemma identified earlier: that staff must determine whether patient compliance represents genuine commitment or merely instrumental behaviour to access resources. As previously noted, in low-trust environments staff tend to perceive compliance as manipulation rather than commitment, which in turn will affect how and if patients coproduce (Hucklesby, 2009; Tyler, 2006). This also reflects the preceding discussion about extrinsic versus intrinsic motivation, where the progression from compliance (extrinsically motivated) to cooperation and eventual coproduction (increasingly intrinsically motivated) depends on the development of trust and meaningful relationships. Braithwaite's work therefore provides a theoretical foundation for understanding how compliance functions within the strategic game for greater freedoms that characterises patient experiences in secure settings.

While the dominance of compliance restricts autonomy, there is nevertheless evidence in this study of autonomous policing of behaviour and cooperation beyond compliance to maintain collective access to a limited or restricted resource. Despite restrictions the collective of patients and staff off ward established '*some of their own rules*' through coproduction. There is, then, a dynamic interaction between forms of compliance - compelled and acceded to - generating small acts or expressions of cooperation, creating the conditions for coproduction. The data in this study reveals a nuanced continuum of definitions between compliance and coproduction across

secure forensic mental health settings. At one end, compliance represents extrinsically motivated adherence to rules primarily to access privileges or progress toward lower security levels - capitulation or game-playing mentioned above. Moving along the continuum, strategic accommodation emerges as patients selectively comply while testing boundaries to determine what behaviours will yield their desired outcomes. Further along, cooperation develops as staff and patients recognise their mutual interest in maintaining peace and security, while still primarily instrumentally motivated. True coproduction appears at the far end, characterised by Ostrom's triptych of trust, reciprocity, and autonomy, where patients and staff develop conditional relationships that go beyond compliance to create intrinsically motivated contributions to shared outcomes. This research demonstrates that this progression is dependent on context, with off-ward environments and lower security settings more conducive to movement toward the coproduction end of the spectrum. Staff conceptualisations of patient behaviour - whether they interpret compliance as manipulation or as a step toward genuine engagement - significantly influences where their interactions fall on this continuum, with relationally oriented staff more likely to recognise and foster movement toward authentic coproduction even within security constraints.

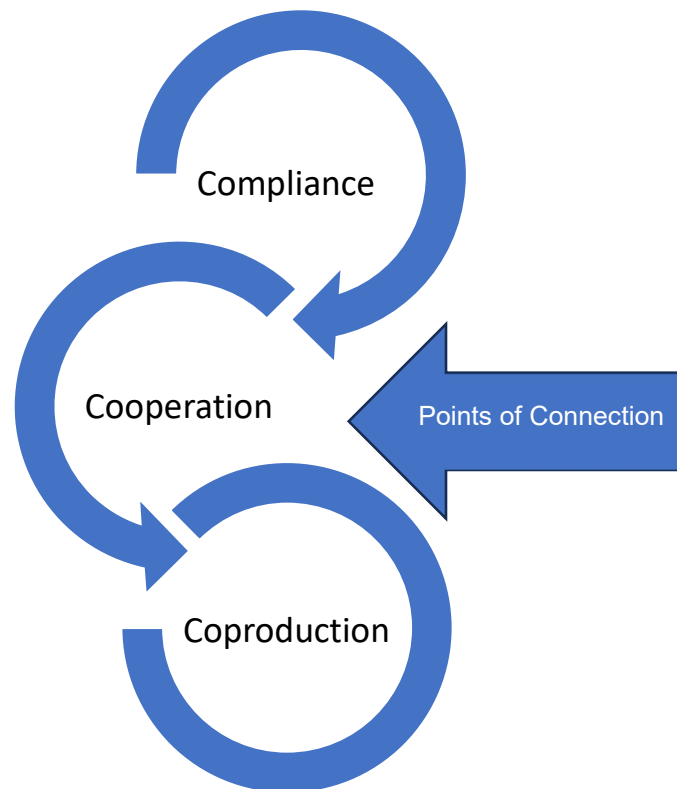
This provides us with a portable heuristic, illustrated in the figure below, which describes the stages that lead to coproduction:

Figure 18 Heuristic of Coproduction



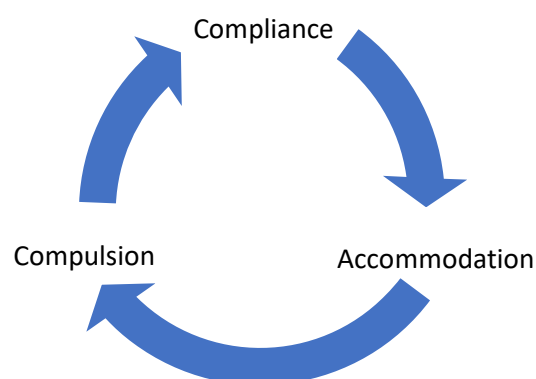
This study highlights the systematic error that those expressions of cooperation go un-noticed or undocumented as they are not perceived as being significant in secure conditions. If we consider the antithesis, compulsion relies on extrinsic motivations which, as Ryan and Deci (2000) shows, have no long term impact on behaviour change, cooperation and consequently coproduction. Whereas compulsion is a feature of restricted environments, staff creating points of connection to humanise their relationship with patients affords reciprocation where maintaining peace and security becomes desirable. Such that, rather than compelled and therefore an extrinsic motivation, cooperation can lead to a coproductive virtuous circle as illustrated in the figure below.

Figure 19 Cycle of coproduction



The antithesis, where compliance is solely the result of the extrinsic motivation of compulsion, results in a temporary strategic accommodation which ultimately results in repeated compulsion, is presented in the figure below:

Figure 20 The compulsion vicious cycle



Building on Ostrom's *trust, reciprocity and autonomy*, the model in figure 19 demonstrates that coproduction exists on a continuum rather than as a binary state.

While traditional definitions might suggest coproduction is impossible in highly restrictive environments, this research reveals a more nuanced reality where coproduction emerges through small, incremental steps beyond mere compliance. There is then a progressive pathway from extrinsically motivated compliance, through strategic accommodation and cooperation, to authentic coproduction characterised by intrinsic motivation and a mutual investment in shared outcomes. Crucially, this definition acknowledges that coproduction can exist within constraints, particularly in off-ward settings or lower security environments where conditional relationships develop beyond the restrictions of wards or the institution. The portable heuristic and virtuous circle model show that coproduction depends on humanising connections that transforms compelled compliance into the mutual creation of peace and security, distinguishing it from a vicious cycle of strategic accommodation and repeated compulsion.

The relationship between staff and patients, and relational security skills are central to developing forms of limited autonomy within which patients can create rules. In Game Theory this is a form of Nash equilibrium in the secure care game. That is:

‘a set of strategies, one for each player, such that no player has incentive to change his or her strategy given what other players are doing’ (Spaniel 2014:34).

Those relationships create stability in secure conditions. This finding expands Ostrom’s definition beyond the autonomy to create *‘some of their own rules’* to include interdependence in effective coproduction, both of the individuals engaged and the objectives each has in the engagement.

The systems to treat and support patients in forensic mental health systems at the highest level of security are dependent on their history. What appears to be clear in this study, however, is that forms of coproduction, compliance with the system and the therapeutic alliance are interlinked. Developing therapeutic relationships rely on the *real* relationship to be effective (Gelso & Kline, 2019). Innovative staff find opportunities for that relationship to develop such that '*interactive value co-creation*' (Osborne 2018:228) occurs and *knowledge power* is exchanged (Bevir, 1999; Foucault & Rabinow, 1982). That is, this study expands the traditional definition of coproduction by identifying and validating the significance of small, seemingly inconsequential interactions in highly restrictive environments. While Ostrom's classical definition emphasises the importance of trust, reciprocity, and autonomy at a systems level, this study highlights that coproduction in secure forensic settings begins with granular, seemingly inconsequential exchanges that previous definitions have overlooked. These small instances of connection - such as shared interests, banter, or collaborative planning for therapeutic restraint - represent nascent forms of coproduction that exist despite significant constraints on commonly recognised forms of autonomy. This study's contribution then is twofold: first, recognising these micro-interactions as legitimate expressions of coproduction rather than dismissing them as insignificant; and second, establishing them as essential precursors that build the foundations for more recognisable forms of coproduction. By acknowledging these foundational exchanges, this study challenges the binary view that coproduction either exists fully or not at all, replacing it with a developmental continuum where even small expressions of autonomy within compliance-focused systems constitute meaningful steps toward authentic coproduction. This more nuanced definition addresses the reality of secure settings where absolute autonomy is impossible, yet

coproductive relationships nonetheless emerge through deliberate, humanising interactions within security constraints.

History, location and whether administrative systems and the staff within them can manage uncertainty are also a feature of coproduction in secure conditions. That is, lower levels of security are more tolerant of uncertainty because there is a greater reliance on relational security and the coproduction of peace and security, as well as patients assessed as posing a lower physical risk of violence. They instead face a different risk of absconsion which is both actively managed through relational security - using the relationship with the patient to identify the triggers and controls for behaviours through coproduction - and passively by ensuring that the benefits in the compliance game outweigh the benefits of escape. The risk profile of patients supported in Irish high secure site, and the fact that the riskiest patients are treated in prison also allows it to tolerate more uncertainty than The State Hospital in Scotland. Lower risk profiles and breaking the link with history is a key factor that unlocked coproduction for Medium Secure 2 (breaking the link with The State Hospital) and Medium Secure 1 (breaking the link with its original remote and rural site). In contrast The State Hospital has retained the staff and its links to the past, despite a total rebuild of the hospital and staff turnover. This represents cultural norms as bounded rationality defining what it is possible to coproduce in each location (Jones, 1999; Simon, 1990), providing internal legitimacy for custodians and in the case of the Scottish site, external legitimacy of punishment over treatment. Bounded rationality, rather than perceptions of the ability to exercise citizenship (Pilgrim, 2018), is the primary barrier to coproduction in secure care, which coproducers use reciprocities to overcome.

In conclusion, this study expands understandings of coproduction beyond classical definitions by demonstrating that it manifests within the constraints of secure forensic mental health settings. While traditional conceptions of coproduction emphasise the importance of full autonomy, trust, and reciprocity, this research reveals a more nuanced reality where coproduction exists on a developmental continuum rather than in a binary state. The research establishes that bounded rationality, rather than the inability to exercise functional citizenship, is the primary barrier to coproduction in secure settings. Historical, cultural, and administrative factors significantly influence what forms of coproduction are possible within different security levels and contexts.

Table 18 Contributions to the Definition of Coproduction in Secure Settings

Classical Definition Elements	Expanded Understanding in Secure Settings
Autonomy	Even small expressions of choice within highly restricted environments constitute meaningful autonomy
Trust	Trust in secure settings is conditional, situational, and developed through incremental exchanges rather than given fully
Reciprocity	Reciprocity begins with seemingly inconsequential exchanges that build foundations for deeper engagement
Binary nature	Coproduction exists on a developmental continuum from compliance through cooperation to authentic coproduction
Systems level focus	Granular, individual micro-interactions are legitimate expressions of coproduction
Independent actors	Interdependence is central to effective coproduction in restricted environments
Voluntary participation	Accounts for strategic accommodation and the progression from extrinsic to intrinsic motivation
Equal power relations	Coproduction can exist despite fundamental power imbalances through managed exchanges of knowledge-power
Environmental neutrality	Physical spaces and contextual factors (on-ward vs. off-ward) critically influence coproduction possibilities
Universal application	Historical, cultural and administrative contexts create bounded rationality that determines what can be coproduced

This expanded definition offers a framework for understanding how authentic coproduction can emerge within even the most restrictive environments, providing insights for both theory and practice.

7.8 Theoretical contribution

The findings from this study reveal that understanding coproduction within secure forensic mental health settings requires theoretical frameworks that can account for the paradoxes inherent in these environments. Traditional coproduction literature, developed primarily within voluntary and democratic contexts, proves insufficient for explaining how authentic collaboration emerges within settings characterised by compulsion, restricted autonomy, and fundamental power imbalances. This study therefore draws upon four complementary theoretical lenses to illuminate the complex dynamics through which coproduction manifests in secure care.

Game theory emerges as a particularly valuable framework for understanding the strategic interactions that underpin coproductive relationships in secure settings. This study applies game theory not merely to analyse resource allocation, but to examine the motivational structures and incentive systems that shape staff and patient behaviour within what can be conceptualised as the 'secure care game'. Through concepts such as Nash equilibrium and the distinction between single-shot and multi-shot games, this analysis reveals how rational actors navigate complex rule systems and competing interests to achieve mutually beneficial outcomes. This theoretical approach illuminates why certain interactions create stable, productive relationships whilst others result in cycles of resistance and control, providing objective insights into the transactional nature of coproduction that normative accounts fail to capture.

The application of citizenship theory, particularly Rowe's "5 R's" framework, adds crucial depth to understanding how agency operates within constrained environments. This study demonstrates that detained patients, unlike prisoners, retain formal citizenship rights and demonstrate citizenship behaviours that contribute meaningfully to collective outcomes. The citizenship lens reveals how patients exercise agency through valued social roles and reciprocal relationships, challenging assumptions about capacity and autonomy in secure settings. This perspective shows how the interplay between relational and structural aspects of citizenship creates opportunities for meaningful participation even within highly restrictive contexts.

Gibson's theory of affordances provides the environmental dimension necessary for understanding how context shapes coproductive possibilities. This study identifies how physical spaces, procedural arrangements, and relational contexts create specific affordances that either enable or constrain collaborative interactions. The affordances framework explains why coproduction emerges more readily in certain environments - such as off-ward settings - whilst remaining limited in others, revealing the dynamic interaction between structural constraints and individual agency that characterises secure care.

Underpinning these theoretical frameworks is the fundamental importance of shared humanity in creating conditions for therapeutic engagement and coproductive practice. This study identifies the recognition of common humanity as essential for moving beyond purely institutional relationships towards authentic collaboration. Drawing upon recognition theory and capabilities approaches, this analysis demonstrates how acknowledgement of personhood - through humour, shared

interests, and mutual respect - creates the foundation upon which trust, reciprocity, and collaboration can develop.

These theoretical contributions combine to reveal coproduction in secure settings as operating simultaneously across strategic, civic, environmental, and fundamentally human dimensions. Rather than representing a compromise or diluted version of *true* coproduction, this study demonstrates that collaboration in secure settings exhibits sophisticated characteristics that expand traditional definitions. This multi-dimensional theoretical approach provides both explanatory power for understanding current practice and practical insights for enhancing coproductive possibilities within the necessary constraints of secure forensic mental health care.

The next sections will explore the key theoretical contributions that this study adds.

7.8.1 Use of game theory

Much of the empirical and theoretical literature explores the coproduction of public services (Bovaird, 2007; Bovaird & Loeffler, 2012; Bovaird et al., 2016; Brandsen & Helderman, 2012; Brandsen et al., 2018; Escobar, 2020; Loeffler & Bovaird, 2016; Osborne et al., 2016), the development of democratic processes to support better municipal decision making (Galuszka, 2019; Radzik-Maruszak & Bátorová, 2015; Sabatinelli & Costa, 2016; Verschuere et al., 2018), and in the UK context reducing demand for health services (Alafaireet & Houghton, 2017; Alakeson et al., 2013; Baim-Lance et al., 2016; Boyle et al., 2006; De Andrade, 2016; Vennik et al., 2016). There are key explorations of coproduction in a justice context (Weaver, 2013, 2019, 2022) but none that explore the conceptualisation of coproduction in secure mental health and the coproduction of peace and security. This is significant for other

contexts characterised by varying degrees of compulsion because it provides a framework to support meaningful collaboration and coproduction where significant disparities in power, the dominance of security or legal restrictions exist.

While game theory has been used by Ostrom and others (Hardin, 2003; Ostrom & Walker, 2003) to understand the motivations to preserve or to exploit a rare resource, chapter 3.1 established that it has not been used to understand the mechanics of coproduction. In this study the use of game theory theoretically provides an insight to the motivations of both patients and staff, not surfaced by commonly used theoretical frames, and may help the forensic mental health system to consistently create the conditions for the win-win (peace and security) and to ensure that the Nash equilibrium (Nash, 1951), is maintained. That is, that the incentive for a defiant motivational posture (Braithwaite, 2003) is minimised because the counter incentive to achieve peace and security provides desirable rewards. In this regard game theory provides the tools to begin to understand the motivations and transactions presented by patients and staff in secure care objectively to anticipate the potential future actions of staff and patients. The game theory lens illuminates the transactional nature of coproduction in secure care, which is not described in the normative accounts. It also suggests that there would be benefit in reorienting risk management processes to incentivise future citizenship behaviour by staff and patients, as well as providing a frame for future research to explore the motivations and incentives for coproduction outwith secure settings.

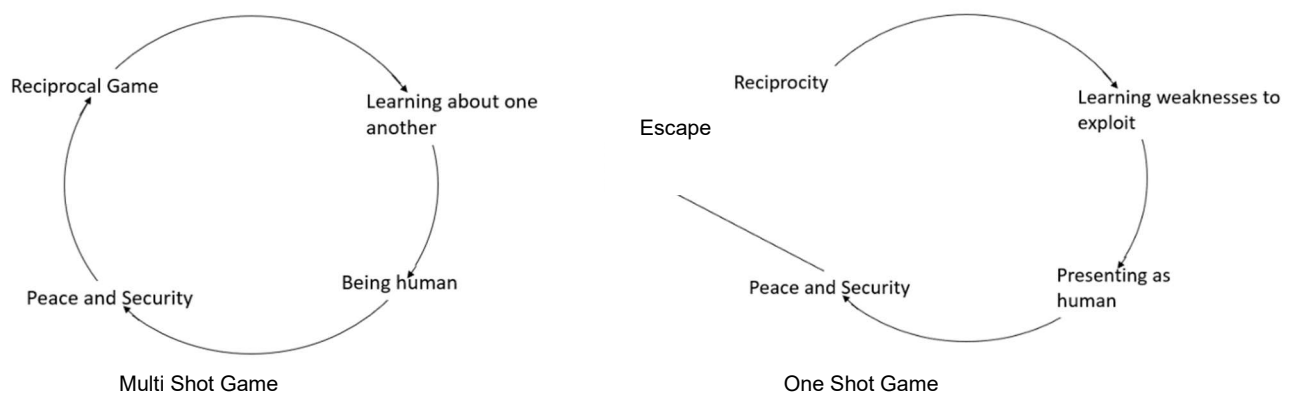
As the process, or game, at work in high levels of security was neither fully understood by staff, nor easily visible, the analysis focussed on identifying the actions and processes that create and maintain a commons of peace and security, as a form of backwards induction (Watson, 2010). That is, the points in the

relationship, negotiation, or game where there are no incentives to change behaviour: Nash equilibria (Dixit & Nalebuff, 2008; Watson, 2010). The use of game theory in secure care suggests that these are the points of interaction which are most stable, where the relational context means that any disruption to that equilibrium has negative consequences or connotations for those involved. In this context, there is no free rider incentive (Brandsen & Helderma, 2012) as that disrupts the equilibrium and the interactions (or games) involve repeat interactions. This suggests that where stability exists, trust and reciprocity are also likely to coexist because:

'[Coproducers] rely on unique aspects of a local resource and the local culture when developing their approach to managing the resource' (Ostrom et al, 2012:80).

Using game theory illuminated forms of reciprocation, from small acknowledgements of commonality and connection through banter, which Honneth describes as moving from the monological to dialogical as recognition (Ikäheimo & Laitinen, 2007), to shared interests and tasks that reduce the likelihood of a one-shot game. This appears to encourage a process of reciprocal learning, investing emotional energy and social capital in one another that appears to be protective of peace and security. The multi-shot game (figure below) generates a mutual understanding which is valued by relationally close staff but identified by custodians as increasing the risk of manipulation or peace and security.

Figure 21 The effect of single and multi-shot games



This model also represents the risks of exploitation. That is, using knowledge gained in a reciprocal interaction to create the conditions for resistance or defiance (Braithwaite, 2003), either by recreational rioting or by *splitting* teams (Green, 2018). In this context the model describes staff as well as potential patient behaviour. For example, a member of staff '*gunslinging*' as described in this study is direct evidence of both resistance and defiance. Into this model I can add the altruism game described by Trivers (1971) where community approbation and loss of access to a desired activity for both staff and patients can create the conditions for a form of reciprocal equilibrium which benefits the patients and the staff equally.

This study also found a theoretical relationship between the key systematic human errors in games that Tversky and Kahneman (1979) describe in prospect theory¹² (see 5.6.3), case note prejudice and the persistence of risk aversion across secure conditions for mental health in Scotland. That is, the likelihood of staff engaging in coproductive relationships is moulded by an interaction between the social and

¹² Prospect theory explains how people make decisions under uncertainty by evaluating potential gains and losses relative to a reference point, typically demonstrating greater sensitivity to losses than equivalent gains.

media attitude to certain types of crime committed when mentally unwell (Hudson, 2003) and data in case notes that not only provides information on risk but also contributes to a perception of risk based on historical events, which in turn becomes a cultural artifact in the transmission of reciprocity averse cultures, which is a barrier to the *games* that lead to and support coproduction. In this study game theory illuminates the motivations and decisions made by patients as they navigate the multitude of rules and restrictions that apply to their behaviour, and the material and emotional incentives to engage in the relational game with staff to pass through the behavioural gateway and to maintain access to a desirable resource.

7.8.2 Concepts of citizenship, game theory and why patients coproduce

The current study similarly brings a novel analysis of coproduction in secure settings using Rowe's 5 R's (Rowe, 2015). Unlike prisoners, detained patients have formal citizenship rights and are supported by care and advocacy staff to exercise them. However, patients who are engaged in the multi-shot games that generate peace and security value the developing relationships with the staff that they have a personal commons and connection with. Through that relationship they may seek to develop forms of reciprocation that demonstrate their competence to take on responsibilities - such as making tea for nurses - which can provide a valued social role for them, contributing to their recovery. As MacIntyre et al. (2022) show in their analysis of citizenship factors identified in Scotland, there is an

'...interplay between the relational and structural aspects of citizenship'

(Macintyre et al 2022:695),

which mirrors a similar interplay between relationships, systematic biases (Tversky & Kahneman, 1979) and informal citizenship behaviour demonstrated in the results.

This study therefore uniquely adds concepts of citizenship, such as valued social roles and the patient's citizenship behaviour in the maintenance of the commons of peace and security to the understanding of the coproduction in secure settings that are characterised by risk aversion, particularly the small instances of sharing of responsibility and the social roles that it engenders. How those roles are valued will be determined through relationships with other patients, staff ability to dynamically manage relational security between them and the impact of case note prejudice on their own actions. These personal and individual coproductions build and test trust and invite bounded reciprocity. That is, that the reciprocity exists in a time and place, is specific to the contributors and will only be extended or repeated if the dynamic risk to peace and security remains low. This process exists as part of the daily interactions between staff and patients and may not be recognised as contributing to coproduction. As such this study recognises the importance of cumulative reciprocities in building trust, and the establishment of transient autonomies in the roles that patients play, to maintain peace and security. While citizenship behaviour in excluded groups has been documented by Strokosch and Osborne (2016), this study adds a novel view on the interactions between staff and patients in secure mental health settings, particularly the reciprocity that would be recognised as *going the extra mile* in other circumstances, which appears central to creating the conditions for coproduction across secure conditions.

7.8.3 Use of affordances

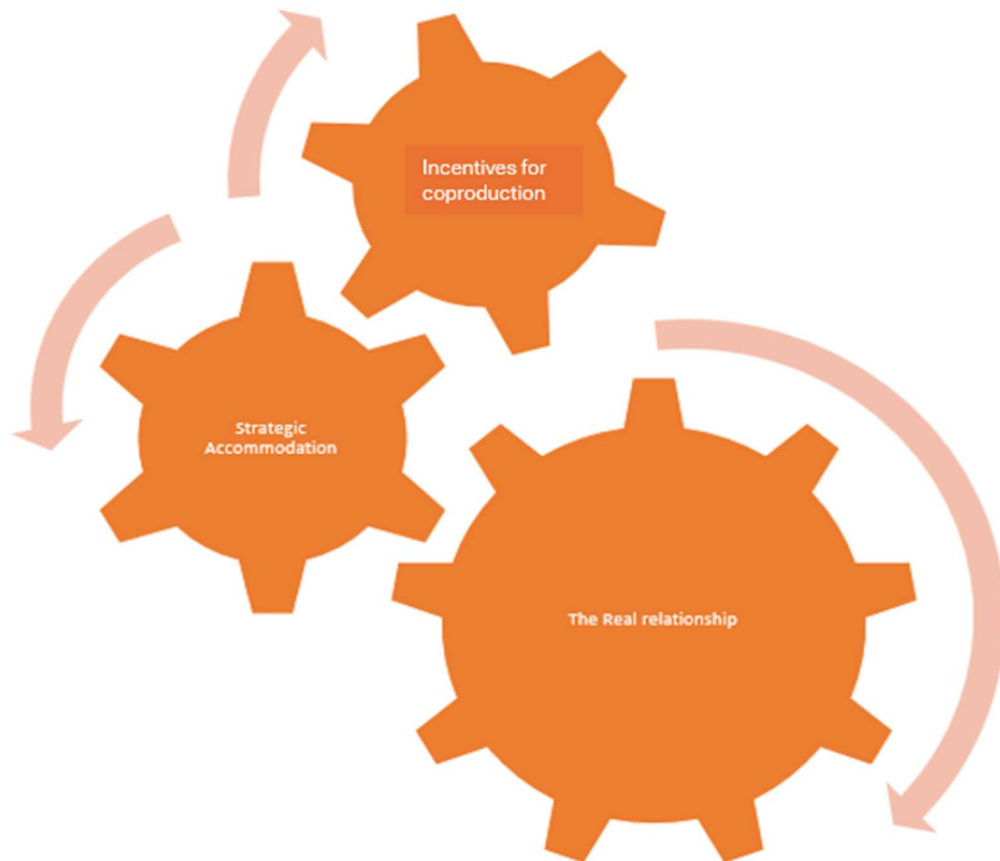
Penultimately, this study used Gibson's notion of affordances to understand the environmental and psychological conditions that support coproduction (Gibson, 1977) (6.3.2). Greeno (1994) describes Gibson's approach as conjoining the internal

and external psychological processes associated with interactions both with other people and spaces, and within the constraints associated with both. This study identified that off ward in the highest level of security afforded coproduction with fewer constraints for patients passing the behavioural gateway and greater opportunity for relational connection. On ward activity afforded greater degrees of constraint, formal relationships and the risk of disruption through new admissions. This affordance was mirrored in other sites but because the level of security and risk were lower, there appeared to be greater affordance for coproduction both in terms of the staff approach and the environment.

It was also notable that locations where greater degrees of interaction and reciprocity with staff were possible appeared to afford a greater likelihood of coproduction beyond peace and security. However, there was evidence of coproduction even on the highest security ward - in the creation of a simple and diverting game - such that the affordances relate to both staff approach and behaviour as much as to what the location and procedures allow.

Affordances therefore add a novel tool with which to understand the enablers and incentives for compliance, including an interaction with strategic accommodation, the constraints on coproduction, and the inter-relationship with the *real* relationship. This is described in the figure below:

Figure 22 Affordances for Coproduction



Strategic accommodation (Moore, 2009) in this context is accepting restrictions and rules in order to achieve another, more desirable goal. In this case the primary desirable goal is off ward activity, with a secondary collective goal of maintaining the commons of peace and security to achieve it. In this model the incentives for coproduction are achieving and maintaining the behaviour gateway to access both off ward activities and greater degrees of autonomy. The affordance in this case is what the constraints and conditions within the environment *allow*. That affordance is influenced by the real relationship that develops between patients and staff which is dependent on instances of reciprocity (shared moments or interests) which lead to a reduction in strategic accommodation, leading in turn to developing trust and the exchange of knowledge power (Bevir, 1999).

Staff behaviours - custodian or relationally oriented - are further affordances, with one affording safety through simple compliance and restriction and the other affording safety through building and maintaining relationships. This adds to current descriptions of coproduction by revealing how the physical and procedural environment in secure settings creates distinct affordances that shape staff orientation towards either custodian or relational approaches. While traditional portrayals of coproduction focus primarily on voluntary participation and shared power, this framework illuminates how environmental factors within highly controlled settings influence the possibilities for collaboration. By identifying specific affordances - such as ward stability, activity levels, and behavioural milestones - this study demonstrates that coproduction exists on a spectrum shaped by contextual factors rather than simply by institutional willingness. This ecological perspective enhances our understanding of how coproduction can emerge even within highly restrictive environments, challenging the binary view that coproduction either exists or does not exist in secure settings. This is a novel way of describing the forms of behaviour that are afforded in highest levels of security dependent on the affordances in the environment, such as admissions disruption, high activity or the achievement of the behavioural gateway.

In the next section I explore the theoretical contribution of *shared humanity* to the understanding of coproduction.

7.8.4 Shared Humanity as a Foundation for Therapeutic Engagement in Secure Settings

A recurring and significant theme throughout the findings is the fundamental importance of recognising and affirming shared humanity between staff and patients as a prerequisite for meaningful therapeutic engagement and coproductive practice. This finding resonates with Honneth's theory of recognition, which posits that human dignity and psychological wellbeing depend on being recognised by others as a person of worth (Anderson & Honneth, 2005; Honneth, 2004). In secure forensic mental health settings, where institutional processes can dehumanise both patients and staff, the deliberate cultivation of shared humanity emerges as both a therapeutic intervention and a foundation for coproductive practice.

The data reveals multiple ways in which shared humanity manifests within the constraints of secure care. Staff described using humour and *banter* as mechanisms for creating what Plester and Sayers (2007) term *temporary equality*, where hierarchical roles are momentarily suspended to allow authentic human connection. This aligns with Rodrigues and Collinson (1995) analysis of humour as a form of safe protest that can bring communities together while testing boundaries. As noted above humour at its most basic is also a demonstration of shared humanity when informal interactions acknowledge personhood beyond institutional roles.

The significance of this finding extends beyond mere interpersonal dynamics to fundamental questions about dignity in healthcare settings. Jacobson (2007) argues that human dignity in healthcare contexts requires recognition of persons as autonomous agents capable of reasoning and choice, rather than merely objects of medical intervention. The findings suggest that in secure settings, this recognition becomes both more challenging and more crucial, as the institutional context actively works to constrain autonomy and agency. Staff who successfully engage in

coproductive practices appear to find ways to acknowledge patient humanity while maintaining necessary security boundaries.

This theme connects to broader literature on therapeutic relationships in challenging contexts. Scanlon 's (2006) work on professional boundaries emphasises that authentic therapeutic relationships require workers to be *human* while maintaining appropriate professional distance. The findings suggest that in secure settings, this balance becomes particularly complex, with staff needing to demonstrate their own humanity in order to recognise and engage with patient humanity. The example of Jim connecting with a patient through shared interest in horse racing illustrates how acknowledging common interests and experiences can transform relationships from purely institutional to genuinely human encounters.

The recognition of shared humanity also appears central to what Miller (2015) describes as mutually empowering relationships where both parties are changed through the encounter. In secure forensic settings, this mutuality is necessarily constrained but remains evident in examples of patients protecting staff, staff adapting their approaches based on patient feedback, and collaborative approaches to managing difficult situations like restraint. These interactions suggest that even within coercive environments, spaces exist for recognition of fundamental human equality and mutual influence.

The findings also align with the capabilities approach described by Nussbaum (2007), which emphasises the importance of creating conditions where human capabilities can flourish. The progression through the *behavioural gateway* and *ladder of freedoms* can be understood as a systematic process of restoring opportunities for patients to exercise human capabilities - choice, relationship,

creativity, and contribution - that are necessarily restricted in secure care (Clark, 2005). Staff who facilitate this progression appear to understand their role as creating conditions for human flourishing rather than merely managing risk.

The theme also connects to literature on moral agency in constrained environments. Liebling and Arnold (2004) argue that even in highly controlled settings like prisons, maintaining moral agency requires recognition of personhood and opportunities for meaningful choice. The findings suggest that in secure mental health settings, coproduction depends on staff's ability to see patients as moral agents capable of contributing to their own care and the wellbeing of others, despite the constraints imposed by their legal status and clinical condition.

However, the data also reveals how institutional processes can undermine recognition of shared humanity. '*Case note prejudice*', where knowledge of historical offences creates barriers to present-focused relationships, represents a form of what Goffman (2009) describes as '*spoiled identity*' where past actions permanently define present possibilities. Staff who deliberately avoid reading case notes prior to meeting patients appear to be protecting space for recognition of current humanity rather than being defined by historical actions.

The significance of shared humanity in these findings challenges traditional models of professional practice that emphasise emotional distance and clinical objectivity. Instead, the data suggests that in secure settings, therapeutic effectiveness may depend on staff's ability to maintain what Noddings (2003) terms '*caring relations*' that acknowledge the fundamental humanity of all parties while working within necessary constraints. This requires what the findings suggest is a sophisticated

form of emotional intelligence that can hold both professional responsibility and human connection in productive tension.

In this study I have brought conceptualisations of motivation and incentives from the game theory literature, understandings of reciprocal behaviour described in the emerging literature on citizenship and the enabling environments and behaviours described in the affordance literature to gain a fuller understanding of the complex interactions common to secure care. This study therefore contributes a novel framework through which to understand and explain the environmental, relational and civic contributors to peace and security in restricted environments.

As the findings illustrate, the games that patients play test the rules and boundaries that apply to them. The games manifest in safe ways through banter, and in unsafe ways through recreational rioting by patients, or gunslinging by staff. By understanding the incentive value of passing through and maintaining the behavioural gateway, staff can better utilise safe games to create the conditions for mutual safety through reciprocity to encourage citizenship behaviour in patients and staff. It is also apparent that spaces that are closely governed by rules or have multiple sources of stimulation that are unpredictable or uncontrolled do not afford reciprocity. The spaces that do afford reciprocity also afford communal coproduction of peace and security. Coproduction in secure settings, across all levels of security, is better understood by also understanding the games that are afforded in particular spaces and the incentives that lead to citizenship behaviour by those that inhabit them.

In the next section I will explore the limitations of the approach taken to this study, and the implications of this analysis and discussion for research, policy and practice

and make recommendations for actions that can be taken within secure care to support coproduction.

7.9 Limitations

The literature review identified a significant gap in studies exploring coproduction in secure settings, particularly in contexts where citizenship rights such as free movement are restricted. While this study attempted to address this gap, several important limitations must be acknowledged.

This study adds additional complexity to a concept that risks becoming magical in nature (Pollitt & Hupe, 2011). In acknowledging this, the study provides a novel conceptualisation of coproduction in the very particular circumstances of secure mental health care, potentially enabling future quantitative studies to measure the experience of coproduction in more detail.

The study employed purposive sampling to reflect the composition of the workforce supporting patients. This approach creates a risk of overweighting stereotypes which may affect representativeness, typical with availability or convenience samples (Marshall & Rossman, 2011). However, as the wielders of considerable power, how participants view its release, and retention provides an essential understanding of coproduction in these circumstances. For example, both medium and low secure staff responses to vignette-based focus groups demonstrated their preference for subtle power in relationship building as a peace and security multiplier over the overt power of detention commonly represented in descriptions of high security.

Perhaps most crucially, significant security and ethical limitations affected recruitment to this study, meaning that there are no patient perspectives on the

forms of coproduction described. The original proposal to observe staff-patient practice was rejected by The State Hospital research ethics committee on the grounds that a non-clinical researcher could inadvertently put themselves, staff, or patients at risk. This decision affected access to patient views across all sites through the Forensic Network, West Research Ethics Committee (WREC), and the Dundrum Hospital REC. This limitation was unavoidable given the novel nature of the concept in these circumstances and the researcher's non-medical position within the system. The absence of patient voices means that the findings only represent staff interpretations of coproductive relationships rather than exploring the crucial full dynamic between service providers and users. This creates an additional hermeneutic layer - staff interpreting their understanding of patients' experiences, which are then interpreted by the researcher - that is inherently subjective and potentially incomplete.

Representation of key groups within the sample also constitutes a significant limitation. Social work perspectives are notably absent, reflecting the small numbers employed at each site, the demands upon their time and the subsequent inability to release them for this research. Despite efforts to include various professional groups, psychiatrists are also not represented in the focus groups, as all psychiatrists in the sample declined invitations to participate. Availability also affected participation from other professional groups, though their greater numbers at each site increased the likelihood of their balanced representation in the sample. These gaps mean that the sample cannot claim to represent all staff viewpoints within secure forensic services, though the multi-site approach helps mitigate this limitation somewhat by capturing broader perspectives across the security gradient.

Focus group limitations were also evident, with some staff reluctant to speak in a group setting. The mixed composition of senior and junior staff levels in the groups may have created an additional silencing effect. Individual interviews, where people could speak more freely, were used to balance this effect in the data. Site-specific constraints also presented additional limitations. Operational constraints prevented the use of a focus group at The State Hospital, which as a result restricted opportunities to observe group dynamics comparable to the other sites. Similarly, access restrictions at some of the sample sites prevented interviews with certain staff groups, particularly on-ward staff at high secure facilities. These limitations created inconsistencies in data collection methods across sites, potentially affecting the comparability of findings across the security levels.

The unique setting presented additional and particular challenges. As a member of administrative staff within The State Hospital, the researcher was well known to many participants, situated as both insider (staff member) and outsider (non-clinical). This created barriers with the TSHREC which declined the original proposal for patient involvement, affecting the subsequent decisions about access to the other study sites. This complication might not affect clinically-based researchers, though they might face different risks of over-rapport (Hammersley and Atkinson after Miller 1952) or understanding affordances through particular professional bounded rationality (Dwyer & Buckle, 2009). While the insider/outsider role was potentially disadvantageous within The State Hospital, it proved advantageous at other sites once access was granted. However, it presented initial challenges to data collection and comparison where sites had developed their own approaches to relational security.

While the inclusion of the Irish High Secure site was intended to provide a realistic comparator to The State Hospital, the cross-cultural comparison presented additional challenges. The differences in health systems, cultural contexts, and resource levels make direct comparisons challenging. Significantly the Irish service was not treating the most unwell patients in the system, who were treated as outreach patients in prison. This means that direct comparisons are problematic as the patient group in Ireland are inherently and comparatively more stable than that in The State Hospital. These differences in organisational history and patient stability must be considered when interpreting the findings comparatively. This was evident at the Irish site, despite an historical reliance on The State Hospital for security guidance.

This study's focus on formal, recognised coproduction practices rather than informal or covert forms of collaboration represents a final limitation. By concentrating primarily on official channels and recognised forms of coproduction, the research may have missed innovative but unrecognised collaborative practices occurring at the edges of formal care provision. Such informal coproduction might offer valuable insights into how staff and patients navigate power imbalances in secure settings as a matter of course rather than as part of a structured approach to coproduction.

Despite these limitations, this study contributes to the body of work on coproduction, particularly to the sparse literature on coproduction in secure conditions. Future studies would benefit from research teams combining both outsider and insider identities to negotiate security sensitivities while providing fresh perspectives on relationships and their contribution to peace and security commons.

The use of vignettes in this study is an example of how research methods can reveal unexpected insights about both the phenomenon under investigation and the nature

of professional practice itself. While the vignettes were intended to create theoretical detachment and enable staff to explore coproduction as independent observers, their actual function diverged significantly from this intention. Rather than promoting abstract discussion, the fictional scenarios consistently served as catalysts for participants to draw upon their concrete experiences with real patients, effectively collapsing the intended analytical distance.

This deviation from the intended method initially appeared problematic, suggesting that the vignette approach had failed to achieve its core purpose. However, this unexpected outcome proved illuminating, revealing that staff conceptualisation of coproduction is fundamentally experiential rather than theoretical. The participants' persistent return to actual cases suggests that their professional understanding of collaborative practice is inseparable from the specific relational contexts in which it occurs, challenging traditional assumptions about the utility of abstract scenarios in highly contextualised professional environments.

This finding highlights both a limitation and an insight: that while vignettes may be less effective in securing theoretical detachment in the coproduction of forensic mental health, they can reveal the deeply embedded, practice-based nature of professional knowledge. The methodology's *failure* therefore became a valuable data source, demonstrating that coproduction in secure settings cannot be meaningfully separated from the lived realities of specific therapeutic relationships and institutional contexts.

Several limitations relate to my formal position within forensic services in Scotland and my professional background. My dual role as both investigator and senior administrative staff member at The State Hospital is likely to have influenced the

collection of the data and the contributions by the people in the sample, despite reflexive efforts to acknowledge this influence in the analysis. Importantly participants may have tailored their responses based on the assumed prior knowledge and influence that I had or assumptions about the sorts of data that were being sought. This dynamic may have been particularly pronounced at The State Hospital, where established relationships and perceived organisational hierarchies could have affected participants' openness.

In addition, my professional background in addictions services rather than forensic mental health may have presented a barrier to my understanding of the particular approaches taken to forensic secure care outwith of The State Hospital. While this outsider perspective offered advantages in terms of fresh eyes and insight, it may also have created a blindness to nuanced care practices, security protocols, or institutional histories that would be apparent to those with forensic mental health experience. These knowledge gaps may have affected the nature of questioning in interviews, facilitation of the focus groups, and the interpretation of the findings.

The relationships that I had with key personnel in some of the sites and the supported access that they provided also potentially influenced how participants perceived the research and its importance. At Medium 2, for example, access was facilitated via a former colleague who was the clinic manager, and I discovered later that the Nurse Manager was a childhood friend of my wife. These personal connections, while facilitating access, may have influenced the participants' perceptions of the research's importance or the degree of institutional support for the investigation. Participants may have felt an increased pressure to participate or to present their institution in a particular, positively biased light due to these connections.

Analytical limitations also need to be acknowledged. While thematic analysis offers systematic procedures for identifying patterns, the field diary I used for sense-checking and reflection does not provide the same rigour as formal quantitative analyses or more robust forms of triangulation. The interpretative nature of qualitative analysis means that my views and understandings inevitably influenced the results as presented, despite my efforts to remain reflexive and critical throughout the analytical process. The absence of participant verification of the themes or co-analysis with other researchers potentially represents a missed opportunity for enhancing analytical rigour and operational responses to the findings.

The context and timing of data collection of this study present limitations on the wider application and relevance of the findings presented. Data collection occurred at specific points in time at each site, providing snapshots rather than a longitudinal understanding of how coproduction practices evolve over time. This temporal limitation is particularly relevant for the Irish site, which was undergoing significant transition during the study period and would ultimately transfer to a new location. The findings therefore represent coproduction challenges, solutions and practices at particular moments in time rather than representing stable, and enduring practices that others could subsequently investigate. The policy contexts in Scotland and Ireland also significantly shaped global expectations for patient involvement during the study period. These policies, which reflect particular national approaches to mental health care and security, form the backdrop against which coproduction was understood and enacted by participants. The findings should therefore be interpreted within these specific policy contexts rather than be assumed to represent universal approaches to coproduction in secure settings. The changes in policy direction since

the data were collected may also have altered the landscape for coproduction in ways that were not captured by this research.

While the inclusion of different security levels and organisational types were designed to strengthen the study, the selected sites represent only a small portion of secure forensic mental health provision available overall. The findings cannot be assumed to represent coproduction in all secure settings, particularly those operating under different legal frameworks, cultural contexts, or to directly apply to other care groups. The focus on Scottish and Irish settings may limit the findings transferability to other national contexts where different approaches to security, patient rights, and therapeutic relationships may exist. It is important to recognise the geographic and cultural specificity of the data when considering the broader implications of the research.

Despite these limitations, the multi-site, multi-method approach provides rich insights into how staff understand and navigate coproduction within the constraints of secure forensic mental health settings. This study's triangulation of different perspectives across varying professional roles, security levels, and national contexts strengthens the study's contribution to understanding this complex phenomenon.

Beyond these methodological limitations, this study's theoretical contributions must be modestly positioned given the constrained scope and specific context examined. The research examines four sites across two national contexts during particular historical moments, preventing claims about universal applicability of findings to other secure settings or user groups. The theoretical framework developed here may be highly context-specific, reflecting particular organisational cultures, national policy

frameworks, and historical legacies rather than transferable insights about coproduction in secure settings generally.

More critically, the study may inadvertently legitimise coercive practices by suggesting that meaningful coproduction can occur within fundamentally coercive relationships. By identifying small instances of reciprocity and collaboration within secure settings, the research risks providing theoretical cover for systems that maintain profound restrictions on human freedom while claiming to engage in coproductive practice. The 'dark side' of coproduction literature warns that collaborative rhetoric can mask the continuation of oppressive practices, and this study's findings may contribute to such masking by theorising cooperation within coercion as authentic coproduction.

The research also reveals systematic undervaluing of the relational security work undertaken by staff, who often lack adequate support for maintaining therapeutic approaches in challenging circumstances. However, the study's focus on identifying coproductive possibilities may pay insufficient attention to the structural and resource constraints that force staff into custodial orientations. By emphasising individual staff choices between custodial and relational approaches, the research may inadequately account for how institutional pressures and resource limitations constrain meaningful alternatives.

The developmental continuum model proposed in this study, while offering a framework for understanding progression toward coproduction, may oversimplify complex power dynamics by suggesting linear progression where none may exist. For example patients may engage in strategic accommodation indefinitely without ever progressing to authentic coproduction, and staff may cycle between custodial

and relational orientations based on immediate pressures rather than following developmental trajectories. The model's implications for practice may therefore be limited without accounting for these cyclical and context-dependent dynamics.

7.10 Recommendations

This section outlines the recommendations from this analysis of the data for policy, practice and research in secure mental health facilities. In the sections below I outline three key recommendations which would support a more coproductive relationship between staff and patients across gradients of security.

7.10.1 Recommendation 1: Rotating staff into wards/off ward positions

Firstly, the archetypes described in the findings, custodian and relationally orientated, are not static stereotypes. That is, dependent on the circumstances and experiences day by day a member of staff can find themselves working closer to one archetype than another and back again. The archetypes are therefore forms of behaviour at two ends of a spectrum across which staff will move dependent on the physical, psychological and social influences on their behaviour.

The first influence is ward stability. A more stable and calmer environment affords the possibility of reciprocity, an exchange of knowledge-power and builds the foundations for trust. To achieve that stability some consideration should be given to dedicated admissions areas that support new patients entering each facility to adjust to the restrictions within a unit or hospital. However, a dedicated admissions ward would be highly stressful for staff to work within (Mangaoil et al., 2023; Weltens et al., 2023), which risks burnout and both the establishment and transmission of

custodian behaviours. Staff should therefore be rotated into admissions, continuing care and off ward in high secure sites. In the highest level of security this could be achieved by ensuring that staff follow the people they support through their behaviour gateway into off ward projects or leaves to visit potential medium security placements. This would allow them to experience the patient away from the intensity of the ward, to develop a differently situated relationship, which could then support on ward peace and security through relationships.

In the lower levels of security there is no distinction between on and off ward staff such that this recommendation would not be necessary in those sites. However, it would support admissions from higher security for ward staff to spend time in that environment with the supported person as part of their step-down induction. This would ensure that there was an existing relationship in the new environment from which to further build coproduction.

In addition to this practical and immediate recommendation, policy should be developed to address the systemic differences observed between forensic mental health settings. In the Irish site, the historical primacy of care and treatment (HSE Ireland, 2024), as noted, promotes reciprocity and as a consequence Ostrom's triptych of trust, reciprocity and autonomy. This creates environments where coproduction emerges naturally from staff-patient interactions. Conversely, in The State Hospital, the emphasis on public protection, peace and security, combined with a patient population with more acute needs, establishes psychological and social barriers to implementing Ostrom's framework effectively. Policy should therefore focus on rebalancing these priorities in Scottish settings without compromising security, potentially through structured opportunities for relational security development, dedicated spaces for therapeutic engagement separate from ward

environments, and progressive training programmes that emphasise both relational security and recovery-oriented approaches. Cross-national knowledge exchange between these systems could facilitate the identification of transferable practices that maintain security while fostering the conditions necessary for meaningful coproduction.

7.10.2 Recommendation 2: Managing culture and exploring the costs and benefits of 'teamness'

While recommendation 1 would support staff to orient themselves towards a safe relationship based on a different experience of the patient as the staff that follow them off ward, it is unlikely to have an impact on the existing psychological needs for teamness culture for on ward staff (Glaser et al., 2004; Tilden et al., 2016).

Addressing cultures that lean toward custodianism as the primary response to risk management would need to address several issues. Firstly, understanding that being safe for staff means being with people they know and trust in each context because they rely on their team to ensure that they are kept safe and protected when a violent incident occurs. That can be the glue that holds a team together, but it can also result in forms of trauma bonding attachment (Dutton & Painter, 1993; Reid et al., 2013). That is, the paradoxical attachment between an abusive person and the person they abuse but, in this case, it is an unhealthy reliance on the stability of the team that shares a common experience of trauma from a violent incident. This experience appears in the data as a mechanism to maintain the predominant, custodian-oriented culture in the highest levels of security. Teamness in these circumstances needs to be better understood so that any changes such as cycling

staff off ward in recommendation 1 does not lose any of the currently hidden benefits associated with it.

7.10.3 Recommendation 3: Dynamic risk and monitoring case note prejudice

The influence of case notes on the actions of staff appeared to be a key factor in this sample of staff across the levels of security. It is understandable to want to know about historical risks to be prepared for and to understand the potential dangers of working with certain people. However, to manage anchoring and availability bias, and to ensure that supported people are not at risk of prejudicial approaches to their treatment, a greater emphasis in policy and practice should be placed on developing dynamic risk assessments *with* the patient, to varying degrees, across the levels of security. The therapeutic approach to minimising violence and aggression described in the Medium Secure 2 site is a prime example of dynamic and coproduced risk management supporting both staff and patients to manage incidents safely, to conclude swiftly and to progressively work towards eliminating violence in that patients' experience of the world.

While dynamic risk assessments are currently in place across the forensic network in Scotland, with the HCR 20 structured clinical judgement tool being the most prominent (Douglas, 2004), they are completed by professionals about the patient rather than with them, and their field validity is disputed (de Ruiter et al., 2020; Silva, 2020). National guidance and policy on developing and applying dynamic risk structured decision tools that engage patients as well as professionals, supporting the Millan principles, should also be developed as an approach to managing violence in secure conditions and as the evidence-based mechanism for reducing future

violence. This approach would also meet the Millan principles to include supported people in all decisions about the design of their care, including how they can coproduce their own de-escalation, restraint and recovery plans. That guidance should also address how staff are supported post restraint, on those occasions where dynamic risk management has not been successful, to recover as a relationally focussed professional and not a custodian. This is an important precursor to prevent the transmission of custodian culture into teams and teamness for staff that feel unsupported or under threat as well as feeling a need to revert to rules for comfort and security over relationships. Both are necessary for safety but, as this study suggests, relationships create greater opportunities for harmony, peace and security.

In addition, while clinical supervision is promoted across the NHS, the application of its principles across nursing are patchy and the narrative of universal access to it is contested by nurses themselves (RCN, 2022). During the COVID 19 pandemic the demand on the NHS and on nurses across the NHS increased dramatically which has had an impact on recruitment and retention (Farahani et al., 2024) and a fall in the resources available to support both reflective practice and clinical supervision (Martin et al., 2022). This should be addressed as evidence from this study suggests that reflective practice and clinical supervision combined may have a significant impact on the development of the custodian type behaviours described and should be provided as a matter of course to all secure care staff. This recommendation has concomitant resource implications: in order to release staff from wards sufficient cover must be provided to do so safely. The staff to patient ratios commonly applied in the forensic network should also be reviewed to ensure that there is sufficient staff

available on ward to allow nurses to follow patients off ward whilst not placing the remaining staff at risk of developing custodian behaviours.

7.10.4 Future Research: Addressing Methodological and Theoretical Gaps

The limitations identified in this study point toward several critical research directions that must address both methodological gaps and theoretical tensions revealed by this work. Most fundamentally, future research must prioritise patient perspectives on coproduction in secure settings, not merely to complete the picture begun here but to critically examine whether staff interpretations of coproductive interactions align with patient experiences of meaningful collaboration. Such research could explore how patients understand and navigate the strategic games identified in this study, whether they experience staff attempts at relational engagement as authentic or as sophisticated forms of control, and what conditions would enable patients to move beyond strategic accommodation toward genuine participation in service design and delivery.

Research could also critically examine the boundaries between cooperation and coproduction in coercive contexts, developing more precise theoretical frameworks for distinguishing meaningful collaboration from adaptive compliance. This may include longitudinal studies that track patient and staff interactions over extended periods, examining whether apparent coproductive moments represent genuine shifts in power dynamics or temporary accommodations within unchanged institutional structures. Such research should draw more critically on the 'dark side' of coproduction literature to examine how collaborative rhetoric may legitimise continued restrictions on patient autonomy.

Comparative research across different secure settings and jurisdictions could also examine how national policy frameworks, organisational cultures, and historical legacies shape the possibilities for coproduction. However, such research designs may wish to avoid assuming universal applicability of findings, instead developing theoretical frameworks that account for contextual specificity while identifying transferable principles. Research could also examine how different professional groups conceptualise and practice coproduction, addressing the gaps in social work and psychiatric perspectives identified in this study.

The relationship between risk management and coproduction requires more critical examination, particularly exploring whether current risk assessment frameworks are compatible with authentic power-sharing or whether they constitute fundamental barriers to meaningful collaboration. Research could examine how patients experience current risk assessment processes and explore alternative approaches that might enable greater participation without compromising safety.

Future research might extend this analysis by applying Trischler and Trischler's (2022) ecosystem framework, examining how the organisational-level practices identified here interact with broader system dynamics, institutional arrangements, and the multiple actors involved in patients' recovery journeys.

Finally, research could address the ethical implications of theorising coproduction in coercive settings, examining whether such theoretical development serves to legitimise oppressive practices or genuinely advances coproduction. This requires engagement with critical disability studies, survivor research traditions, and broader debates about the ethics of psychiatric detention to ensure that coproduction

research serves liberation rather than legitimisation of coercive mental health systems.

7.11 Conclusion

This study has examined coproduction across secure mental health settings in Scotland and Ireland, developing a distinct theoretical understanding of coproduction as a dynamic, contextual process existing along a continuum within highly restrictive environments. Rather than viewing coproduction through the narrow lens of service design or tangible outputs, this research reveals coproduction as a process of interactions that contribute to shared outcomes such as peace and security. This perspective challenges Pilgrim's (2018) assertion that coproduction is impossible in secure settings due to restrictions to liberty and citizenship rights.

The findings demonstrate that while patients in secure forensic mental health settings experience significant constraints on their freedoms, they nonetheless exercise forms of citizenship that support meaningful participation in coproductive relationships. This form of citizenship, aligned with MacIntyre et al.'s (2022) definition emphasising relationship building, autonomy, shared values, and civic responsibilities, manifests through small acts of reciprocity and organisational citizenship behaviours. These behaviours represent citizenship exercised through relational connections rather than functional and formal rights.

The research identifies a developmental continuum ranging from compliance through strategic accommodation and cooperation to authentic coproduction. At one end, compliance represents extrinsically motivated adherence to rules primarily to access privileges or progress toward lower security levels. Moving along the continuum,

strategic accommodation emerges as patients selectively comply while testing boundaries. Further along, cooperation develops as staff and patients recognise their mutual interest in maintaining peace and security. True coproduction appears at the far end, characterised by Ostrom's triptych of trust, reciprocity, and autonomy, where patients and staff develop conditional relationships beyond compliance to create intrinsically motivated contributions to shared outcomes.

This progression depends on context. Off-ward environments and lower security settings appear more conducive to movement toward the coproduction end of the spectrum. Staff conceptualisation of patient behaviour - whether interpreting compliance as manipulation or genuine engagement - influences where interactions fall on this continuum, with relationally oriented staff more likely to recognise and foster movement toward authentic coproduction, even within security constraints.

Central to this study's theoretical contribution is the identification of Ostrom's triptych operating in modified forms across the security gradient. Trust in secure settings manifests as conditional and situated rather than absolute, varying significantly between on-ward and off-ward environments, with greater trust emerging when patients have passed through their behavioural gateways. Reciprocity emerges through small, often unrecognised exchanges that build foundations for potentially more substantial collaboration, such as sharing limited personal information or acknowledging shared interests. Autonomy, while significantly constrained by security requirements, appears in limited forms enabling patients to exercise meaningful choice within restrictions, from withdrawing to personal spaces to participating in designing de-escalation plans.

Environments appear to significantly influence the potential for coproduction.

Physical architecture designed primarily for observation rather than interaction creates barriers, while a lack of withdrawal spaces affects the psychological safety needed for authentic relationship. Off-ward spaces consistently afford greater possibilities for reciprocity, being associated with rehabilitation rather than detention. These environmental factors extend beyond the physical characteristics to include the psychological associations: wards become associated with unpredictability and potential conflict, while off-ward spaces symbolise progression and conditional trust, creating different affordances for coproductive interactions.

The orientation of staff has important impacts on the potential for coproduction. The research identifies two primary orientations: custodian and relationally close; that significantly influence patient interactions. Custodians tend to prioritise procedural and physical security, tending to view relational engagement as potentially risky. Relationally close staff tend to prioritise therapeutic relationships while maintaining dynamic risk assessment skills, viewing connections as enhancing rather than undermining safety. These orientations are not fixed personality traits but responsive positions that staff adopt based on environmental conditions, cultural influences, and personal experiences. A concerning pattern emerges where relationally oriented staff tend to self-select for off-ward positions and as a consequence, but inadvertently, reinforce custodian cultures on wards where relational approaches may be most needed.

The study reveals that teamness - the cohesive sense of mutual protection among staff - creates both benefits and potential barriers to coproduction. In high-risk environments, teamness provides necessary psychological safety but may reinforce a custodian orientation influenced by societal views of patients, personal

experiences, and cognitive biases. Several cognitive biases influence staff perceptions, particularly regarding risk assessment. Anchoring bias risks staff giving a disproportionate weight to historical risk factors documented in case notes, while availability bias risks emphasising recent incidents over longer-term stability patterns.

The research makes significant theoretical contributions through its novel application of game theory to understand coproduction in secure settings. By conceptualising staff-patient interactions as repeated games, the research shines a light on why cooperation might emerge even in environments with pronounced power imbalances. The identification of Nash equilibria provides a useful framework for understanding how stable, mutually beneficial relationships develop within significant security constraints, which should be explored in other settings. Affordance theory further enhances the theoretical framework by illuminating how physical environments alongside interpersonal dynamics support the coproduction of peace and security.

The research findings have practical implications for secure forensic mental health services. They suggest that rotating staff between ward and off-ward positions could break down a cultural tendency towards custodianism by providing a different perspective of the patient. The findings highlight the importance of addressing teamness dynamics that may reinforce custodian cultures while recognising the protective benefits of team cohesion. This can also be addressed by reviewing the risk management process to engage with patients in actively designing dynamic risk assessments and providing both training and support to manage case note prejudice. In addition, the findings underscore the importance of reflective practice

and clinical supervision in helping staff maintain relational orientations despite exposure to potentially traumatic incidents.

Future research should address the absence of patient perspectives by exploring how patients understand and experience coproduction within secure settings. The limited representation of certain professional groups represents another limitation future studies should address. Research should also explore how coproduction manifests in other secure settings, including women's services, youth forensic services, and cross-cultural comparisons beyond the Scottish and Irish contexts examined here.

This study reveals that coproduction in secure settings emerges through countless small interactions between staff and patients, often unrecognised and undocumented, creating the foundations for peace and security that benefit everyone within the system. The challenge for secure services is to create conditions where staff can safely maintain relational approaches despite the real risks they face, requiring systematic attention to environmental design, staffing patterns, reflective support, and cultural dynamics that enable or constrain the potential for coproduction. Most importantly, it requires recognition that relationships themselves constitute a powerful form of security, complementing rather than contradicting physical and procedural security.

This study began with an observation of staff who appeared to be protected from assault through the quality of their relationships with patients. It concludes with a deeper understanding of the complex and dynamic risk management undertaken by staff who are often undervalued and under-supported. It is important to note that the custodian orientation emerges not as a freely chosen approach but as an adaptive

response to consistent exposure to threat without adequate support for maintaining relational skills.

Appendices

Appendix 1: Consent form



Consent Form

Name of department: The School of Social Work and Social Policy

Title of the study: Co-production in compulsory mental health environments

- I confirm that I have read and understood the information sheet for the above project and the researcher has answered any queries to my satisfaction.
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, without having to give a reason and without any consequences.
- I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.

- **I consent to audio and video recordings being made of the proposed workshops (please initial)**

(PRINT NAME)	
Signature of Participant:	Date



Participant Information Sheet

Name of department: The School of Applied Social Sciences

Title of the study: Co-production in compulsory mental health environments.

Introduction

I am Frank Reilly, and I am an MPhil student with the University of Strathclyde doing research as part of my degree.

If you want to talk to me about this project or you are unsure about anything, please contact me using the details at the end of this information sheet and I will arrange to meet with you as soon as I can.

What is the purpose of this study?

I am interested in an approach to working with patients called co-production. I want to work with a group of professionals currently working with patients in low secure environments to explore the skills required for this approach in this setting and the training required to support it.

Do you have to take part?

No, you should only take part if you want to. Choosing not to take part will not count against you in any way. If you decide to take part, you will be given this information sheet to keep and asked to sign a consent form. You can withdraw at any time and without giving a reason.

What will you do in the project?

If you decide to take part in the study, I will arrange a time to meet with you to undertake a semi-structured interview lasting a maximum of 60 minutes

Why have you been invited to take part?

You have been chosen to participate because of your knowledge and experience of recovery approaches in secure settings.

What are the potential risks to you in taking part?

Taking part will involve reading this information leaflet, attending the workshops and allowing me to interview you. Although there are (high/medium/low) secure mental health facilities in most boards in Scotland there is a potential for the location to be identified in any report leading from the research. I am hoping to be able to publish the results of the study in an

academic journal because I think the results may be useful to others. If this happens there is a potential that the location of your facility may be identifiable

As the information from interviews will be aggregated, I don't believe that any participants will be identifiable from their responses. However, I cannot guarantee absolute confidentiality given the relative uniqueness of your facility.

I do not think there are any other risks to taking part in the study

What happens to the information in the project?

The notes that I take will not use your name. I'll create aliases for you so that I can keep track of my notes and recordings. Any paper notes I take, and all recordings will then be transferred on to a secure computer in The State Hospital and stored in an encrypted folder (that's one that needs a password to open it). Only I and my supervisors (Dr. Gillian MacIntyre and Ailsa Stewart) will have access to this file. Once the project is complete and the report written and given to you and the others that helped create it, I will wait for three years and then delete all of the computer files. I need to wait for this time in case there are any questions which examiners might have about the information I have used.

The University of Strathclyde is registered with the Information Commissioner's Office who implements the Data Protection Act 1998. All personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

Thank you for reading this information – please ask any questions if you are unsure about what is written here.

What happens next?

If you are happy to be involved in the project, please sign the consent form at the bottom of this form.

If you do not want to be involved in the project, then thank you for taking the time to read this.

Once the project is completed, I will come back and talk about the results and give a summary of the final report to everyone who participated. I am also hoping to publish the results of the study.

Researcher Contact Details:

If you wish to talk to me about anything please do so using the details below. If you have any concerns, you can also contact my academic supervisor directly using the details below.

Frank Reilly
The State Hospitals NHS Board
Lampitts Road
Carstairs
Lanark ML11 8RP
Tel: 01555 842071
Email: frank.reilly@nhs.net

Supervisor Details:

My supervisor is:
Dr Gillian Macintyre

HaSS (Humanities and Social Sciences)
Lord Hope Building
St James Road
Glasgow
Tel: +44 (0)141 444 8647

This investigation was granted ethical approval by the ethics committee of the School of Applied Social Sciences at the University of Strathclyde.

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Laura Steckley
Convener, Ethics Committee for the School of Applied Social Sciences
University of Strathclyde
Floor 6, Lord Hope
Building
141 St. James Road
Glasgow
G4 0LT

Telephone: 0141 444 8654

Email: Laura.L.Steckley@strath.ac.uk

Appendix 3 Interview Guide

Introduction

As you know I am Frank Reilly, and I am undertaking research on the challenges to adopting a co-productive approach in low secure mental health settings. I sent you an information sheet before this interview which outlines the process for the interview and its analysis as well as the difficulties in ensuring absolute confidentiality in a small sample – which this is. It also mentioned that I am transcribing and analysing the interviews myself, and that I will provide you and the rest of the team with a report once the research is completed. Is there anything you want to ask me about the information sheet? Are you happy to continue? Can we begin with telling me why you decided to work in secure mental health services?

Main question	Prompts/Follow-up	Notes
1 Can you describe for me a typical day as a worker in this facility?		
2 How much do you know about co-production?		
3 Being co-productive suggests the exchange of power and trust between professionals and patients/clients to establish more 'human' partnerships between staff and patients. Can you tell me how you feel about that concept?		
4. What do you think would support this approach in your facility		
5. Can you describe for me the sorts of barriers that might make this approach difficult?		
Why do you think that is the case?		
6. What do you think would make taking this approach more challenging here?		

Appendix 4: Vignettes

Case Study 1

Thomas (24)

Thomas has a history of violent offences beginning in early adolescence. He was referred to secure care aged 14. When he left care aged 18, he was almost immediately convicted of grievous bodily harm but because of the circumstances (category 3) was given a 3-year sentence and was released having served 18 months.

Whilst in custody Thomas was diagnosed with a mild learning disability and had further investigations for schizophrenia. 12 months after his release he was arrested for a serious assault on a neighbour. He was transferred on detention due to his rapidly deteriorating mental health to The State Hospital. He was directed to be detained for treatment after a plea of not guilty by reason of insanity was accepted.

Thomas' assessment period with the hospital was punctuated by violence towards staff and other patients and he was nursed in seclusion for the first 4 weeks.

Over the coming year Thomas was diagnosed as suffering from schizophrenia with command hallucinations being a key feature. This has stabilised by a combination of 'hearing voices' interventions and medication.

After a period of consolidation Thomas was assessed as appropriate for low secure services. On transfer he became unsettled for a period, edgy and unpredictable. He has now been with your service for 4 weeks.

Thomas has a range of interests including football, fitness, and poker.

Case Study 2

Jenny (34)

Jenny was apprehended by security guards for shoplifting. In the process of being detained she assaulted another shopper and two guards before the police arrived to arrest her. A court directed assessment suggested a diagnosis of schizophrenia and borderline personality disorder. A treatment order has resulted in her referral to your establishment.

During her initial admission and assessment period Jenny was frequently verbally aggressive and abusive to staff and other patients. Although instances have reduced dramatically, she is still judged to be at risk of displaying this sort of behaviour with little obvious provocation.

Jenny is single with no living relatives. At the end of her assessment period, she disclosed that she had been abused by her father over a significant period before his death.

Jenny has previously spoken of walking as a particular interest and has indicated that she is keen to learn how to knit but at present her access to 'tool's is limited.

Case Study 3

Gerry (65)

At 18 Gerry became a specified person after murdering and dismembering his girlfriend after a row. He was diagnosed with schizophrenia and was treated by The State Hospital for 35 years. After many years of talking therapies and clozapine treatment Gerry was referred to medium secure services and then to low secure.

Although his overall risk has reduced Gerry has become very institutionalised and hasn't coped well with his transfers.

Gerry has a very keen interest in football, but years of inactivity and the impact of medication has led him to become morbidly obese and has many physical health problems as a result.

Appendix 5 Focus Group Prompts

Focus Group Prompts

What are the risks for this patient?

What are the 'hard' boundaries?

What 'flexibility' might be possible with this patient?

How would you begin to build a relationship with this patient?

What else would you need to know?

How would you involve this patient in designing their care?

Who does this case remind you of? (to connect to previous knowledge)

What strengths do you have with this type of client?

What do you find difficult when working alongside them?

How do you imagine the patient is predominantly feeling at this time?

Appendix 6: Literature Review Data Capture Tool

LITERATURE REVIEW DATA CAPTURE TOOL

Reference									
Abstract									
CASP	1. Was there a clear statement of the aims of the research? ☐ Yes ☐ No ☐ Can't Tell 2. Is a qualitative methodology appropriate? ☐ Yes ☐ No ☐ Can't Tell 3. Was the research design appropriate to address the aims of the research? ☐ Yes ☐ No ☐ Can't Tell 4. Was the recruitment strategy appropriate to the aims of the research? ☐ Yes ☐ No ☐ Can't Tell 5. Was the data collected in a way that addressed the research issue? ☐ Yes ☐ No ☐ Can't Tell 6. Has the relationship between researcher and participants been adequately considered? ☐ Yes ☐ No ☐ Can't Tell 7. Have ethical issues been taken into consideration? ☐ Yes ☐ No ☐ Can't Tell 8. Was the data analysis sufficiently rigorous? ☐ Yes ☐ No ☐ Can't Tell 9. Is there a clear statement of findings? ☐ Yes ☐ No ☐ Can't Tell 10. How valuable is the research? ☐ Yes ☐ No ☐ Can't Tell								
	APPRAISAL SUMMARY: <i>List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Positive/Methodologically sound</th> <th style="width: 33%;">Negative/Relatively poor methodology</th> <th style="width: 33%;">Unknowns</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"></td> <td></td> <td></td> </tr> </tbody> </table>			Positive/Methodologically sound	Negative/Relatively poor methodology	Unknowns			
Positive/Methodologically sound	Negative/Relatively poor methodology	Unknowns							
Key Points									
Contribution to the subject:									
Relationships to other theories/approaches									

Contradictions	
Gaps	
Inconsistencies	
Reasoning	
Does it extend the theory?	
References	

Appendix 7 Literature Review Recording sheet

Reference	A	B	C	D	E	F	G	H
Reference		Conceptual/Theoretical	Snowball?	Methods	Sample	Pros	Cons	
1	Adinolfi, P., Starace, F., & Palumbo, R. (2016). Health Outcomes and Patient Empowerment: The Case of Health Budgets in Italy. <i>Journal of Health Management</i> , 18(1), 117-133. https://doi.org/10.1177/0972063415625324	1		Italian health budget methodology: not a research project. Intention is to integrate health and social care AND to empower patients. Main interest is 'housing and social habitat', 'vocational training and work', 'social inclusion'. HoNoS primary method. Perception of the quality of service measures using in interviews. Comparisons were between traditionally offered service costs and the health budget initiative	43 patients. 29(67.4) male. Mean age 58.7 $\pm$ 42. Schizophrenia predominant diagnosis with long term hospitalisation. 74.4% in state and 14% in private institutions for an average of 30.3 years (median 32). 35 patients treated with high, 6 with medium and 2 with low rehab plan	Comprehensive. Pedagogic nature of the support	Limited patient population included	
2	Akol, A., Moland, K. M., Babinye, J. N., & Egebreetsen, I. M. S. (2018). "We are like co-wives": Traditional healers' views on collaborating with the formal Child and Adolescent Mental Health System in Uganda. <i>BMC health services research</i> , 18(1), 258.	1		In-depth interviews with 20 purposively selected traditional healers were conducted in November 2015. A semi-structured interview guide was used to explore: 1) The experiences of traditional healers with mental ill-health in children and adolescents; 2) their willingness to collaborate with the formal health system; and 3) their perception of clinicians' willingness to collaborate with them. Interviews were conducted in local languages and tape recorded. Data were analysed using thematic analysis		The use of a purposive sample of traditional healers with CAMH experiences provides experience-based views.	Initiators' views were not sought to validate traditional healers' impressions. translation of interviews into English during transcription could have introduced a bias resulting from the coder's and transcriber's own interpretation of the data;	
3	Alm-Andreassen, T. (2018). From Democratic Consultation to User-employment: Shifting Institutional Embedding of Citizen Involvement in Health and Social Care. <i>Journal of Social Policy</i> , 47(1), 99-117. https://doi.org/10.1017/S0047279417000228	1		Synthesis of existing studies building theory. Within case analysis and cross case pattern searching	Mainly UK based studies	Comprehensive development of theory	UK studies may not be representative of other policies	
4	Annamma, C., & Palumbo, R. (2016). Contextualizing	1		Sample trained and tested one month later and	Non rep sample of 40 health	Demonstrates the	Not representative. No	

Appendix 8: Table of Organising Stories

Theme	RQ1: How do rules-based environments affect coproduction?	RQ2: How do staff conceptualise coproduction?	RQ3: What enables/inhibits coproduction?
The Behavioural Gateway	Rules create threshold system where compliance enables access to less restrictive environments. Gateway represents transition from rule-dominated to relationship-based interactions. Rules initially constrain but ultimately enable progression toward coproduction.	Staff conceptualise coproduction as graduated process requiring demonstrated behavioural stability before collaborative approaches possible. Gateway seen as necessary safety mechanism and therapeutic tool.	Enabler: Creates incentive structure for engagement and pathway to environments where coproduction flourishes. Inhibitor: Can become barrier if criteria unclear or applied inflexibly, leading to patient frustration and strategic accommodation.
Staff Archetypes	Rules-based environments produce different staff responses: Custodians embrace rules for safety; Relationally Close staff use rules flexibly; Malicious Custodians manipulate rules for control. Environmental rules shape which archetype dominates.	Relationally Close staff see coproduction as therapeutic tool requiring skilled relationship management. Custodians view it as risky departure from safe procedures. Malicious Custodians see it as threat to their authority.	Enabler: Relationally Close staff skilled in balancing rules with therapeutic engagement. Inhibitor: Custodian dominance in rule-heavy environments; Malicious Custodian resistance to collaborative approaches; Staff self-selection away from challenging environments.

Environmental Affordances	Different environments create different rule applications: On-ward rules focus on containment and control; Off-ward rules enable normalised interactions and relationship building. Physical space shapes rule interpretation and application.	Staff understand coproduction as environment-dependent - easier off-ward where rules less visible and restrictive. See environmental progression as enabling increasing collaboration.	Enabler: Off-ward environments with reduced rule visibility and normalised interactions. Inhibitor: On-ward constraints, particularly in high security; Unpredictable admissions disrupting relational work; Physical space limitations.
Trust Development	Rules initially prevent trust through emphasis on suspicion and control. However, consistent rule application can build predictability that enables conditional trust. Trust emerges despite, not because of, rule-based environments.	Staff see trust as prerequisite for coproduction but recognise security constraints limit its development. Conceptualise trust as earned through compliance and demonstrated over time.	Enabler: Consistent, transparent rule application; Staff authenticity within boundaries; Graduated freedoms that test and build trust. Inhibitor: Arbitrary rule application; Staff fear of manipulation; Historical incidents reinforcing suspicion.
Reciprocity	Rules traditionally prevent reciprocity by maintaining power imbalances. However, off-ward environments allow rule relaxation that enables mutual engagement and shared responsibility.	Staff conceptualise reciprocity as patients taking responsibility for their environment and others' safety. See it as sign of therapeutic progress and indicator of readiness for increased freedoms.	Enabler: Shared responsibility for maintaining privileges; "Garden privilege" allowing informal interactions; Activities suspending traditional hierarchies. Inhibitor: Power imbalances inherent in secure settings; Staff fear of boundary violations; Institutional policies preventing reciprocal relationships.

Security vs. Therapeutic Focus	Fundamental tension where security rules can dominate therapeutic goals. Rules designed for safety may inhibit therapeutic relationships. Balance shifts as patients progress through security levels.	Staff conceptualise this as ongoing tension requiring professional skill to navigate. Some see security and therapy as incompatible; others see security as prerequisite for therapy.	Enabler: Skilled staff who balance both demands; Environmental progression reducing security emphasis; Leadership supporting therapeutic approaches. Inhibitor: Historical incidents reinforcing security focus; Risk-averse cultures; Conflicting professional demands.
Cultural Divisions	Rules create different professional identities: Ward staff as rule enforcers, off-ward staff as relationship builders. Rule-based environments produce "two tribes" mentality with different values and approaches.	On-ward staff conceptualise coproduction as risky or impossible; Off-ward staff see it as natural therapeutic approach. Cultural divisions create conflicting conceptualisations within same organisation.	Enabler: Off-ward cultures valuing collaboration; Leadership bridging cultural divides; Successful examples of coproductive practice. Inhibitor: Professional tribalism; Conflicting values between groups; Resistance to culture change; Historical incidents becoming cultural mythology.
Empathy and Professional Boundaries	Rules can inhibit empathetic responses by emphasising emotional distance and professional boundaries. However, some rules protect both staff and patients from inappropriate relationships.	Staff conceptualise empathy as essential for coproduction but requiring careful management within professional boundaries. See tension between authentic relationships and professional requirements.	Enabler: Supervision supporting empathetic engagement; Clear but flexible boundaries; Staff selection and training emphasising relational skills. Inhibitor: Case note prejudice; Emotional depletion from violence exposure; Fear of boundary violations; Lack of reflective practice opportunities.

Innovation and Cultural Change	Rules can inhibit innovation by creating risk-averse cultures focused on compliance over therapeutic outcomes. However, rule frameworks can also enable safe innovation when supportively applied.	Staff conceptualise innovation as necessary but risky. See tension between maintaining safety and enabling therapeutic progress. Some embrace change; others resist as threatening established safety.	Enabler: Leadership supporting therapeutic innovation; Graduated approach to change; Staff training and support; Evidence of positive outcomes. Inhibitor: Historical incidents creating change resistance; Risk-averse institutional cultures; Staff anxiety about new approaches; External scrutiny limiting innovation.
Progressive Freedoms	Rules become less restrictive as patients demonstrate compliance and stability. "Ladder of freedoms" shows how rule-based environments can enable rather than inhibit coproduction through graduated progression.	Staff conceptualise coproduction as outcome of progressive freedoms rather than starting point. See graduated approach as safely enabling increasing collaboration.	Enabler: Clear progression pathways; Meaningful incentives for engagement; Environmental transitions enabling new relationships. Inhibitor: Unclear progression criteria; Arbitrary removal of freedoms; Lack of meaningful activities to progress toward.
Coproduction Potential	Rules-based environments constrain but don't eliminate coproduction. Traditional rule applications inhibit collaboration, but flexible rule interpretation enables partnership within safety constraints.	Staff conceptualise coproduction as possible but requiring different approach from community settings. See it as outcome of successful relationship building rather than starting assumption.	Enabler: Skilled staff balancing security with therapy; Environmental progression; Meaningful activities enabling collaboration; Supportive leadership. Inhibitor: Rigid rule interpretation; Cultural resistance; Historical incidents; Resource constraints limiting relational work opportunities.

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