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Relationships between Mental Health Services and Faith Communities: A Co-Produced Grounded Theory Study

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and Faith Communities:

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Abstract

Despite demand outstripping provision, mental health services rarely collaborate with faith communities. Their practice contrasts with growing evidence that religious adherence improves resilience and promotes recovery. This thesis examined whether stakeholders wished closer cooperation.

Thirty participants, most from North-West England, were interviewed in five equally sized groups. Service users, carers, and staff were sampled for diverse world views. Faith community leaders and faith-based organization leaders also took part. The research, using semi-structured grounded theory interviews, produced three main conclusions. (1) Almost all participants welcomed faith community involvement. (2) They suggested that mental health services and faith communities offered something distinct and rooted in their fact–value complementarity. (3) The interviewees considered safeguarding and mental health promotion fruitful topics for collaboration.

The notion of fact–value complementarity offered an apt interpretation of the difference between participant and clinician-centred understandings of what promotes well-being. Participants reported that professional distance undermines mental health. Several credited their recovery to staff who had shared their own lived experience. Interviews favoured rebalancing statutory services towards the compassion participants so appreciated in faith community provision. The findings supported co-production literature arguing that staff, service users, and carers have vital contributions.

When patient and carer agency is considered, an ethical argument for co-production emerges. My work is original in suggesting that the ethics of co-production creates a compelling case for redesigning services around users' and carers' life goals and combatting stigma. Drawing on MacIntyre's virtue ethics suggests that service user and carer representation could correct excessive emphasis on targets.

This thesis shows that empirical theological research can contribute to secular professional practice and promote the church's mission in addressing mental health problems.

Relationships between Mental Health Services

and Faith Communities:

A Co-Produced Grounded Theory Study

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Year   2019

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List of Abbreviations

Abbreviation	Full form	Page defined
BAME	Black, Asian, and minority ethnic people	43
C of E	Church of England	265
CMHT	Community Mental Health Team	45
CPE	Co-Productive Ethics	10
EBM	Evidence-Based Medicine	14
FBO	Faith-Based Organization	7
FC	Faith Community	7
GT	Grounded Theory	7
KPIs	Key Performance Indicators	127
LEAP	Lived Experience Advisory Panel	7
MHS	Mental Health Service	7
NHS	National Health Service	17
OED	Oxford English Dictionary	24
PALS	Patient Advice and Liaison Service	259
PT	Practical Theology	10
RQ	Research Question	8
SMART	Specific, Measurable, Attainable, Relevant, Timebound	221
SWOT	Strengths, Weaknesses, Opportunities, and Threats	90
WB	White British	265

Declaration and Statement of Copyright

Though enriched by others' insights, this work is original and my authorship. Any errors or omissions are mine alone.

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Acknowledgements

1   The Challenge of Patient Agency: Introduction

At a time when mental health problems outstrip statutory mental health service (MHS) capacity, collaboration with faith communities (FCs) might be expected, particularly given growing evidence that participation in an FC improves resilience and promotes recovery.[1] However, such collaboration is rare. My findings suggest the lack of collaboration reveals that MHSs are being driven by agendas that do not reflect service user and carer concerns.

My argument emerges from thirty grounded theory (GT) interviews exploring service user, carer, staff, FC leader, and faith-based organization (FBO) leader preferences. I use Charmaz's definition of GT as 'systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories from the data themselves.'[2] Charmaz states that GT 'begins with inductive data, invokes iterative strategies of going back and forth between data and analysis, uses comparative methods, and keeps you interacting and involved with your data and emerging analysis.'[3] Grounded theory's inductive nature yielded 'thick' descriptions and unanticipated insights.[4]

Most participants, seeing MHSs and FCs as embodying fact and value respectively, welcomed greater cooperation.[5] Discussion with a lived experience advisory panel (LEAP) led me to identify a gap in the co-production literature around ethics. Declaring co-production in

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[1] Carl Money, 'Mental Health Bulletin: Annual Statistics, 2014-15' (Leeds: Health and Social Care Information Centre, 2015), pp. 27-29; Harold G. Koenig, *Religion and Mental Health: Research and Clinical Applications* (London: Academic Press, 2018).

[2] Kathy Charmaz, *Constructing Grounded Theory*, 2nd edn (London: Sage, 2014), p. 1.

[3] Ibid.

[4] Clifford Geertz, *The Interpretation of Cultures* (New York: Basic Books, 1973), pp. 6-10.

[5] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd edn (London: Duckworth, 2007), p. 84.

MHSs a moral issue, I build my argument on ethics rather than outcome measures. My findings suggest that, in linking service evaluation with patient and carer agency, co-production has the potential to reconfigure MHSs.[6] A participant suggested co-production might be emancipatory when comparing his experience of delivered services with slavery.[7]

I build on my earlier research exploring service user conceptions of spirituality and experiences of provided care.[8] In co-producing the current project, I have ensured that it both exceeds the participation inherent in GT and satisfies University Regulations (regarding my authorship). I met six-weekly with the LEAP throughout.[9] We planned recruitment, designed the participant handouts, prepared the pilot phase, and reflected on our co-production. I worked closely with the LEAP in reviewing the emerging ideas and findings, and in planning for dissemination. The applications for ethics approval, fieldwork, transcription, literature review, and write-up were conducted entirely by me.

My overarching research aim was to seek a better solution to MHS–FC relationships, most especially to service users' and carers' benefit. The project stems from three research questions (RQs) that explore relationships between MHSs and FCs:[10]

1) Do stakeholders consider that greater cooperation between MHSs and FCs would benefit service users and carers?

2) What would they consider safe and effective protocols?

3) What do they believe contributes to recovery and well-being?

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[6] Julian Raffay, Mick McKeown, and Tim Thornton, 'Co-Production in Mental Health: Lighting up Dark Places' (Monmouth: PCCS Books, 2020). Accepted for publication.

[7] See comment by staff participant 'Stephen' on pp. 79-80.

[8] Julian Raffay, Emily Wood, and Andrew Todd, 'Service User Views of Spiritual and Pastoral Care (Chaplaincy) in NHS Mental Health Services: A Co-Produced Constructivist Grounded Theory Investigation', *BMC Psychiatry,* 16:200 (2016).

[9] This project was one of several agenda items.

[10] I provide key definitions in the text and clarifications in footnotes. FC: an assembly of people identifying themselves with a non-monastic religious community associated with a church, mosque, gurdwara, synagogue, or similar.

Addressing these questions led me to propose the ethics of co-production as a new branch of applied ethics. I define the ethics of co-production as 'the branch of applied ethics ensuring service users, carers, and staff have just and fair opportunity and responsibility in shaping services'.[11] My findings invite more extensive co-production of MHSs and potentially other services.[12] Despite co-production being a significant trend in service design, my work is novel in proposing ethical grounds for supporting co-production. My thesis explores the argument that failure to co-produce might be ethically deficient.

I deploy Slay and Stephens' definition of co-production as 'a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.'[13] I use the term 'provided' to describe conventionally delivered services that lack co-production. By provided, I mean MHSs researched, designed, delivered, and evaluated primarily by professionals.[14] I employ the 2014 World Health Organization definition of mental health: 'A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.[15]

I have sought fidelity to participants' views on spirituality and religion. The theological content and exploration of the Trinity reflect my faith position, yet I have attempted to respect diverse perspectives and desire that my work might inspire general discussion.[16] Though MHSs

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[11] Service user: A person who has a clinical record with and uses secondary care mental health services. Carer: someone 'who provides or intends to provide care for another' person [who uses mental health services] HM Government, 'Care Act 2014' (London: The Stationery Office, 2014), (p. 10); Oxford University Press, 'Oxford Dictionary Premium. Online Version.' (Oxford: OUP, 2015), (p. 131).

[12] MHS: A National Health Service Trust providing services to people with mental health problems.

[13] Julia Slay and Lucie Stephens, 'Co-Production in Mental Health: A Literature Review' (London: New Economics Foundation, 2013), p. 3.

[14] I include services having limited service user and carer involvement. I have attempted to use terminology sensitively and apologise for any offence caused.

[15] World Health Organization, 'Mental Health: A State of Well-Being' (Geneva: WHO).

[16] For a definition of the Trinity, see page 182.

are my primary focus, I examine co-production's relevance to FCs and practical theology (PT).[17]

I also consider co-productive ethics (CPE), an approach characterized by forming ethical theory through a process of co-production.

I begin the first of this chapter's four sections by situating co-production and explaining its relevance to MHSs. In Section 2, I declare my contribution and outline the structure of my thesis. The remaining two sections present my theoretical and conceptual frameworks.

1.1   Beyond Delivered Services

Arguably, co-production began with Adam.[18] Genesis 2.19 describes God bringing every animal for him to name. God and Adam appear as conversation partners, each making their 'vital' contribution.[19] In our day, we encounter co-production in ecosystems throughout creation. Similarly, manufacturing has come a long way since Henry Ford supposedly said: "Any customer can have a car painted any colour […] so long as it is black".[20] Other exemplars of co-production, include jazz, open source software, creative dance, and hairdressing.[21] Co-production finds increasing application in social care and education.[22] Its very span makes the term hard to appropriate.

In the first of four subsections, I argue that a radical solution is necessary to address the current burden on MHSs. In doing so, I prepare the ground for an ethical case based on service user, carer, and staff preferences. In the second, I propose that co-production holds the prospect

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[17] PT: 'The application of theology to practical questions and problems; theology put into practice'. Oxford University Press.

[18] In making this statement, I am not advocating biblical literalism.

[19] Slay and Stephens, p. 3.

[20] Source uncertain; B. Joseph Pine II, *Mass Customization: The New Frontier in Business Competition* (Cambridge, MA: Harvard Business Press, 1999).

[21] Helen Nicholson, *Applied Drama: The Gift of Theatre*, 2nd edn (Basingstoke: Palgrave Macmillan, 2014).

[22] Peter Beresford and Sarah Carr, 'Social Care, Service Users and User Involvement', in *Research Highlights* (London: Jessica Kingsley, 2012); Mark Hedges and Stuart Dunn, *Academic Crowdsourcing in the Humanities: Crowds, Communities and Co-Production* (Kidlington: Chandos, 2018).

of better services. In the third subsection, I argue its relevance to MHSs. Finally, I suggest that

patient agency might play a critical role in preventing organizational failure.[23] I begin by

outlining why a transformative vision for MHSs might be needed.

A 'Broken and Demoralised System'

My findings corroborate evidence suggesting that a radical solution is necessary to address the

stresses on MHSs. These pressures include spiralling demand with fewer staff.[24] (In 2015/16,

MHSs struggled with over 63,622 detentions).[25] Insufficient capacity, however, does not appear

to be the primary problem. As far back as 2012, The Schizophrenia Commission reported

'fragmentation of services', identified that wards have become 'frightening places', and

considered medication 'prioritized at the expense of psychological interventions'.[26] The

Commission declared MHSs 'a broken and demoralised system that does not deliver the quality

of treatment that is needed for people to recover'.[27] Similarly, the 2016 Adult Psychiatric

Morbidity Survey found worsening support on wards and after discharge, often leading to

readmission.[28]

    In 2010, Boyle and associates advocated co-production to address a 'dysfunctional

relationship between the state and the people who are supposed to benefit from state-funded

services'.[29] Labelling this relationship 'dysfunctional' reveals the necessary reconfiguration

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[23] Though I prefer the term 'service user', I refer instead to 'patient agency' as in Mark D. Sullivan, *The Patient as Agent of Health and Health Care: Autonomy in Patient-Centered Care for Chronic Conditions* (Oxford: Oxford University Press, 2017), pp. 11-12.

[24] Money.

[25] Health and Social Care Information Centre, 'Inpatients Formally Detained in Hospitals under the Mental Health Act 1983, and Patients Subject to Supervised Community Treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16' (Leeds: Health and Social Care Information Centre, 2016), p. 1.

[26] Schizophrenia Commission, 'The Abandoned Illness: A Report from the Schizophrenia Commission: Main Report' (London: Rethink Mental Illness), p. 4.

[27] Ibid.

[28] Sally McManus and others, 'Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014: Executive Summary' (Leeds: NHS Digital), p. 2; Schizophrenia Commission, p. 52.

[29] David Boyle and others, 'Right Here, Right Now: Taking Co-Production into the Mainstream' (London: NESTA), p. 7.

(and anticipated resistance).[30] Psychoanalysis alerts us to the diverse opportunities and risks for all concerned.[31] Boyle, Slay, and Stephens asked 'whether existing structures can be modified […] or if we need new frameworks'.[32] My findings suggest the latter but I propose rebalancing Peplau's 'art and science' as a significant step forward.[33] The problem, I shall argue, is not MHSs' mostly excellent front-line staff but a target-driven culture and deficit-based perception of service users.[34] Co-production stands to mitigate these weaknesses.

The Promise of Co-Production

In the 1970s, Ostrom coined the term 'co-production' to defend community policing in the face of rising crime.[35] Cahn later added the concept of consumers as assets.[36] In the 1980s, Coote applied the term to clinicians and patients.[37] Slay and Stephens' 2013 definition (page 9) usefully values 'vital' contributions and offers broad objectives.[38] However, it falls short on two counts. First, aggregating service users and carers into the term 'citizen' makes carers invisible.[39] Second, the reference to 'both partners', misrepresents 'professionals' and 'citizens'

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[30] Catherine Needham and Sarah Carr, 'Co-Production: An Emerging Evidence Base for Adult Social Care Transformation' (London: Social Care Institute for Excellence, 2009); Jijian Voronka, 'Troubling Inclusion: The Politics of Peer Work and 'People with Lived Experience' in Mental Health Interventions' (University of Toronto, 2015), pp. 136-41.

[31] Sigmund Freud, James Strachey, and Angela Richards, *Introductory Lectures on Psychoanalysis, Volume 1*, 2nd edn (London: Pelican, 1973), p. 496.

[32] David Boyle, Julia Slay, and Lucie Stephens, 'Public Services Inside Out: Putting Co-Production into Practice' (London: NESTA, 2010), p. 28.

[33] Hildegard Peplau, 'The Art and Science of Nursing: Similarities, Differences, and Relations', *Nursing Science Quarterly,* 1 (1988), pp. 8-15.

[34] Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary* (London: The Stationery Office, 2013), p. 3; Edgar Cahn, *No More Throw-Away People: The Co-Production Imperative* (Washington, DC: Essential Books, 2000), pp. 87-99.

[35] Roger B. Parks and others, 'Consumers as Coproducers of Public Services: Some Economic and Institutional Considerations', *Policy Studies Journal,* 9 (1981), pp. 1001-11.

[36] Cahn, pp. 87-99.

[37] Alba Realpe and Louise M. Wallace, 'What Is Co-Production?' (London: The Health Foundation, 2010), p. 7.

[38] Slay and Stephens, p. 3.

[39] Alan Worthington, Paul Rooney, and Ruth Hannan, 'The Triangle of Care, Carers Included: A Guide to Best Practice in Acute Mental Health Care in England' (London: Carers Trust, 2013), p. 7.

as distinct categories.[40] Nonetheless, the claim that service users and carers have 'vital'

contributions is fundamental to my thesis.

In considering the promise of co-production, we must distinguish it from alternatives

and counterfeits, their value aside. A collaboration between professionals within or across

organizations is not co-production. Neither is co-production merely involvement, recovery, or

representation on senior management committees.[41] Co-production transcends co-research,

co-design, co-delivery, co-commissioning, and co-evaluation combined. In my experience, it is

foremost about relationships with a shared focus — reaching towards equality as in Rublev's

Trinity.[42]

Though senior managers may colonize co-production, its advocates seek authenticity.[43]

Genuine co-production places primacy on relationships. I liken co-production to an icon,

pointing beyond itself as means, not end.[44] For committed Christians, co-production is merely a

concept looking to our vocation as co-creators alongside the Trinity and people of goodwill.[45]

Anything less, or indeed any focus limited to the object itself — whether in MHSs, FCs or

elsewhere — may be deemed counterfeit.[46]

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[40] Helen Kara, 'Mental Health Service User Involvement in Research: Where Have We Come from, Where Are We Going?', *Journal of Public Mental Health,* 12 (2013), pp. 122-35 (p. 131); Jijian Voronka, 'The Politics of 'People with Lived Experience' Experiential Authority and the Risks of Strategic Essentialism', *Philosophy, Psychiatry, and Psychology,* 23 (2016), pp. 189-201.

[41] Sophie Staniszewska and others, 'Moving Forward: Understanding the Negative Experiences and Impacts of Patient and Public Involvement in Health Service Planning, Development, and Evaluation', in *Critical Perspectives on User Involvement,* ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012), pp. 129-41 (p. 138).

[42] Andrei Rublev, 'The Trinity' (Moscow: Tretyakov Gallery, c. 1410).

[43] Simon Champ, 'Questionnaires from the Heart: National Agendas and Private Hopes', *Nurse Researcher,* 9 (2002), pp. 20-29 (p. 23).

[44] I note recent departures from this usage in referring to celebrities.

[45] I am not suggesting that co-production is necessarily Christian; Alistair I. McFadyen, *The Call to Personhood: A Christian Theory of the Individual in Social Relationships* (Cambridge: Cambridge University Press, 1990), pp. 151-61.

[46] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor, 1961).

The Relevance of Co-Production

To confirm co-production's relevance, I must show that it addresses MHSs' problems. As mentioned, these problems run deeper than inadequate staffing, fragmented services, and a dysfunctional relationship with service users. Mention of Bedlam or Hogarth evokes MHSs' problematic history.[47] Authorities such as Foucault, Goffman, Laing, and Szasz testify to internecine conflict. Today, a kaleidoscope of opinion exists among users, carers, and staff alike.[48]

Insight into the problems that co-production might address comes from the public inquiry into patient neglect at Mid Staffordshire NHS Foundation Trust. The Inquiry found that the Trust suffered from 'a culture focused on doing the system's business — not that of the patients'.[49] The Inquiry was unconvinced the problems causing its failure were 'unique'.[50] Indeed, the trust employing me during the fieldwork recently acquired two failing trusts.[51]

An explanation of what might drive patient neglect came from my prior GT research, conducted concurrently with the Mid Staffordshire Inquiry.[52] It suggested that 'mental healthcare is being driven by a perfect storm [comprising evidence-based medicine (EBM), fear of litigation, quality measures, cost improvements, and similar] that risks turning nurses into technicians and patients into data'.[53] Six years on, I submit that the perfect storm has devastated MHSs.[54] I propose that however legitimate individual targets might be, in combination and to

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[47] Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), p. 29.

[48] Jan Wallcraft, Beate Schrank, and Michaela Amering, 'Handbook of Service User Involvement in Mental Health Research' (Chichester: Wiley, 2009), (pp. 8-9); Antoine Mooij, *Psychiatry as a Human Science: Phenomenological, Hermeneutical and Lacanian Perspectives* (Amsterdam: Rodopi, 2012), pp. 155-210; Voronka, The Politics, pp. 56-58.

[49] Note: I capitalize the word 'trust' where necessary to indicate an NHS organization; Francis, p. 4.

[50] Ibid., pp. 25, para. 76.

[51] Care Quality Commission, 'Calderstones Partnership NHS Foundation Trust Quality Report' ([London]: Care Quality Commission, 2014); Bill Kirkup, 'Report of the Liverpool Community Health Independent Review' ([n.p.]: Liverpool Community Health Independent Review, 2018).

[52] Julian Raffay, 'What Are the Factors That Prevent or Enable the Development of a Spiritual Assessment Tool in Mental Health and That Stand in the Way of or Facilitate the Provision of Quality Spiritual Care?' (unpublished master's dissertation, Cardiff University, 2012).

[53] Ibid., p. 39.

[54] Ibid.

excess, they create 'a culture focused on doing the system's business'.[55] My current research

suggests that linking service evaluation with patient and carer agency might offer the necessary

corrective.

McKinley and Yiannoullou argue that 'the impact of involvement [in MHSs] is

influenced by the [*sic*] purpose, presence and process, and [that] measuring the wellbeing

impact of any type of service user involvement is critical to its success'.[56] Assuming this to be

equally true of co-production, we should not be preoccupied with blanket coverage. Instead, we

should focus co-production — alongside involvement and similar as appropriate — on

leveraging change in those areas that service users and carers most wish to influence. Given

that, to date, representation beyond patient-centred care and Experience Based Design is

minimal, considerable scope exists for new initiatives.[57]

The Significance of Patient and Carer Agency

The Mid Staffordshire Inquiry acknowledged that patients and staff might have a role in

correcting excessive focus on targets. It reported that the trust board:

> *did not listen sufficiently to its patients and staff* or ensure the correction of
> deficiencies brought to the Trust's attention. Above all, it failed to tackle an
> insidious negative culture involving a tolerance of poor standards and a
> disengagement from managerial and leadership responsibilities. This *failure*
> was *in part the consequence of allowing a focus on reaching national access
> targets, achieving financial balance and seeking foundation trust status to be
> at the cost of delivering acceptable standards of care.*[58]

If, as Francis contends, listening to patients and staff can mitigate organizational failure,

I propose that it is because they bring a 'vital' contribution.[59] This contribution potentially also

addresses other challenges, including 'selective reporting and publishing of data by the

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[55] Francis, p. 4.

[56] 'Changing Minds', in *Critical Perspectives on User Involvement,* ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012), pp. 115-28 (p. 117).

[57] Helen Baxter, Mark Mugglestone, and Lynne Maher, *The Experience Based Design Approach: Concepts and Case Studies* (Aldridge: NHS Institute for Innovation and Improvement, 2010).

[58] Francis, p. 3. My italics.

[59] Slay and Stephens, p. 3.

pharmaceutical industry'.[60] Kendall and associates suggest 'the future role of service users in monitoring their own experience of care and ensuring that trusts are accountable to them is now a real possibility and is likely to have an impact upon the traditional power relations in mental health'.[61]

However, the ethics of co-production is not simply about organizational troubleshooting. It envisages service user and carer agency as axiomatic. As in Heaney's poem *Skylight* (page 85), agency potentially frees individuals and organizations from their paralytic condition (Mark 2.1-12).[62]

In recognizing service users and carers as assets, co-production has the potential to improve MHSs.[63] It redefines relationships, locating healthcare in its wider social context.[64] Drawing stakeholders towards a common goal, it confronts paternalism and passivity alike.[65] In transactional analysis terms, co-production encourages everyone to share adult responsibility, including those hard to engage.[66] Co-production addresses Foucault's mad-sane divide:

> We have yet to write the history of that other form of madness, by which men,
> in an act of sovereign reason, confine their neighbors [*sic*], and communicate
> and recognize each other through the merciless language of non-madness.[67]

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[60] Tim Kendall and others, 'Quality, Bias and Service User Experience in Healthcare: 10 Years of Mental Health Guidelines at the UK National Collaborating Centre for Mental Health', *International Review of Psychiatry,* 23 (2011), pp. 342-51 (p. 350).

[61] Ibid., p. 342.

[62] Seamus Heaney, *Opened Ground: Poems, 1966-1996* (London: Faber, 2002), p. 350.

[63] Slay and Stephens, p. 3; Tony Bovaird and Elke Loeffler, 'We're All in This Together: Harnessing User and Community Co-Production of Public Outcomes' (Birmingham, 2013), pp. 2-3; Cahn, p. 24.

[64] Slay and Stephens, p. 3.

[65] George Ikkos, 'Mental Health Service User Involvement: Teaching Doctors Successfully', *Primary Care Mental Health,* 3 (2005), pp. 139-44 (p. 139).

[66] Eric Berne, *Games People Play: The Psychology of Human Relationships* (London: Penguin, 2010), pp. 28-29; Anne Cooke, 'Understanding Psychosis and Schizophrenia: Why People Sometimes Hear Voices, Believe Things That Others Find Strange, or Appear out of Touch with Reality, and What Can Help' (Leicester: The British Psychological Society, 2014), (pp. 70, 113); Liz Forbat, 'Practitioner Views on Service User Involvement in Mental Health: Rhetoric and Contradictions', *The Journal of Mental Health Training, Education and Practice,* 1 (2006), pp. 24-31 (p. 27).

[67] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (London: Routledge, 2001), p. xi; cf. Kara, p. 131.

> Then and only then, can we determine the realm in which the man of madness
> and the man of reason, moving apart are not yet disjunct; […] existing for each
> other, in relation to each other, in the exchange which separates them.[68]

Foucault's 'merciless language of non-madness' masquerading as empirical fact, readily
sanctions nosological colonization of service user and carer distress. In contrast, the ethics of
co-production recognizes that, quoting Carroll's Cheshire Cat, "we're all mad here. I'm mad.
You're mad".[69]

Attention to patient agency curbs anyone's right to define another's reality. [70] From this
perspective, co-production's worth lies not in whether it makes MHSs more efficient or even
more palatable.[71] It centres on a more basic premise, recognized in the opening declaration of
the National Health Service (NHS) Constitution, that 'the NHS belongs to the people.'[72]

Summing up this section, I have supplied a rationale for reconfiguring MHSs, suggested
the mechanism causing MHS organizational failure, and proposed that co-production may offer
a solution. Framing this schema within ethics complements the descriptive and polemic
arguments others have advanced.[73]

1.2   Contribution and Thesis Outline

Three studies (further discussed in Section 2.1) alerted me to EBM's insufficiency in mental
health.[74] Each reported service users favouring spiritual approaches to their distress while

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[68] Foucault, p. xii.

[69] Lewis Carroll, *Alice's Adventures in Wonderland* (New York: Millenium, 2014), p. 40.

[70] Baxter, Mugglestone, and Maher, p. 12.

[71] Ibid.

[72] Department for Health and Social Care, 'The NHS Constitution for England' (London: DHSC, 2015), p. 2.

[73] Slay and Stephens; Cahn.

[74] Julia Walsh, Wilf McSherry, and Peter Kevern, 'The Representation of Service Users' Religious and Spiritual Concerns in Care Plans', *Journal of Public Mental Health,* 12 (2013), pp. 153-64; Emily Wood, Roger Watson, and Mark Hayter, 'To What Extent Are the Christian Clergy Acting as Frontline Mental Health Workers? A Study from the North of England', *Mental Health, Religion and Culture,* 14 (2011), pp. 769-83; Sarah Wonders, 'The Experiences of Those Providing Pastoral Care in the Christian Church

simultaneously reporting such explanations ignored by MHSs. The findings concurred with

what I viewed on psychiatric wards and contrasted with the rise of consumer experience in

deciding business success.[75] In consequence, I identified the NHS's 'monolithic top-down

paternalism' as slow in adopting elements of co-production found to be effective in

manufacturing and commerce, including mass customization and co-design.[76] Shifting 'more of

the responsibility for health onto the shoulders of those who would be healthy' affirms patient

and carer agency.[77] Observing 'traditional [delivered] approaches' as poor, I recommend

co-production.[78]

In this section, I first declare my contribution to the debate and anticipate

counterarguments to co-production. I then outline my thesis' structure.

My Contribution to the Debate

My contribution, emerging from my GT fieldwork, enables discernment — from service user

and carer opinions — of issues in MHSs unlikely to be identified by professionals.[79]

Participants suggested that MHSs and FCs might complement each other, acting as critical

friends to prevent organizational failure. They perceived systemic weaknesses embedded in the

different approaches. One participant named non-cooperation as rooted in the Enlightenment.[80]

My findings suggest that MHSs and FCs broadly offer fact and value respectively,

(though recognizing within each a fact–value tension). I inferred that exclusive focus on fact or

value — whether narrow positivism or otherworldly religion — disadvantages people with

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Community: Supporting People with Their Mental Health and Interacting with Health Professionals'
(University of Sheffield, 2011).

[75] Pine II, p. 6.

[76] Department of Health, 'Our Health, Our Care, Our Say: A New Direction for Community Services'
(Norwich: The Stationery Office, 2006), (p. 19); Cooke, p. 104; Karin Teichmann, Ursula Scholl-
Grissemann, and Nicola E. Stokburger-Sauer, 'The Power of Codesign to Bond Customers to Products
and Companies: The Role of Toolkit Support and Creativity', *Journal of Interactive Marketing,* 36
(2016), pp. 15-30; Pine II.

[77] Kathryn Church and David Reville, 'User Involvement in the Mental Health Field in Canada', *Canada's
Mental Health,* 37 (1989), pp. 22-25 (p. 32).

[78] Ibid.

[79] Paulo Freire, *Pedagogy of the Oppressed*, Rev. edn (London: Penguin, 1996), p. 41.

[80] Oscar C155.

mental health problems. The current project corroborated my earlier findings that service user and carer lived experience, rooted in human spirituality–materiality resists disproportionate positivism.[81] I propose that EBM's exclusive focus on clinician agency creates artefacts that interact with excessive utilitarianism to disadvantage service users and carers. I argue that Co-production may reinject value.

My work's originality lies in proposing a new branch of ethics, the ethics of co-production, to explore the possibility that co-production might be considered axiomatic for MHSs (and potentially elsewhere). I develop my ideas, using Moore's application of MacIntyrean virtue ethics to businesses.[82] Moore offers a framework that explains the unhelpful relationship between delivered services' inclination to prioritize fact and 'a culture focused on doing the system's business — not that of the patients'.[83]

I see the fact–value distinction that MacIntyre names as having an enormous influence on our self-understanding, leading to atomization and emotivism. The ethics of co-production might conceivably contribute to feminist, liberation, and ordinary theology to guide fresh expressions of church.[84] Though churches (and other FCs) generally have rich understandings of community to withstand EBM's atomization, liberation and feminist theologians testify to collusion with power.[85] Co-production between ordinary, academic theologians, and non-theologians may enrich our approach to mission and ecclesiology.

My study invites future research exploring the ethics of co-production. I envisage combinations of service users, carers, and staff co-producing ethical frameworks that might later

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[81] Raffay, Wood, and Todd.

[82] Geoff Moore, *Virtue at Work: Ethics for Individuals, Managers, and Organizations* (Oxford: Oxford University Press, 2017).

[83] Francis, p. 4; Moore, pp. 66-70.

[84] Jennie Barnsley, 'Grounded Theology: Adopting and Adapting Qualitative Research Methods for Feminist Theological Enquiry', *Feminist Theology,* 24 (2016), pp. 109-24. Ordinary theology: 'the theological beliefs and processes of believing that find expression in the God-talk of those believers who have received no scholarly theological education', Jeff Astley, *Ordinary Theology: Looking, Listening and Learning in Theology* (Farnham: Ashgate, 2002), p. 1.

[85] Catholic Institute for International Relations, *The Road to Damascus: Kairos and Conversion* (London: CIIR, 1990).

drive co-produced services. In chapters 6 and 7, I give examples of good practice and make detailed recommendations.

Counterarguments

I anticipate six counterarguments to co-producing MHSs. The most common is service user incapacity. My earlier research, however, showed service users having insight into many aspects of their situation.[86] Where capacity is lacking, there are workarounds. By simply gathering participant insights after capacity returned, Chambers and associates improved forced detentions.[87] Second, EBM is predicated on randomized controlled trials, commonly advanced as the gold standard, yet the National Institute for Health and Care Excellence admits other factors as relevant.[88] Third, people express concern that co-production burdens service users. Here, I reject both coercion and Parsons' 'sick role'.[89] In Section 2.1, I argue that patient agency is vital for recovery in long-term conditions.[90] (I exclude from my understanding of co-production any practices lacking free, informed consent from all parties). Fourth, it might be argued that co-production absolves the state of its responsibility. I suggest that, instead, co-production reconfigures that responsibility. Fifth, some advance that service users represent their views rather than the group they claim to represent.[91] This matter could be addressed through recruitment, selection, and training suitable for particular co-production projects or programmes. (It would additionally be foolish to deny staff self-interest in delivered projects). Sixth, co-production is sometimes thought too expensive. However, if as my findings imply,

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[86] Emily Wood, Julian Raffay, and Andrew Todd, 'How Could Co-Production Principles Improve Mental Health Spiritual and Pastoral Care (Chaplaincy) Services?', *Journal of Health and Social Care Chaplaincy,* 4 (2016), pp. 51-56 (p. 55).

[87] 'The Experiences of Detained Mental Health Service Users: Issues of Dignity in Care', *BMC Medical Ethics,* 15 (2014), pp. 1-8.

[88] Mike Crawford and others, 'Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services. NICE Clinical Guideline 136' (Manchester: National Institute for Health and Care Excellence, 2011), pp. 7-8.

[89] 'The Sick Role and the Role of the Physician Reconsidered', *The Milbank Memorial Fund Quarterly. Health and Society,* 53 (1975), pp. 257-78.

[90] Sullivan, p. 96.

[91] Peter Beresford and Fran Branfield, 'Building Solidarity, Ensuring Diversity', in *Critical Perspectives on User Involvement,* ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012), (pp. 39-40).

MHSs' problems are more qualitative than quantitative, co-production may prove cheaper. Should this be the case, savings could support further improvements.[92] Regardless, I propose that delivered services might be considered ethically flawed and should be proscribed anyway.[93]

From an ethics perspective, my findings — though based on a small sample — suggest we should only deliver services (designed exclusively by professionals) when a person lacks capacity, doing so to save life and restore capacity.[94] I draw inspiration from Jesus who restored Lazarus to life (John 11.38-44) but asked the blind Bartimaeus: "What do you want me to do for you?" (Mark 10.46-52).[95] Were we to hold 'surprise wide open' by asking people with mental health problems this same question, they might prioritize 'promoting social justice' and the 'narrowing of unjust inequalities' over delivered services.[96]

Having considered my contribution to the debate and counterarguments to co-production, I now outline the structure of my thesis.

Structure: Literature Review and Fieldwork

Despite deploying GT, my study's epistemological complexity led me to use the conventional thesis form: introduction, literature review, findings, synthesis, conclusions. This structure belies the inductive shuttling I elaborate in Section 3.1. For now, it is essential to be aware that I was familiar with the literature before the present study. However, in keeping with GT order, I conducted the computerized search (Section 2.4) after my fieldwork.

My Introduction and Recommendations encompass two outer chapters sandwiching the three findings chapters. The earlier outer chapter, my literature review, mostly addresses MHSs. Chapter 2, 'The Ethics of Co-Production: Literature Review', begins by recapping my study's

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[92] M. J. Kreitzer and others, 'Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing', *Global Advances in Health and Medicine,* 4 (2015), pp. 40-4.

[93] Slavery, child-trafficking, and similar bring considerable revenue to their perpetrators but are rightly outlawed; William Hague, *William Wilberforce: The Life of the Great Anti-Slave Trade Campaigner* (London: Harper Perennial, 2008), pp. 196-97.

[94] David Seedhouse, *Ethics: The Heart of Health Care*, 3rd edn (Chichester: Wiley, 2008), pp. 149-51.

[95] Bible quotations are from the *New Revised Standard Version*, unless otherwise stated.

[96] Heaney, p. 350; Needham and Carr, pp. 9-10.

origins in researching spiritual care. I elaborate on what may lie behind dissatisfaction with

EBM, often experienced as the 'bio-bio-bio model'.[97] I develop my suggestion that MHSs might

be more effective and user experience improved were services centred around patient agency.

Displacing front-line staff as sole ethical agents, I prepare for the second section which, drawing

on MacIntyre's *After Virtue*, frames the lack of MHS–FC collaboration within the fact–value

distinction.[98] Using Moore's workplace contextualization of MacIntyre, I next argue that

positivist reductionism interacts with market forces to disadvantage service users, carers, and

staff.[99] I then suggest that a broader evidence base, including service user experience, can

mitigate these vulnerabilities. I argue that the ethics of co-production might both safeguard the

practice of virtue and direct us towards greater well-being.

My findings chapters, Three to Five, each detail a GT core concept and its three

subordinate core categories (see Table 1 below). Each chapter has an added explanatory section

(at the start of Chapter 3 and end of the other two chapters).

Chapter	Core Concept (and sections)	Additional section
Three	All Hands on Deck (3.2-3.4)	How I present the material (3.1)
Four	Critical Friends (4.1-4.3)	Excursus: Case studies (4.4)
Five	Partners in Health Promotion (5.1-5.3)	Evidencing and Integration (5.4)

Table 1 Structure of Findings Chapters

Chapter 3 evidences that most participants thought the surge of mental health problems

exceeds MHSs' capacity and that they especially welcome FCs' more compassionate approach.

Chapter 4 develops the proposal that MHSs and FCs might become critical friends, affording

both protection from organizational failure. Chapter 5 proposes stepped care for health

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[97] F. Borrell-Carrio, A. L. Suchman, and R. M. Epstein, 'The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry', *Annals of Family Medicine,* 2 (2004), pp. 576-82; John Read, 'The Bio-Bio-Bio Model of Madness', *The Psychologist,* 18 (2005), pp. 596-97; Emily Wood, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool, 2016).

[98] Agent: 'A person [… who] takes an active role or produces a specified effect', Oxford University Press.

[99] Moore, pp. 64-65.

promotion. Its last section integrates the three core concepts and prepares for the more theological argument in Chapter 6.

Structure: Synthesis and Appendices

Chapter 6 balances and develops Chapter 2. I begin by with an overview of the Trinity after which I offer a theologically informed integration of fact and value. In Section 2, I critique PT, Leach's model in particular, addressing the epistemological questions my work raises. Section 3, entitled 'Reviewing Co-Production' explores how patient agency might reshape our understanding of mental health. I consider the ethics of co-production in the context of major ethical theories and introduce CPE. Sections 4 and 5 illustrate co-production in action in four areas of my work (meetings, training, progression, and ethos) and I offer four hypothetical examples. These aim to show what is possible without forestalling co-produced alternatives.

Chapter 7 'Recommendations' begins with two sections specific to MHSs and FCs respectively. Section 3 reviews the three GT core concepts, and in doing so, looks beyond traditional approaches to care. Section 4, the closing section, defends my work's validity and rigour, considers its limitations, and suggests areas for future research. My thesis concludes with a short Chapter 8 holding the conclusions.

I have proposed that EBM's sole emphasis on clinician agency creates artefacts that support excessive utilitarianism. I have argued that my work's originality lies in suggesting a new branch of ethics. In the second half of this chapter, I introduce my theoretical and conceptual frameworks.

1.3   Theoretical Framework

Theoretical frameworks, according to Ravitch and Riggan, 'represent a combination or aggregation of formal theories in such a way as to illuminate some aspect of [...the study's]

conceptual framework'.[100] In this section, I detail three approaches followed by a formal theory. In the first subsection, I argue that positivist EBM is but one way of understanding mental well-being. My second subsection introduces Leach's constructivist action–reflection method. Describing itself as a 'tool for spiritual discernment', this develops researchers' attentiveness, not least to excluded voices.[101] The third subsection, liberative ethics, explores the interplay between *habitus* and perspective, reaching beyond zero-sum games towards the possibility of co-production. The last subsection, virtue ethics, presents a formal theory that affirms human flourishing in the community and considers value as important alongside fact. Its scope is recognizably broader than EBM to which we turn.

Evidence-Based Medicine's Limits in Chronic Conditions

To understand MHS–FC relationships, we need to appreciate modern medicine's positivist underpinnings.[102] Positivism takes a deductive approach to knowledge, seeing the observer as detached from the object of their investigation. The Oxford English Dictionary (OED) defines positivism as 'a philosophical system recognizing only that which can be scientifically verified or which is capable of logical or mathematical proof, and therefore rejecting metaphysics and theism'.[103] For pure positivists, EBM is central to quality healthcare. Rosenberg and Donald see EBM as having four logical steps:

- 'Formulate a clear clinical question from a patient's problem

- Search the literature for relevant clinical articles

- Evaluate (critically appraise) the evidence for its validity and usefulness

- Implement useful findings in clinical practice.'[104]

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[100] Sharon M. Ravitch and Matthew Riggan, *Reason and Rigor: How Conceptual Frameworks Guide Research* (London: Sage, 2012), p. 12.

[101] Leach, p. 23.

[102] Porter, pp. 60, 212-14.

[103] *OED*, Oxford University Press.

[104] William Rosenberg and Anna Donald, 'Evidence Based Medicine: An Approach to Clinical Problem-Solving', *British Medical Journal,* 310 (1995), pp. 1122-26 (p. 1122).

The approach promises each patient the best quality care based on the latest research. Most people would acknowledge its relevance in addressing, say, a simple fracture. However, EBM is more contentious in chronic conditions. Sullivan argues that 'patients seek the ability not just to pursue health, but also to define and produce health' in response to what they want to achieve in life.[105] Though a skilled practitioner routinely balances each patient's uniqueness with the principle of verification through replication which advances their discipline, when austerity-driven performance targets become linked with EBM, attention to patient priorities risks becoming compromised.[106]

In psychiatry, not to mention other branches of medicine, EBM narrows the range of legitimate debate. After Salvador-Carulla and associates (see Section 2.2), I seek to broaden that debate.[107] I welcome Sullivan's claim that 'emphasis on disease-related clinical services retard[s] other means of enhancing health'.[108] In the second half of Section 2.1, I develop my argument that neither MHSs nor FCs should accept EBM's claim to rest on incontrovertible fact, let alone necessarily be the best path to mental well-being.

In developing my argument, I refer extensively to two concepts allied to EBM: biomedical ethics and the biopsychosocial model (see Section 2.1). The former applies ethical principles to the work of clinicians.[109] As I have suggested, biomedical ethics is blind to patient agency.[110] The biopsychosocial model might be considered an uncomfortable attempt to resolve the competing interests of disparate professional perspectives.[111] Though holistic by intention,

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[105] Sullivan, pp. 369-70.

[106] Baxter, Mugglestone, and Maher, p. 12.

[107] L. Salvador-Carulla, S. Lukersmith, and W. Sullivan, 'From the EBM Pyramid to the Greek Temple: A New Conceptual Approach to Guidelines as Implementation Tools in Mental Health', *Epidemiology and Psychiatric Sciences,* 26 (2017), pp. 105-14.

[108] Sullivan, p. 359.

[109] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th edn (Oxford: Oxford University Press, 2013).

[110] Sullivan, p. 105.

[111] Peter Kinderman, *A Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing* (Basingstoke: Palgrave Macmillan, 2014); Borrell-Carrio, Suchman, and Epstein, pp. 578-80.

and seeking to base practice on research evidence, it is not co-produced.[112] We encounter

similar weaknesses in Leach's action–reflection method to which we now turn.

Leach's Action–Reflection Method

In contrast with positivism, constructivism (on which Leach's method is predicated) takes an

inductive approach to knowledge, seeing the observer as integral to their observations. It

considers perceptions of reality to be socially framed and is how service users tend to

experience their mental health problems. I suggest that staff with lived experience of mental

health problems embody a positivist–constructivist bridge and can guide us towards services

that balance these perspectives.[113] Similar insights might enrich FCs, albeit a path well-trodden

by theologies of liberation.

Leach's constructivist theological action–reflection method, influenced by feminism,

invites deeper than purely intellectual engagement.[114] She suggests:

> the priorities of the western church are so often turned in on its own religiosity
> that it is unsurprising if reflection on that practice seems […] remote from the
> urgency and excitement of the priorities of the Kingdom. Perhaps the most
> urgent question for the teaching of theological reflection is not about method,
> but about content: are we reflecting on practice which is anodyne and stifling,
> rather than seeking to discern, ourselves, where God is at work in the world,
> and asking […] to engage with that.[115]

Leach invites healthy questioning of standard practice in FCs. Though Christian, her approach is

widely adaptable. It fits comfortably with GT in attending to context. It asks whose voices are

absent or silenced, (a frequent oversight in GT).[116]

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[112] Borrell-Carrio, Suchman, and Epstein, pp. 578-80.

[113] Joseph A. Maxwell, *A Realist Approach for Qualitative Research* (London: Sage, 2012), pp. 3-4.

[114] Leach, pp. 22-24.

[115] Ibid., pp. 22-23.

[116] Ibid., p. 25.

Leach's method invites discernment of the 'still, small voice' through a series of questions promoting deeper engagement and delayed conclusions.[117] Used alongside GT, it can support better attention. Leach brings insights from Belenky and associates who, using the term 'voice', seek deeper engagement and intimacy than visual metaphors.[118] Thus 'voice' implies resistance to positivism, deliberately immersing the researcher in their context. In mental health, it entails recognizing one's own 'mutable identity'.[119] Listening at Leach's deeper level unmasks what Kara terms 'constructed group identities'.[120] It reveals that service users, carers, and staff are by no means separate people. The terms may reflect convenient polarities, yet unless I acknowledge psychiatric admission as a real prospect for my family or myself, I have arguably not 'heard' let alone understood.[121]

However, as I explain in Section 6.12, Leach's action–reflection method suffers similar weaknesses to GT and PT. It has traditionally been uncritical in accepting professionals' right to select the research methodology and decide the conclusions.[122] Hearing the 'voices' — including mine — surfaces power imbalances and brings us to our third approach, liberative ethics.

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[117] I acknowledge the complexity of voice-hearing in mental health. See, for instance, Christopher C. H. Cook, *Hearing Voices, Demonic and Divine: Scientific and Theological Perspectives* (Abingdon: Routledge, 2019); Leach, Pastoral Theology, p. 21.

[118] Mary Belenky, *Women's Ways of Knowing: The Development of Self, Voice, and Mind*, 10th anniversary edn (New York: Basic Books, 1986), p. 124.

[119] Kara, p. 131; Forbat, p. 27.

[120] Kara, p. 131.

[121] Leach, p. 23; Voronka, The Politics, pp. 189-90.

[122] Cf. Helen Cameron and others, *Talking About God in Practice: Theological Action Research and Practical Theology* (London: SCM Press, 2010), pp. 63-69.

Liberative Ethics

Liberative ethics is more favourable to co-production than classical liberation theology.[123] It challenges inequality without construing conflicts as a zero-sum game or imposing liberation theology's specifically Christian and often Marxist frame.[124] De La Torre states:

> If we are to deal with issues of ethics, grounded in today's world, then we are forced to deal with the structural forces that form the *habitus* of those who benefit from the present social structures. If Christian ethics, constructed at the center of society, is rooted in a cultural discernment of the Bible as understood from a position of power and privilege, then to do ethics from the margins becomes an attempt to transform how ethics itself is done.[125]

De La Torre helpfully declares: 'all ethics is contextual […] it can only be determined by local people living under oppressive structures.'[126] Thus framed, liberative ethics is relevant to contexts utterly different from 1960s Latin America and, arguably, applicable wherever inequality exists, or agency is oppressed.

Liberative ethics, in contrast with anti-psychiatry and early liberation theology, invites a more mutually profitable solution. Rather than chastise the oppressor — myself included — De La Torre, building on Freire, considers our minds imprisoned by our *habitus,* making us unable to see *lo cotidiano* (the everyday*).*[127] Thus liberative ethics supports reintegrating objective (fact) and subjective (value) approaches.[128] It enables me, a senior NHS manager, to stand alongside service users and carers while declaring my own 'mutable' identity.[129]

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[123] Miguel A. De La Torre, *Doing Christian Ethics from the Margins*, 2nd edn (Maryknoll, NY: Orbis Books, 2014).

[124] Justin Welby, *Dethroning Mammon: Making Money Serve Grace* (London: Bloomsbury, 2017), p. 109; Miguel A. De La Torre, 'Introduction', in *Ethics: A Liberative Approach,* ed. by Miguel De La Torre (Minneapolis, MN: Fortress, 2013), (pp. 3-4).

[125] De La Torre, *Doing Christian Ethics*, p. 20.

[126] De La Torre, *Ethics: A Liberative Approach*, pp. 3-4.

[127] De La Torre, *Doing Christian Ethics*, pp. 28-29; Freire, pp. 41, 137.

[128] De La Torre, pp. 42-43.

[129] Though I have not used MHS, I identify myself as someone with my own lived experience; Kara, p. 131.

The importance of perspective is illustrated by Hull whose physical blindness led him to castigate the 'hegemony of the average':

> The [theological] criteria of transcendence and transfiguration also apply to the spiritual development of disabled people, although in each case relative to the characteristics of the body which is disabled, transcended and transfigured. This enables us to conceive of a multiplicity of known and lived human worlds.[130]

Hull endorses the expertise by experience of the blind man in John 9.25. His perspective affirms vital contributions without collapsing into emotivism. In contrast, the recent Anglican report *Setting God's People Free* is disturbingly silent on alternatives to formal theology.[131]

Astley, like Hull, challenges formal theology's deductive method, arguing that most practical theologians work more inductively, beginning with the subjective and then blending the objective before returning to the subjective.[132] He writes:

> When confronted by norms of orthodoxy and rationality, ordinary belief is likely to respond in the way adopted by the man born blind who was healed by Jesus: 'I do not know whether he [Jesus] is a sinner. One thing I do know, that though I was blind, now I see' (John 9: 25). The application of theological standards and rules of evidence or logic do not rank among the most important issues where matters of healing are concerned.[133]

De La Torre's liberative ethics, co-production, and Astley's ordinary theology provide tools to move beyond rigid approaches that disallow patient agency, whether positivist, constructivist, or indeed theological.[134] This brings us to consider the formal theory I deploy.

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[130] 'A Spirituality of Disability: The Christian Heritage as Both Problem and Potential', *Studies in Christian Ethics,* 16, pp. 21-35 (p. 21).

[131] Archbishops' Council, '"Setting God's People Free": A Report from the Archbishops' Council' (London: Archbishops' Council, 2017); Helen Cameron, '"Life in All Its Fullness" Engagement and Critique: Good News for Society', *Practical Theology,* 5 (2012), pp. 11-26.

[132] Astley, *Ordinary Theology*, p. 2.

[133] Ibid., p. 40.

[134] Ibid., p. 57.

Virtue Ethics

Strictly speaking, my reference to virtue ethics emerged as a reflection on rather than as intrinsic to my original theoretical framework. However, its significance and complexity call for early introduction. Virtue ethics explores the human qualities contributing to *eudaimonia* (human flourishing). In contrast with Seligman's positive psychology, MacIntyre, virtue ethics' chief proponent, favours collective over atomistic solutions to society's problems.[135] He contends that much debate is incomprehensible because it has become de-contextualized.[136]

MacIntyre suggests that 'in moral argument the assertion of apparent principles masks expressions of personal preference', leaving 'the social world [as] nothing but a meeting place for individual wills'.[137] Into this solipsistic reality, he sees contemporary utilitarianism's contentless assertions as problematic. MacIntyre identifies utilitarianism as a 'pseudo-concept available for a variety of ideological uses'.[138] Underpinned by distributive justice, it appears objective until we name it as an instrument of current 'politically chosen austerity'.[139] We might suspect it of appealing to elites, likely to benefit from free-market economics.[140] Smith warns:

> "The individual" is a liberal construction that makes the world ready for the advance of capitalism and a kind of liberal democracy that serves the desires of certain groups at the expense of a proper human self-understanding. And, since the fiction of the individual departs so far from the reality of the person, that foisting has required a great deal of ideological indoctrination and practice in various institutional settings to make it seem remotely plausible and attractive to people.[141]

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[135] Martin E. P. Seligman, *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment* (London: Free Press, 2003); MacIntyre, p. 261.

[136] MacIntyre, p. 10.

[137] Ibid., pp. 19, 25.

[138] Ibid., p. 64; De La Torre, *Doing Christian Ethics*, p. 25.

[139] Ray Jones, 'Scanning the Horizon: Hopes and Fears for the Future of Children's Social Services and Social Work', in *I4P Public Event: Statutory Social Work with Children*, ed. by Institute for Public Policy and Professional Practice (Edge Hill: Edge Hill University, 2018); De La Torre, *Doing Christian Ethics,* p. 25.

[140] Peter Block, Walter Brueggemann, and John McKnight, *An Other Kingdom: Departing the Consumer Culture* (Hoboken, NJ: Wiley, 2016), pp. xxi-xxii; Christian Smith, *To Flourish or Destruct: A Personalist Theory of Human Goods, Motivations, Failure, and Evil* (Chicago, IL: University of Chicago Press, 2015), pp. 48-49.

[141] Ibid.

MacIntyre likens modern bureaucratic colonization to the barbarian invasion preceding the Dark Ages.[142] We may identify in companies like Facebook, the cynical substitution of *homo consumptor* for *Homo Imago Dei*.[143] In contrast, MacIntyre hopes for a latter-day St Benedict to embody Aristotelian virtues and create 'new forms of community within which the moral life could be sustained so that both morality and civility might survive'.[144]

MacIntyre's analysis is far-reaching and deeply troubling. Thankfully, my more limited work is not logically dependent on his more detailed propositions (such as the relativity of virtues).[145] I am, nevertheless, indebted to his assertions that we (a) 'possess […] the fragments of a conceptual scheme, parts which now lack those contexts from which their significance derived' and that (b) 'the dominant philosophies of the present, analytical or phenomenological' are 'powerless to detect the disorders of moral thought and practice' on which they are predicated.[146] Specifically, I suggest that EBM is incapable of recognizing its insufficiency in enabling people with mental health problems and their carers to attain *eudaimonia* or shalom.[147] Sadly, FC responses are often equally fragmented and inadequate.

These four elements of my theoretical framework (alongside GT which I outline in the next section and elaborate in Section 3.1) underpin my thesis. My findings suggest that rebalancing MHS and FC provision to affirm fact and value (through co-production) would

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[142] MacIntyre, pp. 77, 263.

[143] *Consumptor* is Latin for consumer (but also means destroyer, waster). BBC News (30 March 2018), 'Facebook 'Ugly Truth' Growth Memo Haunts Firm' (London: British Broadcasting Corporation).

[144] MacIntyre, p. 263.

[145] Ibid., pp. 121-225.

[146] Ibid., p. 2.

[147] Daniel E. Hall, 'The Guild of Surgeons as a Tradition of Moral Enquiry', *Journal of Medicine and Philosophy,* 36 (2011), pp. 114-32 (p. 125); Richard Lakeman, 'Talking Science and Wishing for Miracles: Understanding Cultures of Mental Health Practice', *International Journal of Mental Health Nursing,* 22 (2013), pp. 106-15 (p. 112); Roger A. Newham, 'Virtue Ethics and Nursing: On What Grounds?', *Nursing Philosophy,* 16 (2015), pp. 40-50.

improve both.[148] Having shown how virtue ethics frames the debate, I now explain my

conceptual framework.

1.4   Conceptual Framework

Having presented my theoretical framework, I introduce the 'means proposed to study' my

topic.[149] In the next two subsections, I elaborate on my RQs and then present my research

design and method. After that, I explain my approach to dissemination.

Ravitch and Riggan define a conceptual framework as 'an argument about why the

topic one wishes to study matters, and why the means proposed to study it are appropriate and

rigorous'.[150] Thus far, I have declared my study's relevance, asserting the ethics of

co-production's potential to improve MHS–FC responses to spiralling mental health problems.

However, I have yet to evidence meeting Ravitch and Riggan's added requirements for a

conceptual framework, namely that it:

> should argue convincingly that (a) the research questions are an outgrowth of
> the argument for relevance; (b) the data to be collected provide the researcher
> with the raw material needed to explore the research questions; and (c) the
> analytic approach allows the researcher to respond effectively (if not always
> answer) those questions.[151]

I evidence my data's sufficiency (b) when detailing my use of GT in Section 3.1. I argue for

(c) when I defend my validity and rigour in Section 7.4. I address (a) below.

Research Questions

My RQs (see the introduction to Section 1) seek a better solution to MHS–FC relationships. The

RQs, addressed using GT methodology — chosen to theorize from participant experience and

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[148] Peter Kevern, 'Ageing, Religion and (In)Equality', in *Ageing, Diversity and Equality: Social Justice Perspectives,* ed. by Sue Westwood (Abingdon: Routledge, 2018), pp. 210-22.

[149] Ravitch and Riggan, p. 7.

[150] Ibid.

[151] Ibid.

opinion — interrogate my argument for relevance. Fortuitously, a core concept matches each RQ. I consider each in turn.

My first RQ — the expectation of benefits from greater MHS–FC cooperation — arose from Wonders' analysis.[152] She argued that MHSs might gain from FC perspectives on community and that MHS non-cooperation hampers FCs.[153] My rationale for exploring stakeholders' opinions is that, if service users and carers welcome greater cooperation between MHSs and FCs, any contrary opinion may expose covert interests. To triangulate and contextualize service user and carer views, I interviewed other stakeholders. In phrasing RQ1, I sought equipoise, allowing the possibility that stakeholders might want less cooperation (in contrast with Wonders).

RQ2 — safe and effective protocols — acknowledges that closer cooperation would call for careful attention to processes in order to mitigate possible harms. Obtaining stakeholder opinion on protocols circumvented possible institutional anxieties projected onto service users and carers. It also addressed the converse, that organizations might overlook genuine service user concerns. I chose the five participant groups to balance these risks and seek a 'thick' description.[154]

RQ3 — factors believed to contribute to well-being and recovery — draws on GT's surfacing of basic social processes to underpin proposals for MHS–FC cooperation. Challenging assumptions behind MHS delivery and potentially realigning the church to God's kingdom purposes, this question invites a Christian (and other–faith) response to mental health statistics. It deliberately gives 'voice' to stakeholders, placing them centrally in essential debates.

Since GT's inductive/abductive nature encourages new insights beyond researchers' horizons, the ethics of co-production is a reasonable candidate for legitimacy. I provide the warrant for its legitimacy in Section 5.4 which I delay because, being more abstracted than my

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[152] Wonders, p. 61.

[153] Ibid., pp. 85-86.

[154] Geertz, pp. 6-10.

core concepts, its relevance will be more apparent after reading the intervening material.[155]

Having argued that my RQs are 'an outgrowth of the argument for relevance', I introduce my research design.

Research Design

In 1967, the sociologists Glaser and Strauss introduced GT to systematize qualitative enquiry.[156] The methodology offers an epistemology and set of methods broadly corresponding to those used in quantitative research. Grounded in interview data, GT enables researchers to explore social processes and derive theories from participants' experience. The methodology was particularly suited to addressing my RQs.

To follow GT order, I sought ethical permissions at the earliest possible opportunity. I received a favourable opinion from Durham University, North East — Newcastle and North Tyneside 1 NHS Research Ethics Committee (reference 15/NE/0327), and from Mersey Care NHS Foundation Trust's Research and Development Committee. While waiting, I read widely on methodology and study skills, avoiding literature that might prejudice my interpretation of participants' opinions. I deliberately interviewed service users and carers ahead of staff and other leaders.

Further to discussion with the LEAP, I used purposive sampling (see Appendix B) to recruit six each of MHS users, carers, staff, FC leaders, and leaders of FBOs serving people with mental health problems. I tried to ensure the participants were:

a) as representative of the local population (or their FBO role) as possible

b) representative of different faith/non-faith groups (where fitting)

c) able to give informed consent

d) fluent in English.

Service user participants were additionally:

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[155] Charmaz, p. 38.

[156] Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Chicago, IL: Aldine, 1967).

e) receiving services from Mersey Care

f) reflective of a sample of psychiatric conditions

g) reflective of a spread of ages within the service.

I excluded anyone:

a) under eighteen

b) needing an interpreter (due to costs)

c) lacking capacity to consent

d) likely to experience distress from taking part.

My study included qualitative data consisting of interview recordings, interview notes, and basic demographics (see Appendix C). I used the constant comparative method to read in pursuit of lines of enquiry raised by participants in their interviews. [157] No participants asked for a copy of their transcript, and none withdrew. There were no adverse incidents. Of the thirty participants, twenty-six requested and were sent a Summary of Findings.

Research Method

I recruited service users through Mersey Care's User and Carer research leads. I circulated posters and Invitation Letters, Participant Information Sheets and Consent Forms, offering the choice of declining, supplying contact details, or getting in touch via the nursing team. I ensured that prospective participants had capacity to consent.

Because of possible fluctuating capacity, I invited staff to screen prospective service user participants.[158] I addressed sensitive subject matter in the Participant Information Sheet. During the interviews, I offered to pause/stop the recorder/interview, checked for concerns, and sought advice where appropriate (see Appendix E).

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[157] Charmaz, pp. 140-41.

[158] Bridgit Dimond, 'The Mental Capacity Act 2005: Mental Capacity and Mental Illness', *British Journal of Nursing,* 17 (2008), pp. 182-4.

I recruited carers through Service User and Carer Coordinators, attending carer groups to publicize the research. I recruited the other participants, prioritizing service user and carer interviews. I built the pilot study into the research evidence base.

I recorded semi-structured interviews, most lasting up to an hour. I transcribed and analysed the interviews within a few days.[159] Using *NVivo* software and Charmaz's approach to coding, I formed initial codes and early memos.[160] Deploying axial coding and GT's 'constant comparative method', I created focused codes and advanced memos to frame the questions for the next interview and build categories.[161] I reached theoretical saturation in each participant group.[162]

I derived my theory from the categories, codes, memos, interview notes, and research journal. To ensure rigour, I followed Corbin and Strauss's criteria for evaluation.[163] The core concepts guided my literature review. I used elementary quantitative analysis to compare my sample with the population.

Regarding confidentiality, I alerted all participants to Trust policies at the beginning of interviews. I explained that any disclosure might result in communication with staff. The Participant Information Sheet listed sources of support. I anonymized all data at the earliest possible opportunity. I used encrypted recorders, directly downloading recordings to NHS-approved servers. I encrypted all documents, storing them on Mersey Care's servers. I secured paper records in a locked filing cabinet following Trust policies. Separate passwords restricted

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[159] See Appendix D for my analysis framework.

[160] QSR International, 'Nvivo' ([n.p.]: QSR International, 2012); Charmaz, pp. 109-61; Saldaňa defined a code as 'a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data'; *The Coding Manual for Qualitative Researchers* (Los Angeles, CA: Sage, 2010), p. 3.

[161] Charmaz, pp. 140-41, 47, 32, 57-60, 72-85.

[162] Ibid., p. 214.

[163] Juliet Corbin and Anselm Strauss, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, 3rd edn (London: Sage, 2008), pp. 297, 305-07; Charmaz, pp. 337-38.

auditor access to either participant or research data (see Appendix D). I used lean principles to manage the project and evidence how I formed the theory from codes.[164]

My employer paid service user and carer participants' expenses in line with their policies.[165] I neither offered nor received any direct financial reward. I had no reason to declare any conflict of interest.

Dissemination

Far from an afterthought, dissemination is concurrent with my write-up. Publication and presentation enabled me to test my ideas continually and evaluate responses. Major works include a chapter on co-production in *Essentials of Mental Health Nursing* and another in *Chaplaincy and the Soul of Health and Social Care*.[166] An edited book, *Co-Production in Mental Health: Lighting up Dark Places* — co-edited with the LEAP — is accepted for publication.[167] More deliberately popular contributions include an article in the Trust magazine.[168]

Early signs suggest my project is gaining interest, not least 200 reads of one on ResearchGate.[169] I have led a couple of seminars at Durham; one at the College of Health Care Chaplains' Annual Conference, and another at the Critical Voices Network.[170] These

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[164] Neil Westwood, Mike James-Moore, and Matthew Cooke, 'Going Lean in the NHS' ([Coventry]: NHS Institute for Innovation and Improvement/Warwick University, 2007).

[165] Cf. Michael Turner and Peter Beresford, 'Contributing on Equal Terms: Service User Involvement and the Benefits System' (London: Social Care Institute for Excellence, 2005).

[166] Julian Raffay and Don Bryant, 'Spiritual Care: Understanding Service Users, Understanding Ourselves', in *Essentials of Mental Health Nursing,* ed. by Karen Wright and Mick McKeown (London: Sage, 2018), pp. 232-48; Julian Raffay and Don Bryant, 'Co-Production and Promoting Spiritual Wellbeing in Mental Health', in *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care,* ed. by Ewan Kelly and John Swinton (London: Jessica Kingsley, 2019), pp. 232-48.

[167] Raffay, McKeown, and Thornton.

[168] Jackie Rankin and Julian Raffay, 'More Tea Vicar? More People Than Ever Are Turning to a Faith Community in Times of Mental Anguish', in *MCT Magazine* (Prescot: Mersey Care NHS Foundation Trust, 2018), pp. 13-15.

[169] Raffay, Wood, and Todd; ResearchGate, '200 Reads' (Berlin: ResearchGate, 2018).

[170] Julian Raffay, 'Perspectives on the Relationship between Statutory Mental Health Services and Faith Communities: A Co-Produced Constructivist Grounded Theory Study', in *Spirituality, Theology and Health Seminar* (Durham: Durham University, 2016); Julian Raffay, 'Co-Productive Ethics: Bridging the Fact–Value Divide in Mental Health Service Provision', in *Spirituality, Theology and Health Seminar* (Durham: Durham University, 2018); Julian Raffay, 'Co-Productive Ethics: Transforming Tomorrow's

contemporaneous projects enabled me to revise my claims. I am planning to publish further

papers in academic and practitioner journals and author a book or monograph. I predict

speaking at conferences.

In the first two sections of this chapter, I declared the importance of the study, asserting

the ethics of co-production's potential to improve MHS–FC responses to spiralling mental

health problems and presented my theoretical framework. In Section 3, I outlined the

components of my theoretical framework. In Section 4, I introduced my conceptual framework

as the 'means proposed to study' my topic.[171] I evidenced that my methodology was suitable for

answering my RQs. I then explained the coherence of my approach to dissemination.

Conclusions

Since Mid Staffordshire's failure, pressures on services have mostly increased while, despite

best efforts, the Inquiry's 290 recommendations have failed to achieve 'fundamental culture

change'.[172] I liken MHSs — and all too commonly FCs — to the first verse of Heaney's poem,

solidly focused on their business yet almost incapable of life-giving 'surprise'.[173]

The broader perspective (developed in the next chapter) suggests that service users and

carers would gain from rebalancing EBM's and MHSs' corporate focus with (effectual) FCs'

greater emphasis on compassion. I will further argue that atomistic positivism (see Section 1.3)

is incapable of fostering *eudaimonia* or shalom and that virtue approaches, embodied in lived

experience supply the necessary corrective.

NHS', in *College of Health Care Chaplains' Annual Study Conference - Curating Chaplaincy: Envisioning Healthcare Chaplaincy for the Future* (High Leigh, Hertfordshire: College of Health Care Chaplains, 2018); Julian Raffay, 'The Ethics of Co-Production: Bridging Fact and Value in Mental Health Services', in *Critical Perspectives on and Beyond 'Recovery': Ten Years On* (Cork, 2018).

[171] Ravitch and Riggan, p. 7.

[172] Francis, p. 5; Julian Raffay, 'The Francis Report (2013): Neo-Pharisaism in the NHS?', *Health and Social Care Chaplaincy,* 4 (2016), pp. 20-34 (p. 21); Department of Health, 'Culture Change in the NHS' (London: Department of Health, 2016), pp. 47-49.

[173] Heaney, p. 350.

I suggest that co-production resonates with the church's call to be the people of God and offers a model for sharing responsibility. The overwhelming impact of mental health issues on our society offers clear justification for my research. I now turn to my literature review.

2   The Ethics of Co-Production: Literature Review

In this chapter, I situate the case for the ethics of co-production in the literature, questioning approaches to MHS design and provision that ignore patient agency. I propose that service user agency addresses positivist vulnerabilities to disproportionate utilitarianism. This chapter comprises four sections.

I first set my argument within the spirituality debate in mental health to develop my case regarding EBM's insufficiency.[1] The importance many service users attach to spirituality suggests that, in contrast with front-line staff, they prioritize value over fact. Drawing on Sullivan's concept of the patient as agent, I place the service user centre stage.[2] In doing so, I displace the front-line staff member as sole ethical agent.

The second section surfaces assumptions widely overlooked in practice. I frame the minimal MHS–FC collaboration within MacIntyre's fact–value distinction.[3] I next draw on Moore's workplace contextualization of MacIntyre, suggesting that positivist reductionism interacts with market forces to disadvantage service users, carers, and staff.[4] I then argue that service user and carer perspectives can protect organizations and individuals from these vulnerabilities. I end the section by proposing a broader evidence base for practice.

Section 3 argues that co-production might encourage this broader evidence base, address organizational dynamics, and promote the practice of virtue. I begin with the context of

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[1] George L. Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine', *Science,* 196 (1977), pp. 129-36.

[2] Sullivan, p. 13.

[3] MacIntyre, pp. 57, 84, 196.

[4] Moore, pp. 24, 64-65. 83.

co-production in MHSs. I next explore models of co-production, noting that its proponents

mostly assume it self-evidently preferable. I then outline co-production's vulnerabilities.

I develop my ethical argument for co-production, suggesting it might mitigate the loss of virtue

in MHSs.

The closing section reiterates my suggestion that patient agency bridges fact and value,

giving warrant for reconsidering the general lack of collaboration between MHSs and FCs.

I introduce the section with a computerized search for 'patient' and 'agent'. I propose that the

findings invite us to think beyond the clinician–service user dyad. I then suggest tenets for the

ethics of co-production, arguing that biomedical ethics is deficient in seeing front-line staff as

the sole agent. I next take a wider sweep, affirming that MHS and FC engagement with service

users and carers should mainly support their flourishing in the community. The chapter closes

by linking the fieldwork findings and literature, showing they are part of the evidence for

co-production. I begin by setting my argument within the spirituality debate in mental health to

argue the biopsychosocial model's insufficiency.

2.1   Spirituality and Biopsychosocial Insufficiency

Three papers, exploring the spirituality debate in mental health, introduce key ideas framing my

study's sensitizing concepts. Walsh and colleagues suggested that service users and clinicians

have different priorities around spirituality and religious belief.[5] Wood and associates showed

MHSs sidelining FC leaders.[6] Wonders reported MHSs viewing care through a positivist lens.[7]

Alongside Sullivan's book *The Patient as Agent of Health Care,* they formed the logical

sequence that inspired me to reach beyond EBM to propose the ethics of co-production.[8]

Beginning with Walsh and colleagues' research, I respond to the three papers in turn, continuing

to consider Sullivan's argument throughout the thesis.

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[5] Walsh, McSherry, and Kevern, p. 162.

[6] Wood, Watson, and Hayter, pp. 775-76.

[7] Wonders, pp. 33, 65, 70.

[8] Engel, p. 129; Sullivan, p. 120.

Service Users Favour Faith Communities

Walsh and colleague's study, unique in mental health, showed differences between staff and service user priorities. They reported an 80 per cent error rate in patient records regarding 'religious and spiritual concerns'.[9] Their findings invite critical reflection on the assumptions underlying service delivery models, matters we explore throughout this chapter.

Walsh and colleagues used mixed methods, giving out 300 questionnaires to a purposive sample of people using community MHSs in Sheffield. Employing Likert scales and free text fields, they compared service user recollections of their interactions with staff around spirituality with electronic patient records. They inferred: 'the majority of Care Coordinators [*sic*] are unable to see the relevance of spiritual or religious concerns or feel incompetent to record them faithfully'.[10]

Bias may have arisen from their small sample (n=71), 24 per cent response rate, and 41 per cent Black, Asian, and minority ethnic (BAME) participants (18 per cent expected). Some error may be attributable to service users changing faith or commitment and to data compression by the patient database drop-down boxes. However, the 80 per cent error rate suggests neglect of matters important to service users, likely to have 'a negative impact on their overall care and well-being'.[11] Walsh and colleagues recommended:

> the Care Plan should be regularly reviewed with the service user concerned; and
> […] the service user may be encouraged to articulate their religious and
> spiritual concerns and practices in their own terms rather than those supplied by
> the database and/or Care Coordinator.[12]

Significantly for our purposes, Walsh and colleagues suggested that a service driven by service user concerns might differ from what is delivered.

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[9] Walsh, McSherry, and Kevern, p. 158.

[10] Ibid., p. 161.

[11] Ibid., p. 162.

[12] Ibid.

Walsh and colleagues' finding corroborated my previously mentioned suggestion that 'mental health care [*sic*] is being driven by a perfect storm that risks turning nurses into technicians and patients into data'.[13] It led me to theorize that 'interest in spiritual care in mental health is, to a large degree, a response to the perfect storm — a call for a more humane approach to care'.[14] Differently expressed, if nurses have become distracted, service users will adapt their behaviour to ensure their needs are met. Burkhart and Hogan's GT study, albeit in chronic physical healthcare settings, suggests virtuous and vicious cycles of interaction, built around mutual assumptions and ensuing expectations.[15]

Services Sideline Faith Community Leaders

Evidence that 'interest in spiritual care in mental health is […] a call for a more humane approach' may be found in FC leaders' continuing role as front-line mental health workers.[16] Had EBM successfully addressed mental health problems, we would not expect that 'even in countries in Europe with socialised health care systems, a significant proportion of the population chooses to visit clergy either instead of or as well as MHSs'.[17] I suggest three reasons for clergy popularity. First, there is increasing evidence that spirituality and religion are favourable to mental well-being.[18] Second, service users see FC leaders (and their communities) offering something complementary to MHSs. Finally, I propose that this something is precisely their 'more humane approach to care'.[19]

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[13]Julian Raffay, 'Are Our Mental Health Practices Beyond HOPE?', *Journal of Health Care Chaplaincy,* 12 (2012), pp. 68-80 (p. 74).

[14] Ibid.

[15] 'An Experiential Theory of Spiritual Care in Nursing Practice', *Qualitative Health Research,* 18 (2008), pp. 928-38.

[16] Raffay, Are our Practices?, p. 74.

[17] Wood, Watson, and Hayter, p. 771.

[18] Koenig.

[19]Wood, Watson, and Hayter, p. 770; Raffay, Are our Practices?, p. 74.

If MHSs and FCs are complementary, we might expect extensive cooperation.

However, Wood and colleagues found resistance from MHSs. Their postal survey of thirty-nine

clergy (Likert scales with free text space) backed up earlier UK studies:

> collaborative working between clergy and mental health professionals has been
> negative for some of the ministers in this city. Many comments were generated
> to this effect including ''CMHT [Community Mental Health Team] is
> inaccessible'' [… The] ''system is under resourced so it cannot be accessed
> when needed''.[20]

They reported dismal referral patterns:

> 82% [of clergy] had referred to a GP and 67% had referred to the local CMHT
> on at least one occasion. […] More startling is that almost half of all
> respondents (49%) had never received a referral from a GP and almost two-
> thirds (62%) had never received one from the CMHTs.[21]

Despite possible response bias (21 per cent response rate), their findings (alongside Leavey's

and Foskett's) invited reflection on the potential benefits of greater cooperation and suitable

approaches.[22] That people with mental health problems continue using FCs suggests they

perceive EBM (or at least their experience of care) to be insufficient.[23]

Services' Positivist Lens

Further explanation as to why people with mental health problems often approach FCs as their

first port of call is provided by Wonders who used interpretative phenomenological analysis

with eight clergy:[24]

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[20] Wood, Watson, and Hayter, p. 778.

[21] Ibid., p. 777.

[22] Gerard Leavey, 'U.K. Clergy and People in Mental Distress: Community and Patterns of Pastoral Care', *Transcultural Psychiatry,* 45 (2008), pp. 79-104; John Foskett, James Marriott, and Fay Wilson-Rudd, 'Mental Health, Religion and Spirituality: Attitudes, Experience and Expertise among Mental Health Professionals and Religious Leaders in Somerset', *Mental Health, Religion and Culture,* 7 (2004), pp. 5-22.

[23] Read, p. 596.

[24] Wonders.

> Min[i]sters don't have tight boundaries, whereas often the NHS is absolutely screaming with boundaries and I think that there are plusses and minuses to both.... [*sic*] and I think you have a lot of burnt out Ministers [*sic*] who don't know how to put any boundaries in and I think you have some NHS health care professionals that can't do diddly squat because some rule has said they can't and that is a real shame.[25]

Wonders described relational boundaries being reinforced by tight epistemological boundaries. She noted that 'in the secular setting, the scientific domain still holds precedent and there is some sign that spirituality is, at best tolerated or worked with inconsistently or at worst, avoided or side-lined'.[26] Her work, however, showed this 'scientific' precedence rather than equipoise. She remarked that 'two […] studies utilised samples of therapists who rated [… religion and spirituality] as important […] *and therefore may be biased*'.[27]

> Banicki (though commenting on positive psychology) alerts us to the hazard:

> The scientific ideal of contemporary social science, namely, can be most revealingly read not as an isolated entity, but rather as one emerging from and pervaded by Western culture. Positive psychology overtly and enthusiastically endorses this ideal, so despite its best intentions to become a culture-free, universally applicable, and normatively neutral science, [it] turns out to be "pervaded by Western cultural values and assumptions" […]. This fact, importantly, is usually unacknowledged and remains hidden, not only from the general public view but also from the theoretical self-awareness of positive psychologists.[28]

> When 'science' alleges neutrality, entire domains important to service users — not just spirituality — risk omission from MHS practice.[29] However, Duncan and associates provide strong evidence that service user and carer perspectives are vital and that the engine for

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[25] Ibid., p. 81.

[26] Ibid., pp. 34-35.

[27] Ibid., p. 21. My italics.

[28] Konrad Banicki, 'Positive Psychology on Character Strengths and Virtues. A Disquieting Suggestion', *New Ideas in Psychology,* 33 (2014), pp. 21-34 (p. 23).

[29] Ann-Marie Yamada and others, 'Integrating Spirituality and Mental Health: Perspectives of Adults Receiving Public Mental Health Services in California', *Psychology of Religion and Spirituality,* Mar (2019), pp. 1-12.

recovery is in the client.[30] In the rest of this section, I contend that positivist science has 'feet of clay' (Daniel 2) and that its dominance disadvantages service users.[31]

Patient Agency Exposes Positivism's 'Feet of Clay'

The biopsychosocial model's insufficiency is, I suggest, a logical outcome of a 'restricted and simplistic approach to scientific knowledge'.[32] I identify the 'feet of clay' as arising from restricting ethics to clinicians' agency, creating artefacts, including EBM's conventional framing. While clinician agency may legitimately be central in emergency medicine, research suggests its insufficiency elsewhere.[33]

Fernandez and associates question EBM's gold standard, the randomized controlled trial, suggesting such trials do not 'assess real world outcomes'.[34] Despite EBM's seemingly rigorous adherence to scientific method, it suffers from circularity, seeking to evidence that which it can evidence, potentially limiting medicine's scope and effectiveness. Notwithstanding its notable merits in emergency medicine, EBM remains an approach based on a particular philosophy of science practised in a specific political context.

Services are likely to be different if, rather than basing practice on the clinician's sole agency, we start from the premise that capacitous service users, carers, and staff all have agency.[35] Sullivan argues that recognizing service user agency improves effectiveness.[36] I support his claim that 'patients are trapped inside the descriptions provided by their

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[30] Barry L. Duncan and others, *The Heart and Soul of Change: Delivering What Works in Therapy*, 2nd edn (Washington, DC: American Psychological Association, 2010), pp. 423-24.

[31] Goffman, *Asylums*, pp. 4-5.

[32] Ana Fernandez and others, 'Evidence-Based Medicine: Is It a Bridge Too Far?', *Health Research Policy and Systems,* 13 (2015), pp. 1-9 (p. 1).

[33] King's Fund, 'The Patient-Centred Care Project: Evaluation Report' (London: The King's Fund, 2011); Susanne Forrest and others, 'Mental Health Service User Involvement in Nurse Education: Exploring the Issues', *Journal of Psychiatric and Mental Health Nursing,* 7 (2000), pp. 51-57; Raffay, Wood, and Todd; Sullivan, pp. 206-07.

[34] Fernandez and others, p. 6.

[35] Cf. Chambers and others.

[36] Sullivan, p. 13.

physicians', but my focus is more comprehensive than (typically) dyadic clinical encounters.[37] My argument reaches beyond 'autonomy' (however broadly defined) to explore the ethical and organizational impacts of stakeholder agency.[38]

By robustly asserting mutual responsibility for shaping services and determining outcomes, I firmly reject anti-psychiatry and the tug of war Sullivan censures.[39] However, I dispute his assertion that 'health is best understood as a goal internal to the practice of medicine' for that privileges its practitioners above other legitimate stakeholders.[40] Again, we may recognize the nosological colonization of human distress.[41] Kitwood's seminal work on dementia, subtitled *The Person Comes First*, significantly admitted fact (organic brain decay) yet argued for a value-based approach.[42] Kitwood recognized the difference between a broken leg and a broken heart.

The admittedly simplistic distinction between a broken leg and a broken heart questions EBM's sufficiency and MHSs' positivist lens. Faith communities' continuing involvement suggests that people with mental health problems consider something important that MHSs cannot (or chose not to) see or provide. As a service user put it: "I'm not a target and a figure, I'm a human being".[43] In the next section, I frame this conversation within MacIntyre's fact–value debate, arguing that MHSs prioritize fact and FCs value.

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[37] Ibid., p. 66.

[38] Ibid., pp. 65-70.

[39] Ibid., p. 78.

[40] Ibid., p. 105.

[41] Damien Brennan, 'A Consideration of the Social Trajectory of Psychiatric Nursing in Ireland', *Journal of Psychiatric and Mental Health Nursing,* 11 (2004), pp. 494-501 (p. 500); Philip J. Barker, 'The Tidal Model: Psychiatric Colonization, Recovery and the Paradigm Shift in Mental Health Care', *International Journal of Mental Health Nursing,* 12 (2003), pp. 96-102; Sullivan, p. 144.

[42] Tom M. Kitwood, *Dementia Reconsidered: The Person Comes First* (Buckingham: Open University Press, 1997), p. 208; Peter Kevern, 'The Grace of Foolishness: What Christians with Dementia Can Bring to the Churches', *Practical Theology,* 2 (2009), pp. 205-18.

[43] Anonymized, "I'm a Human Being", ed. by Julian Raffay (Mersey Care Life Rooms Focus Group, 2017).

2.2   The Fact–Value Divide in Mental Health

If a simple fracture can be addressed primarily by nurse-technicians, a broken heart demands a different approach. Indeed, the argument we have considered so far suggests the experience of mental health problems more closely resembles the broken heart, and that service users find FCs more compassionate. However, I do not rest my thesis on a handful of studies. It is embedded in the broader debate advanced by the influential philosopher MacIntyre.[44]

My first subsection introduces MacIntyre's argument that our culture has lost sight of its underpinnings. I suggest that low-lying epistemological mist shrouds EBM's feet of clay.[45] I infer that MHSs and FCs — prioritizing fact and value respectively — speak different languages and have lost the phrase book.

The second subsection picks up Moore's application of MacIntyrean theory to organizations.[46] Moore's argument that managers and their organizations are driven by fact but benefit from value gives insight into failure (as in Mid Staffordshire). In subsection 3, I develop my case that service user preferences might serve as a protective factor, rebalancing fact with value. In the last subsection, I explore Salvador-Carulla and associates' paper that proposes a broader evidence base for clinical decisions.[47] This leads to my third main chapter section where I suggest that co-production has the potential to support that broader evidence base. We now consider MacIntyrean virtue ethics.

MacIntyre and Conceptual Fragmentation

I frame my work within MacIntyre's *After Virtue* to assert the legitimacy of service user, carer, and staff agency over unfalsifiable utilitarian truth claims.[48] I first outline MacIntyre's argument

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[44] MacIntyre.

[45] Daniel 2.

[46] Moore.

[47] Salvador-Carulla, Lukersmith, and Sullivan, pp. 107-09.

[48] MacIntyre, p. 64.

to suggest that excessive erring on the side of fact or value by MHSs and FCs respectively risks deficiency and failure.

Historically, MHSs wrested territory from FCs, each securing niches in fact and value.[49] MacIntyre argues that religions' eventual failure to provide a shared discourse was succeeded by the Enlightenment's similar failure as it looked to deliver people from 'traditional theism and […] teleological modes of thought'.[50] He proposed that confusion occurs because 'almost everyone, philosopher and non-philosopher alike' implies otherwise.[51]

Without teleology, MacIntyre contended, fact becomes uncoupled from morality, leaving only the 'incoherent fragments of a once coherent scheme of thought and action'.[52] This uncoupling, I suggest is the low-lying mist shrouding EBM's feet of clay, terrain far too disorientating for the 'theoretical self-awareness' of most front-line staff.[53] Many positivists, aspiring to value-neutrality and lacking an epistemological compass, find worth in the measurable, uncritically accepting utilitarianism. Regrettably, for service users, 'not everything that counts, can be measured. Not everything that can be measured counts'.[54]

MacIntyre proposed that the 'polymorphous character of pleasure and happiness' makes utilitarianism 'a pseudo-concept available for a variety of ideological uses'.[55] He added: 'it is always necessary to ask what actual project or purpose is being concealed by its use'.[56] His insight exposes the Government's political and economic struggle to contend 'it has resources of

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[49] Porter, p. 32.

[50] MacIntyre, pp. 50, 60.

[51] Ibid., p. 68.

[52] Ibid., pp. 56-57, 55.

[53] Daniel 2; Banicki, p. 23.

[54] William Bruce Cameron, *Informal Sociology: A Casual Introduction to Sociological Thinking* (New York: Random House, 1963), p. 13. Often attributed to Albert Einstein.

[55] MacIntyre, p. 64.

[56] Ibid.

competence which most citizens do not possess'.[57] We may recognize MHS provision as a suitable contender for such claims.

MacIntyre ominously likened contemporary technocrats to the barbarian raiders who launched the Dark Ages.[58] He considered our society riven by 'too many disparate and rival moral concepts' and doomed to failure.[59] He argued that 'the Aristotelian moral tradition is the best example we possess of a tradition whose adherents are rationally entitled to a high measure of confidence in its epistemological resources'.[60] In effect, MacIntyre argued that Aristotelian virtue ethics, focused on the *polis* — the collective rather than the individual — offers the only sure footing for an ethical argument.

Moore and Virtue as a Protective Factor

If MHS failure were only a risk, resorting to virtue ethics might appear heavy-handed. However, as I have argued, failure is pervasive.[61] Moore proposes that virtue rather than technocracy offers organizations' best protection. He cites Hinings and Mauws who, responding to church and health provider failures, argue:

> The events in question were in fact *made possible* by well-accepted and highly regarded organizational practices. It is because these organizations were as well organized as they were that these events took place […]. The implication of this explanation is that it applies to the phenomenon of "organization" itself and, thus, to potentially *all* organizations.[62]

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[57] Ibid., p. 85.

[58] Ibid., p. 263.

[59] Ibid., p. 252.

[60] Ibid., p. 277.

[61] Schizophrenia Commission, p. 3.

[62] C. R. (Bob) Hinings and Michael K. Mauws, 'Organizational Morality', in *Church Ethics and Its Organizational Context: Learning from the Sex Abuse Scandal in the Catholic Church*, ed. by Jean M. Bartunek, Mary Ann Hinsdale, and James F. Keenan (Oxford: Sheed and Ward, 2006), pp. 115-22. (p.116). Cited in Moore, p.24. Italics original.

Moore sees organizational hierarchy replacing moral with technical responsibility, effectively 'turning nurses into technicians and patients into data'.[63] If the practice of virtue mitigates such failure, FCs may be more resilient, despite their historic failures:

> More than the comparatively thin or limited notions of utilitarian happiness or the socially contracted justice of reciprocal tolerance, Aristotle and MacIntyre develop the concept of human flourishing (*eudaimonia*) as a thick or full notion of genuine happiness, health, integration, and harmony.[64]

Moore argues that virtuous organizations ensure internal goods (like compassionate care) take precedence over external goods (such as targets). His organizational ethics perspective lifts our horizons beyond the clinician–patient dyad towards the *polis*. It reveals features central to our argument yet invisible to positivism.

Though I arrived at my Perfect Storm Theory (see Figure 1 below) independently of either MacIntyre or Moore, it might be considered an MHS contextualization of MacIntyre.[65] We could liken the weak vector in Figure 1, representing a staff member's compassionate care for a service user, with the MacIntyrean concept of practice.[66] The multiple vectors reflecting the drag of the perfect storm would then represent the 'corrupting power' of the institution.[67]

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[63] Moore, p. 25; Raffay, Are our Practices?, p. 74.

[64] Hall, p. 124. Cited in Moore, p.177.

[65] This would risk substantial eisegesis of all three texts.

[66] Moore, p. 64; MacIntyre, p. 191.

[67] Moore, p. 69; MacIntyre, p. 194.
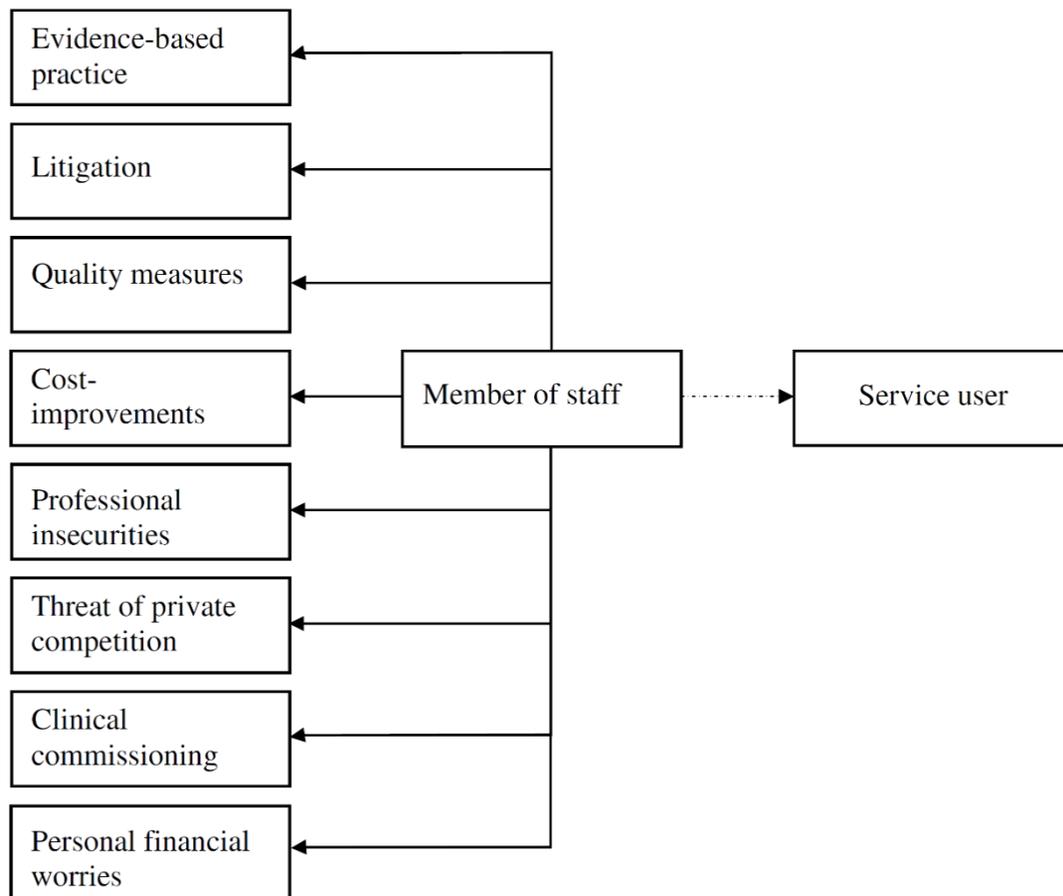
Figure 1 Perfect Storm Theory

Service User Preferences as a Protective Factor

Typical organizational response to failure is a self-defeating 'vicious circle' of tighter regulation.[68] The Mid Staffordshire Inquiry found failure 'in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care'.[69] Yet, the Report's '290 recommendations contain 390 instances of "should" and 51 of "must"', many of them examples of tighter regulation'.[70] Positively, Francis suggested that service users might have a role in

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[68] Linus Johnsson and others, 'Making Researchers Moral: Why Trustworthiness Requires More Than Ethics Guidelines and Review', *Research Ethics,* 10 (2014), pp. 29-46 (p. 31); Derek Sellman, 'Professional Values and Nursing', *Medical Health Care and Philosophy,* 14 (2011), pp. 203–08 (p. 207); Nicholas Taleb, *Anti-Fragile: How to Live in a World We Don't Understand* (London: Allen Lane, 2012), p. 17.

[69] Francis, p. 3.

[70] Raffay, The Francis Report, p. 25.

mitigating failure. He proposed 'a set of fundamental standards, easily understood and accepted

by patients […] the breach of which will not be tolerated'.[71]

I propose that service users' (and carers') role in mitigating failure has to do with their

general preference for value over fact:

> Many [interviewed service user] participants suggested that nurses who had
> been educated and professionalized through the hospital based mental health
> 'system' ended up perceiving and interacting with users as 'text book cases',
> rather than individuals with unique experiences of distress. Professional
> qualities were also seen as eroding the human qualities they valued and this in
> turn led to 'distance'.[72]

Emphasizing relationship rather than distance gives internal goods (value) precedence over

external goods (fact). It supports the 'practice' or 'art' of nursing, rebalancing positivism's

preference for outputs or 'science', thereby mitigating Francis's 'insidious negative culture'.[73]

Forrest and associates' perspective corroborates my argument about EBM's

insufficiency. They suggest nurses 'slide up and down the 'human' 'professional' continuum' in

their practice.[74] Given that nurses (and other front-line staff) may experience the 'perfect storm',

hardwiring service user and carer preferences into service evaluation may prospectively prove a

robust means of ensuring virtuous services.[75]

Towards a Wider Evidence Base for Evidence-Based Medicine

We cannot ensure virtuous services without addressing organizational complexity. Handy

suggests:

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[71] Francis, p. 4.

[72] Forrest and others, p. 53.

[73] Moore, pp. 60-8; Peplau, pp. 13-14; Francis, p. 3.

[74] Forrest and others, p. 53.

[75] Raffay, Are our Practices?, p. 74.

> Organizations can be looked at as a fine weave of influence patterns whereby individuals or groups seek to influence others to think or act in particular ways. If we are to understand organizations we must understand the nature of power and influence for they are the means by which the people of the organization are linked to its purpose.[76]

Displacing value leaves no ground for valid moral or evaluative argument other than utilitarianism's questionable circular logic.[77] Setting fact over value legitimizes the Enlightenment project, benefiting technocracy and powerful technocrats. It favours managers serving the organization's ends and finds a ready ally in positivism's quantifiable outputs.[78] Cook offers the following insight:

> Spirituality and religion, in our secular age, are subject to what Charles Taylor calls 'closed world structures' which make disbelief in transcendence appear incontrovertible when in fact, rationally speaking, it is not. It is arguably an effect of these closed world structures on psychiatric practice that excludes from the clinical consultation spiritual matters which patients themselves wish to discuss with their psychiatrist. In fact, the evidence base suggests that spirituality and religion should be routinely assessed in psychiatric practice and that the possible beneficial influence on outcome of spiritual practices and faith communities should be considered when formulating treatment plans.[79]

Thankfully, after Forrest and associates, we need not reject EBM, only restrain its hubristic tendencies. My findings suggest that, by broadening the definition of evidence and co-producing, we may be able to bind value into organizational structures and clinical interactions. In doing so, we deliberately reframe the discourse, legitimizing value as necessary.

Salvador-Carulla and associates helpfully propose a 'broader multi-domain perspective' for EBM that leverages user experience.[80] Drawing on systems theory and philosophy of science, the authors argue that randomized controlled trials devalue experience, excluding 'context, expert 'opinion' and consumers' experience as relevant sources of knowledge'.[81]

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[76] *Understanding Organizations* (Oxford: Oxford University Press, 1993), p. 123.

[77] MacIntyre, p. 64.

[78] Moore, p. 109.

[79] Christopher C. H. Cook, 'Spirituality, Secularity and Religion in Psychiatric Practice: Commentary On ... Spirituality and Religion in Psychiatric Practice', *Psychiatrist*, 34 (2010), pp. 193-95 (p. 193).

[80] Salvador-Carulla, Lukersmith, and Sullivan, p. 106.

[81] Ibid., p. 107.

Though, not using a virtue framework, their more eclectic approach reveals positivism's 'feet of clay'. They suggest scientific knowledge should include (a) observational and experimental evidence based on data, (b) contextual knowledge, and (c) expert and experiential knowledge.[82] Significantly, as I elaborate in the next section, they suggest this knowledge should be considered from discovery, through corroboration to implementation.[83] Salvador-Carulla and associates thus offer an epistemological rationale for moving beyond arguments inspired by anti-psychiatry or liberation theology towards exposing the status quo as scientifically and ethically indefensible.

Locating my argument within the fact–value debate, I have suggested that positivism cannot of itself lead to *eudaimonia*. In the next section, I argue that hardwiring service user preferences into service evaluation and building their experience into the evidence base holds the hope of more ethical and potentially safer, more effective services.

2.3   Facilitating the Practice of Virtue through Co-Production

In *Broken yet Beloved*, Thornton reveals the importance of learning from people experiencing mental health problems:

> No matter how nondirective the caregiver is, the shepherd perspective and the pastoral functions originate within the pastoral office or professional guild and are directed toward [*sic*] the client. Their creation, interpretation, and practice have not been generated from the perspective of those seeking relief from what malady is theirs. This limits the sources of knowledge we draw from for practicing [*sic*] our vocation and neglects the authority of those who may experience different social and historical realities from ours.[84]

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[82] Ibid., p. 110.

[83] Ibid., p. 108.

[84] Sharon G. Thornton, *Broken yet Beloved: A Pastoral Theology of the Cross* (St. Louis, MO: Chalice Press, 2002), p. 42.

Her point is echoed in Slay and Stephens' previously quoted definition of co-production with its emphasis on 'vital' contributions.[85]

In this section, I explore the significance of service user and carer 'vital contributions' by looking at diverse approaches to co-production. I address co-production's vulnerabilities before elaborating my ethical argument for the ethics of co-production. I first set co-production in its historical context.

A Short History of Co-Production

The early pioneers, Tuke (1796) and Pussin (1793), co-produced their MHSs.[86] Sadly, it has taken two centuries to rediscover their message.[87] Within the last forty years, however, user involvement has moved beyond isolated protest movements to statutory representation.[88] Though service users have gained influence, there is little consensus about what should constitute co-produced services.[89]

Alongside the more extensive 'crisis of confidence in the professions' has been the rise of consumer experience in deciding business success.[90] Raised expectations have driven a shockwave through the NHS making 'top-down paternalism' and inertia deeply unattractive.[91] Compounding these expectations is the structural crisis affecting the public sector:

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[85] Slay and Stephens, p. 3.

[86] Brenda Rush, 'Mental Health Service User Involvement in England: Lessons from History', *Journal of Psychiatric and Mental Health Nursing,* 11 (2004), pp. 313-8.

[87] Porter, pp. 103-05.

[88] Marian Barnes and Phil Cotterell, 'From Margin to Mainstream', in *Critical Perspectives on User Involvement,* (Bristol: The Policy Press, 2012), pp. xv-xxvi.

[89] Theodore Stickley, 'Should Service User Involvement Be Consigned to History? A Critical Realist Perspective', *Journal of Psychiatric and Mental Health Nursing,* 13 (2006), pp. 570-77 (pp. 570-71); Jan Wallcraft and Mary Nettle, 'History, Context and Language', in *Handbook of Service User Involvement in Mental Health Research,* ed. by Jan Wallcraft, Beate Schrank, and Michaela Amering (Chichester: Wiley, 2009), pp. 1-12 (pp. 8-9).

[90] Donald A. Schön, *The Reflective Practitioner: How Professionals Think in Action* (New York: Basic Books, 1984), pp. 3-20; Pine II, p. 6.

[91] Department of Health, *Our Health*, p. 19; Cooke, p. 104.

> As reliance on institutional responses becomes ever more expensive, and as
> health status bears less and less relationship to expenditure, governments and
> societies will face a difficult choice. Either they will cling to traditional
> approaches and contain costs by rationing services or they will develop new
> approaches and shift more of the responsibility for health onto the shoulders of
> those who would be healthy.[92]

Moving away from Parson's sick role may benefit service users as sewing mailbags may have helped prisoners.[93] We need to understand co-production in the context of rapidly changing services.

Potential Vulnerabilities in Co-Production

Despite its strengths, co-production in mental healthcare may be weak on four issues. First, it may be naively optimistic and lack insight into social processes.[94] When service users confront professionals in meetings or staff stand their ground, we may recognize obvious influence. However, power is often covert, serving to protect vested interests.[95]

Second, co-production is hard to measure, especially if framed as a 'mosaic'.[96] Horgan's review raises the issue of the desired outcome.[97] Kalathil, for instance, might seek a reduction in

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[92] Church and Reville, p. 32.

[93] Parsons.

[94] Ada Hui and Theodore Stickley, 'Mental Health Policy and Mental Health Service User Perspectives on Involvement: A Discourse Analysis', *Journal of Advanced Nursing,* 59 (2007), pp. 416-26 (p. 424).

[95] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (London: Penguin, 1990), p. 179; Jijian Voronka, 'Peer Work: The Value of Mad Labour', in *Critical Perspectives On and Beyond 'Recovery': Ten Years On* (Cork: CVNI, 2018).

[96] Deborah Buck and others, 'From Plans to Actions in Patient and Public Involvement: Qualitative Study of Documented Plans and the Accounts of Researchers and Patients Sampled from a Cohort of Clinical Trials', *British Medical Journal Open,* 4 (2014), pp. 1-19 (pp. 15, 17); Jonathan Tritter and Alison McCallum, 'The Snakes and Ladders of User Involvement: Moving Beyond Arnstein', *Health Policy,* 76 (2006), pp. 156-68.

[97] Áine Horgan, 'Review: Service User Involvement in the Evaluation of Psycho-Social Intervention for Self-Harm: A Systematic Literature Review', *Journal of Research in Nursing,* 18 (2012), pp. 131-32 (p. 132); Staniszewska and others, (p. 138).

discrimination against black service users.[98] A Patient and Public Involvement service might prefer metrics around trust board decisions with user participation.[99]

Co-production's third vulnerability concerns mental capacity, yet it is precisely the social and environmental origin of much mental illness that makes co-production so relevant.[100] If, as Duncan and associates suggest, clients' motivation is the most significant force for recovery, then harnessing their experience may well lead us towards success.[101] Professionals and experts by experience are ultimately interdependent.[102] (We should equally accept that senior managers may sometimes out of their depth).[103] Any thick description of co-production should be robust enough to address the above arguments.

A fourth, significant challenge, concerns the execution of co-production. I focus on ethics and outcomes but am unable to give attention to an area of concern important to Voronka who asks:

> What does it mean to embody [*sic*] as a 'person with lived experience' in research production, and what are some of the conditions, limits, and possibilities of such embodiments? Often, when as individuals we are brought in to represent 'people with lived experience' to work on research projects as mental illness embodied, we risk entrenching and naturalizing difference outside of our own terms.[104]

Her understanding enriches Tritter and McCallum's mosaic and concurs with Handy. Despite EBM's best efforts, internecine conflict continues between professionals and, in my experience,

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[98] Jayasree Kalathil, 'Dancing to Our Own Tunes: Reassessing Black and Minority Ethnic Mental Health Service User Involvement' (London: National Survivor User Network in collaboration with Catch-a-Fiya, 2008), pp. 5-6.

[99] Marianne Storm, Kjell Hausken, and Aslaug Mikkelsen, 'User Involvement in In-Patient Mental Health Services: Operationalisation, Empirical Testing, and Validation', *Journal of Clinical Nursing,* 19 (2010), pp. 1897-907 (pp. 1903-04).

[100] Alison Hill, 'From the Patient's Perspective', in *What's Gone Wrong with Health Care?: Challenges for the New Millennium,* (London: King's Fund, 2000), pp. 27-39; Jim van Os, Gunter Kenis, and Bart Rutten, 'The Environment and Schizophrenia', *Nature,* 468 (2010), pp. 203-12 (p. 210).

[101] Duncan and others, pp. 423-24.

[102] Geoff Shepherd, Jed Boardman, and Mike Slade, *Making Recovery a Reality* (London: Sainsbury Centre for Mental Health, 2008), p. 3.

[103] Marianne Storm and Adrian Edwards, 'Models of User Involvement in the Mental Health Context: Intentions and Implementation Challenges', *Psychiatric Quarterly,* 84 (2013), pp. 313-27 (p. 322).

[104] Voronka, The Politics, p. 198.

authentic multidisciplinary working is rare. However, if co-production is as much about relationships as about structures, it is there that the demanding work needs doing. If relationships can protect against organizational failure, demanding work is preferable to the alternative.[105]

Models of Co-Production

Co-production, 'recognising that both partners have vital contributions' interprets service delivery as a non-zero-sum game.[106] Slay and Stephens' descriptive review of community initiatives offers a model of co-production based on six principles, including recognizing service users as assets, engaging peer support, and facilitating instead of providing services.[107] They reasonably highlighted 'how power is balanced between [the] people getting support, and the professionals who deliver it' but risk envisaging co-production as end rather than means.[108] Drawing on Arnstein's ladder of participation, they described three levels of co-production: 'doing to', 'doing for', and 'doing with'.[109] The flaw in this one-dimensional model is exposed by my recent illustration of prisoners sewing mailbags, entailing both co-production and compulsion.

Mudhoni rejected Arnstein, arguing that 'participation is a complex and interactive process [...] that is essentially political in nature and takes place in a broader political context'.[110] She favoured Tritter and McCallum's more 'complex and dynamic' mosaic model.[111] Tritter and McCallum suggested that 'that for user involvement to improve health

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[105] Francis, p. 83.

[106] Slay and Stephens, p. 3.

[107] Ibid.

[108] Ibid., p. 5; Rublev.

[109] Sherry Arnstein, 'A Ladder of Citizen Participation', *Journal of the American Institute of Planners,* 35 (1969), pp. 216-24; Slay and Stephens, p. 3.

[110] Catherine Mudhoni, 'Service User Involvement: Development of a Communication Strategy between Service Users and Senior Management in a Healthcare Voluntary Organisation' (unpublished master's thesis, Royal College of Surgeons in Ireland, 2014), p. 31; Arnstein, pp. 216-24.

[111] Tritter and McCallum, pp. 165-66.

services it must acknowledge the value of the process and the diversity of knowledge and experience of both health professionals and lay people'.[112]

While we need to map involvement, focusing on outcomes will likely be more profitable.[113] Staniszewska and associates explain why:

> The outcomes of involvement seemed to be predominantly defined by the organisations involved rather than service users so we know relatively little about the outcomes that service users wanted to achieve. Such difficulties challenge the notion of true partnership as certain groups dominate the ways in which methods, context or process are decided.[114]

A poignant challenge in applying co-production to mental health involves the final say. Slay and Stephens cite inspiring examples but ignore the potential issues were service users and carers to be given majority control of a trust board. Such admittedly not insuperable complexities lead me to prefer resting co-production on an ethical footing, to which we now turn.

An Ethical Argument for Co-Production

In this subsection, I explore the possibility that the ethics of co-production might potentially become a legitimate branch of applied ethics. In doing so, I admit that more fieldwork and conceptual reflection is needed to confirm its place alongside other branches. Nevertheless, the concept offers the possibility of moving beyond polemics to establishing co-production as normative for services and its absence as a deficiency. The increasing literature on co-production merely assumes its desirability. Including vital service user and carer insights within the evidence base for service evaluation holds the prospect of safer services that are likely to be more positively experienced.[115]

My work is original in introducing ethics into the argument. I propose that the ethics of co-production begins with the premise that MHSs should be researched, designed,

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[112] Ibid., p. 156.

[113] Ibid., p. 165.

[114] Staniszewska and others, (p. 138).

[115] Baxter, Mugglestone, and Maher, p. 12.

commissioned, delivered, and evaluated jointly between service users, carers, and staff.[116] Additionally, I understand care as the total user and carer experience rather than EBM's narrow definitions of treatment. I deliberately set up the ethics of co-production as normative rather than aspirational.

The ethics of co-production is not CPE (see page 199). Its focus is not on the (admittedly important) practice of co-production but on building the ethical case for co-production. The ethics of co-production is not a one-time solution applicable across contexts and cultures (again, see page 197) but a set of heuristic ethical tenets.[117] Its original scope is MHSs. There is evidence that the ethics of co-production may apply to cancer care.[118]

I propose that co-production, especially with mutually agreed outcomes, supports well-being and promotes recovery. Service users and carers are likely to experience greater satisfaction with co-produced services.[119] Co-produced services may prove cheaper and more effective than delivered ones. However, neither savings nor improved recovery rates are enough reason for co-production.

Grounding co-production in ethics may help reconfigure the 'broken and demoralised system'. [120] Embedding virtue within the organization could result in safer and more effective services. Bringing service users, carers, and staff together in a shared venture may offer greater resilience to economic downturns.[121] Tritter and McCallum's mosaic usefully complexifies zero-sum approaches.[122]

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[116] This is not to deny the legitimate place of service user, survivor, and mad research.

[117] I deliberately avoid the term 'principles' though recognize that principlist framings of my work may be valid.

[118] King's Fund, pp. 3-5.

[119] Baxter, Mugglestone, and Maher, p. 12.

[120] Schizophrenia Commission, p. 3.

[121] Ibid.

[122] Tritter and McCallum, p. 165.

In this section, I have advanced the ethics of co-production. I began by outlining the context of co-production. I then considered approaches to co-production and co-production's vulnerabilities in MHSs. The following section widens out from my computerized search to suggest that MHSs and FCs should interact with people experiencing mental health problems to promote their flourishing in the community.

2.4   Bridging Fact and Value

To build my argument, I have implied that front-line staff prefer fact and service users prefer value. A more nuanced understanding sees current austerity pressurizing both. We do service users and carers (not to mention staff) an injustice if we only contemplate their interactions within MHSs. Further exploration of patient agency should consider MHSs in the context of service users' and carers' lives rather than the opposite. It should direct us to view mental health within the broader frame of social inequality, discrimination, health promotion, and social capital.[123] It is within this wider perspective that we must understand MHS–FC relationships and their impact on service users, carers, and society. It is prospectively with further degraded MHSs and social care that FCs must plan their social responsibility.[124]

From this perspective, I now outline my computerized search for 'patient' and 'agent' (one of several I performed). This search confirms my earlier research findings on the social processes shaping MHS practice and leads into a subsection looking beyond the clinician–patient dyad. This wider framework elaborates on the tenets of the ethics of co-production. The final subsection, 'Co-Producing Social Inclusion', offers a provisional vision of MHS–FC partnerships shaped by service users' and carers' concerns.

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[123] John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon Press, 2000), p. 10.

[124] Jones, Scanning the Horizon.

Computerized Search

I performed a computerized literature search in July 2017. Using the NHS Healthcare Databases

Advanced Search online tool, I explored AMED, BNI, CINAHL, EMBASE, Health Business

Elite, HMIC, Medline, and PsycINFO. I searched for articles with both 'patient' and 'agent' in

their title.[125] The search yielded 448 results. After deduplication and filtering for relevance and

quality, thirty articles remained.[126] Twelve articles were relevant, including MacLeod's review

of Sullivan.[127] I analysed them, using *NVivo 11* qualitative data analysis software.

Most authors wrestled with assumptions underpinning the clinician's role yet did so

within an implicit biomedical ethics model.[128] Dillon and Cushman offer a striking example:

'As agents form intentions to act upon the world, they are responsible for the consequences of

those intentions. Similarly, because *patients only experience the world*, [my italics] they have

moral rights to be protected from injustice'.[129] Only Sullivan (and MacLeod) recognized

autonomous patient agency.[130] Toulmin explored philosophical and ethical issues in psychiatry

but did not move beyond conceptualization.[131] Alibrahim and Wu, using an agent-based

simulation model, argued that patient agency could save chronic heart fatigue treatment costs.[132]

However, healthcare professionals modelled their virtual patient, another case of biomedical

ethics' entrapment.

A crucial second theme was the MacIntyrean concept of practice. Sellman quotes Miller

who suggested that purposive practices (like nursing but not chess) with an end beyond

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[125] This was one of several searches I have conducted.

[126] Critical Appraisal Skills Programme, 'CASP Qualitative Review Checklist' (2015).

[127] Tanya MacLeod, 'Book Review: Patient as Agent of Health and Health Care', *Journal of Evaluation in Clinical Practice,* 23 (2017), pp. 1099-100.

[128] Beauchamp and Childress, pp. 121, 38.

[129] Kyle D. Dillon and Fiery Cushman, 'Agent, Patient … Action! What the Dyadic Model Misses', *Psychological Inquiry,* 23 (2012), pp. 150-54.

[130] Sullivan, pp. 213, 337; MacLeod.

[131] Stephen Toulmin, 'Agent and Patient in Psychiatry', *International Journal of Law and Psychiatry,* 3 (1980), pp. 267-78 (p. 278).

[132] Abdullah Alibrahim and Shinyi Wu, 'An Agent-Based Simulation Model of Patient Choice of Health Care Providers in Accountable Care Organizations', *Health Care Management Science,* 21 (2018), pp. 131-43.

themselves 'can be judged in terms of excellence by those not actively engaged in the practice itself'.[133] Offering a valuable insight, the author accepted this judge might be the service user or carer. Overall, the computerized search revealed Sullivan (and MacLeod) as the uniquely proximate studies to my work. The search, however, shed further light on leadership and management to which we now turn.

Beyond the Dyad

In 1988, the Government deliberately modelled the NHS on commerce, building the 'perfect storm' by lining up internal markets, EBM, and biomedical ethics.[134] Kempster argued that, in such a system, managers are 'seen to inevitably increase the emphasis upon external goods and the parallel decline in internal goods and the exposition of *telos'*.[135] Sellman described how healthcare providers become ensnared:

> Frustratingly, the response to each successive failure of the target culture to deliver on its promises is yet another set of targets with even tighter levels of surveillance leading to ever more severe punishments for failures to meet the targets; a move that encourages ever more unscrupulous behaviour within institutions desperate not to be penalised in the competitive market generated by the league tables that accompany measurement against imposed targets.[136]

Kempster argues that effective MacIntyrean leadership can halt this, though my findings suggest that co-production would be more effective.[137] Kempster makes no mention of the possibility that managers may have a more limited understanding of the context than service users whose support they may need in finding the way forward. Managers with lived experience could help us navigate the new territory.[138] Such an approach may require an active campaign to

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[133] Derek Sellman, 'Alisdair MacIntyre and the Professional Practice of Nursing', *Nursing Philosophy,* 1 (2000), pp. 26-33; John Horton and Susan Mendus, *After MacIntyre: Critical Perspectives on the Work of Alasdair MacIntyre* (Cambridge: Polity, 1994), pp. 250-51.

[134] Sir Roy Griffiths, *Community Care: Agenda for Action* (London: Her Majesty's Stationery Office, 1988), pp. 72, 74-75; Raffay, Are Our Practices?, p. 76.

[135] Steve Kempster, Brad Jackson, and Mervyn Conroy, 'Leadership as Purpose: Exploring the Role of Purpose in Leadership Practice', *Leadership,* 7 (2011), pp. 317–34 (p. 322). Note: The context suggests the author may have intended 'erosion' rather than 'exposition'.

[136] Sellman, Professional Values, p. 207.

[137] Kempster, Jackson, and Conroy, p. 329.

[138] Kara, pp. 122, 31.

destigmatize staff with mental health problems, though 'attempts to do so are likely to produce resistance at every level'.[139]

Redesign — placing the service user rather than profitability — centre stage may paradoxically be more profitable than traditional models of delivery.[140] Sullivan unhelpfully states that 'treatment should help the recipient "move from being a patient to a person". Indeed, persons are active in pursuit of their vital goals while patients often are not.'[141]

Instead of lining up an emphasis on external goods, biomedical ethics, and EBM, co-production has the potential to realign MHSs to service users' and carers' concerns. Their wishes supply a powerful value base from which to offset Kempster's 'inevitable decline'.[142] This brings us to re-examine the ethics of co-production from the viewpoint of patient agency.[143]

Developing the Ethics of Co-Production

From the perspective of service users' vital goals, we need an alternative to Beauchamp and Childress's *Principles of Biomedical Ethics*, one that is not centred on clinician agency.[144] Here, I empathize with Hall:

> for reasons eventually furnished to me by MacIntyre, I intuitively understood
> that I could not follow in the moral tradition I now playfully call "The Gospel
> according to St. Beauchamp": Autonomy, beneficence and justice; these three
> abide, but the greatest of these is autonomy.[145]

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[139] Rufus May, 'Crossing the "Them and Us" Barriers: An inside Perspective on User Involvement in Clinical Psychology', *Clinical Psychology Forum,* 150 (2001), pp. 14-17 (p. 15); Kara, p. 131; Siobhan Fenton, 'Majority of Britons 'Uncomfortable' Letting Someone with Mental Illness Look after Their Child, Study Finds', in *Independent* (London: Independent Digital News and Media, 2016); Voronka, Peer Work.

[140] A. Gafni, C. Charles, and T. Whelan, 'The Physician-Patient Encounter: The Physician as a Perfect Agent for the Patient Versus the Informed Treatment Decision-Making Model', *Social Science and Medicine,* 47 (1998), pp. 347-54 (p. 352).

[141] Sullivan, p. 160.

[142] Kempster, Jackson, and Conroy, p. 329.

[143] Sullivan, p. 160.

[144] Beauchamp and Childress, p. 107.

[145] Hall, p. 128.

Biomedical ethics considers whether the clinician has behaved ethically in the clinical encounter. In contrast, I propose that the ethics of co-production challenges the 'objectivity–autonomy pairing that radically separates facts from values […] dominant in medical ethics since the Enlightenment'.[146] The ethics of co-production names this divide in MHSs as an artefact of clinician-focused ethics.[147]

The ethics of co-production does not begin with the clinician–patient relationship as that would be to make a priori assumptions, privileging both clinician and treatment. Autonomy has its proper place, as do 'vital goals', but virtue ethics' concept of *eudaimonia* offers a more fruitful perspective, not least in its recognition of the common good.[148] An interrelated concept, relevant to mental health, is *telos* (purpose, hope).[149] Indeed, The Royal College of Psychiatrists asserts: 'recovery is probably impossible without hope'.[150]

In distinguishing co-production from its counterfeits, I propose the following tenets, namely that the ethics of co-production:

a) begins with the premise that MHSs should be researched, designed, commissioned, delivered, and evaluated jointly between service users, carers, and staff towards attaining *eudaimonia*[151]

b) seeks to embed virtue through service user, carer, and staff experience[152]

c) recognizes *telos* as vital

d) sees all capacitous stakeholders as mutually responsible for outcomes

e) understands care as the total user and carer experience rather than narrow definitions of treatment

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[146] Sullivan, p. 73.

[147] Michel Foucault, *The Birth of the Clinic* (Abingdon: Routledge, 2012).

[148] Seedhouse, p. 150; Sullivan, p. 160; MacIntyre, p. 148.

[149] MacIntyre, p. 160; Kempster, Jackson, and Conroy, p. 322.

[150] Royal College of Psychiatrists, 'Recommendations for Psychiatrists on Spirituality and Religion' (London: Royal College of Psychiatrists, 2011), pp. 5, 12.

[151] Here, I re-emphasize the legitimate place of service user, survivor, and mad research.

[152] Jackie Mahendra, 'Wheeling in the Trojan Mice', in *Stanford Social Innovation Review* (Stanford: Stanford Center on Philanthropy and Civil Society, 2016).

    f)   is not fulfilled through service user and carer representation alone

    g)   is not fulfilled unless diversity is valued, and discrimination mitigated[153]

    h)   envisages departure from these norms as an ethical breach needing clear reasoning, only to be considered as a short-term local arrangement, and subject to formal review.[154]

Sullivan presents something of the fact–value hybrid that I envisage the ethics of co-production striving for:

> Health is not only a feeling of well-being or even a feeling of capability. It is capability itself or the capacity for personally meaningful action. This power or capacity is not a purely objective, observable property of bodies. Nor is it a subjective feeling, available only to private introspection. It sits between these and cannot be reduced to an impersonal observation or a personal feeling.[155]

Supremely, I suggest the ethics of co-production is not so much about curing mental illness or even promoting psychological well-being. It is about seeking *eudaimonia* alongside people with mental health problems in the *polis*. Its vision is social inclusion, which we now consider.

Co-Producing Social Inclusion

Many people with chronic illness consider social exclusion a more significant burden than their diagnosed condition[156]. Swinton suggests this may be the case in mental health:

> When we reflect on the life experiences of many people with mental health problems, we find individuals who have to struggle with psychological difficulties that are frequently destructive, incapacitating, and soul-destroying. However, such difficulties are only the beginning of the story of their life struggles. Running alongside the biological and psychological history of people with mental health problems is a form of social experience that is fundamentally degrading, exclusionary, and frequently dehumanizing. When we look into the social experience of people with mental health problems, we discover a level of oppression, prejudice, exclusion, and injustice that is deeply concerning. Negative media images, powerful stigmatizing forces, and exclusion from basic sources of value are just some of the negative experiences

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[153] Zoebia Islam, Fatemeh Rabiee, and Swaran P. Singh, 'Black and Minority Ethnic Groups' Perception and Experience of Early Intervention in Psychosis Services in the United Kingdom', *Journal of Cross-Cultural Psychology,* 46 (2015), pp. 737-53.

[154] Chambers and others, p. 2.

[155] Sullivan, p. 161.

[156] Samuel Wells, *Incarnational Ministry: Being with the Church* (Norwich: Canterbury Press, 2017), p. 182.

that many people experience on a daily basis, simply because they are diagnosed as having a mental health problem.[157]

Ideally, service users, carers, and staff would jointly decide future mental health support. If this sounds far-fetched, Chambers and associates' workaround (see Section 1.2) could readily improve responses from MHSs, FCs, and other organizations.[158] Similarly, Kristiansen offers an excellent example of co-production in Swedish addiction services.[159]

The Royal College of Psychiatrists acknowledges the need for a novel approach.[160] The ethics of co-production suggests MHSs may need to move beyond EBM. It encourages us to recognize that rather than choosing treatment or care — except in emergencies — service users might consider efforts better spent in combatting stigma and securing employment (or meaningful occupation).[161] Sullivan reckons that 'autonomy enhancement and the internalization of behavior change are better addressed in educational theory and classical virtue ethics than in theories of health behavior change'.[162] Without new inspiration, the 'broken and demoralised system' risks obsolescence.[163]

This section, expecting continued economic uncertainty and further economic stress on services, has identified much of the literature as entrapped in biomedical ethics and organizational decline. I have argued that co-production is likely to prove a better safeguard

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[157] Swinton, p. 10.

[158] Chambers and others, pp. 7-8.

[159] Arne Kristiansen, 'Rainbow Quality System: User-Led Innovation in Quality Assurance', in *Social Care, Service Users and User Involvement,* ed. by Peter Beresford and Sarah Carr (London: Jessica Kingsley, 2012), pp. 84-95.

[160] Tom Foley, 'Bridging the Gap: The Financial Case for a Reasonable Rebalancing of Health and Care Resources' (London: The Royal College of Psychiatrists, 2013), p. 3.

[161] Magdalena Tyszkowska and Magdalena Podogrodzka, 'Stigmatization on the Way to Recovery in Mental Illness—The Factors Directly Linked to Psychiatric Therapy', *Psychiatria Polska,* 47 (2013), pp. 1011-22; Helen Barnes, 'Does Mental Illness Have a Place Alongside Social and Recovery Models of Mental Health in Service Users' Lived Experiences? Issues and Implications for Mental Health Education', *The Journal of Mental Health Training, Education, and Practice,* 6 (2011), pp. 65-75.

[162] Sullivan, p. 202.

[163] Schizophrenia Commission, p. 3.

than Kempster and associates' hope that managers might show MacIntyrean leadership.[164]

Inclusion might be service users' and carers' priority desire from MHS and FC support.[165]

However, that should be their call.

Conclusions

I have argued that the task of the ethics of co-production lies in supporting people with mental health problems and their carers towards *eudaimonia*. Drawing on MacIntyre and Moore, I proposed that service user and carer preferences could mitigate MHS failure.[166] I suggested that including user experience in the evidence base could embed value within the organizational structure. Finally, I reframed the ethics of co-production beyond MHSs, within the broader hopes of people with mental health problems.

A striking feature of the next chapter, the first of three presenting my GT core concepts, is the recognition that MHSs and FCs compete for epistemological as much as economic legitimation. However, participants found relative strengths (in fact and value respectively). Most drew what they could from MHSs and FCs.

Since I drafted the findings chapters (3-5) ahead of my literature review, they do not refer to the ethics of co-production or the *telos* of *eudaimonia*. I have deliberately avoided reworking them to obscure this fact.

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[164] Kempster, Jackson, and Conroy, p. 322.

[165] Clare Rotheram and Julian Raffay, 'The Life Rooms: An Innovative Recovery Approach', *Journal of Recovery in Mental Health,* 1 (2017), pp. 35-41.

[166] MacIntyre, pp. 237, 59; Moore, p. 120.

3   All Hands on Deck: Core Concept One

In 2012, I described mental healthcare as 'being driven by a perfect storm that risks turning nurses into technicians and patients into data'.[1] Six years on, my findings suggest the storm may have turned into a full-blown hurricane, needing all hands on deck. Participants, across all five groups, considered the trained crew exhausted and needing urgent help. Involving the passengers might bring reprieve, but all saw the ship taking in water, in distress and no longer self-sufficient. The time has come to call air–sea rescue and onshore emergency aid.[2]

If I have likened MHSs to a sinking ship, what of FCs? Participants' views suggested a rescue crew terrified to go on mission, its equipment in disrepair, urgently needing the ship's technician's skills. This rescue team appear overwhelmed and isolated, snubbed by other onshore organizations. The organizations, most verging on insolvency, are preoccupied with their uncertain survival. While these 'antifragile' bodies struggle against the raging hurricane, huge crowds are pleading to embark.[3]

Facing a surge in mental health problems, participants implied that no single agency has either the capacity or range of solutions.[4] Many saw distressed MHS staff repeating what they already knew with ever greater insistence and futility.[5] I recalled Titanic's Captain Smith of

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[1] Raffay, What are the Factors, p. 39.

[2] Patricia Deegan, 'Recovery, Rehabilitation and the Conspiracy of Hope: A Keynote Address', (1987) <https://www.patdeegan.com/sites/default/files/files/conspiracy_of_hope.pdf> p. 9.

[3] Taleb, *Anti-Fragile*, p. 17.

[4] Health and Social Care Information Centre; Money.

[5] Robert Yerkes and John Dodson, 'The Relation of Strength of Stimulus to Rapidity of Habit-Formation', *Journal of Comparative Neurology and Psychology,* 18 (1908), pp. 459-82.

whom the salvage coordinator said: "Twenty-six years of experience working against him […] everything he knows is wrong".[6]

This chapter and the following two each introduce a GT core concept. I devote three full sections apiece to the concepts' subordinate core categories. As mentioned in Section 1.2, each chapter has a fourth shorter section incorporating supporting material, equivalent to the elaboration on GT below. Chapter 4 includes two project case studies. Chapter 5's last section consolidates the earlier chapters, preparing for the more theological material in Chapter 6 that I have delayed to surface participants' 'ordinary theology'.[7]

I shortly present my first of three GT concepts: 'All Hands on Deck'.[8] This concept supports greater cooperation, seeing MHSs and FCs as complementary. I take a multi-agency approach, exploring participants' response to my first RQ: 'Do stakeholders consider that greater cooperation between MHSs and FCs would benefit service users and carers?'.

3.1   Grounded Theory: How I Present the Material

To show that I have not jumped from sensitizing concept to core concept, I first elaborate on my use of informed GT, explaining its relevance. I then define my GT nomenclature before detailing my approach to presenting the fieldwork over the three chapters. I later outline the five participant groups, explaining how I enable audit.

Informed Grounded Theory

I first address two issues with GT that I glossed over in Chapter 1. The more complex is epistemological. Grounded theory, especially in its constructivist forms, risks relativism and emotivism.[9] It may appear unfavourable to theology.[10] However, GT is usable as a research

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[6] James Cameron, 'Titanic' (20th Century Fox, 1997).

[7] Astley, *Ordinary Theology*, pp. viii, 35.

[8] A similar metaphor is used in Philip J. Barker and Poppy Buchanan-Barker, 'All Hands to the Pumps: Group Care', in *The Tidal Model: A Guide for Mental Health Professionals,* (Hove: Brunner-Routledge, 2005), pp. 159-75.

[9] MacIntyre, pp. 23-35.

[10] Astley, *Ordinary Theology*, pp. 42-43.

methodology without signing up to its accreted theoretical framings.[11] Like other

methodologies, it contains contradictions. Indeed, acknowledgement of sensitizing concepts (let

alone RQs) reveals that no researcher approaches their work *tabula rasa*.[12]

Neither inductive nor deductive approaches appear entirely faithful to actual knowledge

acquisition, let alone to the real manner of scientific discovery.[13] In his *Informed Grounded*

Theory, Thornberg advances 'abduction'.[14] He describes it as 'something between deduction

and induction'.[15] Thornberg suggests it is 'an innovative process because every new insight is a

result of modifying and elaborating prior knowledge or putting old ideas together in new ways

as the researcher explores and tries to explain the new data'.[16] Abduction, he proposes, loosens

up GT, allowing reflexive researchers and participants greater scope to follow lines of enquiry

without forcing the data. Thornberg's informed GT allowed my sensitizing concept 'a perfect

storm' to influence and be influenced by participants' later responses. Core Concept One's

nautical metaphor 'All Hands on Deck' was unapologetically a result.[17]

The second issue with classic GT is the delayed literature review.[18] My response has

been twofold. First, for readability (as mentioned), I have given my thesis a conventional form.

However, abductive shuttling lies beneath its content, reflecting my GT order research timeline.

To satisfy University Regulations, I first conducted a proximate literature review on service user

involvement.[19] Following GT principles, I carried out the research fieldwork and analysis ahead

of preparing the current literature review. My approach ensured readability while prioritizing

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[11] Charmaz, pp. 277, 81, 84.

[12] Ibid., pp. 30-31.

[13] Karl R. Popper, *The Logic of Scientific Discovery* (London: Routledge, 2002).

[14] Robert Thornberg, 'Informed Grounded Theory', *Scandinavian Journal of Educational Research,* 56 (2012), pp. 243-59.

[15] Ibid., p. 247.

[16] Ibid.

[17] Another metaphor would not materially have altered the intensity of participants' response to the 'broken and demoralised system'; Schizophrenia Commission, p. 4.

[18] Thornberg, pp. 244-45.

[19] Julian Raffay, 'The Increasing Role That People Who Use Mental Health Services Play in Governing Services' (unpublished literature review, Durham University, 2015).

participants' perspectives. It specifically enabled the three core concepts to emerge ahead of my reflection on the fact–value divide (itself arising from an interview).

Nomenclature, Approach, and Participants

Before detailing my approach and listing the participant groups, I briefly define my GT nomenclature in ascending order of abstraction from initial code to theory (see Table 2).[20] For clarity, I capitalize GT core categories and concepts throughout the thesis, leaving subordinate items in lower case. I use double inverted commas to show verbatim participant quotes and single inverted commas for other codes and memos.

Item	Definition
Sensitizing concept	Idea inspiring researcher to begin the project
Code (initial, focused)	A fragment of transcribed interview text
Memo (early, advanced)	Researcher reflections on a code fragment
Category (early, advanced)	Basic grouping of codes and memos
Core Category	Intermediate grouping
Core Concept	Highest level grouping
Theory	Model or representation of reality

Table 2 GT Nomenclature

The nine GT sections across the three chapters — reflecting nine core categories —have three subsections apiece. This repeating structure elaborates each GT core category, drawing on Leach's action–reflection framework to prioritize *participants' 'voices'*.[21] In each instance, the first subsection presents focused GT codes (Leach's Step One). The second details GT memos to clarify issues and locate *my own 'voice'* (Step Three). The third subsection attends to the *theological tradition* (Step Four). I purposely foreground PT's contribution to debate beyond the church, leaving *attention to the mission of the church* (Leach's Step Five) to chapters 6 and 7.

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[20] For audit purposes, I have not revised any of the focused codes or advanced memos.

[21] Leach, p. 31.

I have attempted throughout to give 'prayerful attention to who God is and what God is saying'.[22]

My treatment of Leach's *wider issues* (Step Two) reflects my abductive approach. Each interview raised matters which I either (a) recorded as memos, (b) included in my research journal, or (c) reflected on informally. Some *wider issues* influenced later interviews by means of the constant comparative method.[23] Others became draft chapter titles. Some guided my literature review, and I repositioned further material during drafting. Throughout, I considered prioritizing participants' voices more critical than strict adherence to either GT or Leach. For clarity, I have italicized Leach's steps as I use them extensively.

In attending to *participants' 'voices',* I give precedence to service users and carers, considering each in turn. I then give 'voice' to staff, FC leaders, and FBO leaders. Rather than cycling through the groups and nesting the categories, I express the views by participant group for all nine core categories.

Group	Examples
Carers	Charlie, Christine, Claire
FC leaders	Fred
Organization leaders	Olive
Service users	Patrick ('P' as in patients)
Staff	Stephen

Table 3 Participant Group Initials

To reveal differences between the five participant groups, I allocated pseudonyms beginning with the group's initial (see Table 3). To enable auditing, I assigned unique identifiers. For instance, 'Fred C23' stands for the twenty-third transcribed interview fragment of the FC leader pseudonymized 'Fred'. The prefix 'C' indicates a GT code, 'Fred M23' being

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[22] Ibid.

[23] Charmaz, pp. 181-82.

the equivalent memo. The resulting transparency enabled me to move easily between codes and core concepts and build my theoretical model while staying close to the data.[24]

I introduced this first of three findings chapters by narrating participants' perception of a mental health surge overwhelming both MHSs and FCs. Having clarified my use of Leach's action–reflection framework, this chapter's remaining three sections explain how core categories one to three form Core Concept One 'All Hands on Deck'.

3.2   Surviving the Storm: Core Category One

My first core category deliberately elaborates my sensitizing concept's nautical metaphor yet is rooted in the current interview data. The core category 'Surviving the Storm' reflects the distress participants sensed in MHSs. Their concerns were recently echoed by Mersey Care's Chief Executive who said: "We've done a really good job of keeping the ship afloat".[25] After one interview, I noted: 'My quote about the perfect storm needs to be strengthened, [namely] that patients are actually [being] turned into numbers'.[26]

I gathered the core category 'Surviving the Storm' from four subordinate categories: (a) feeling knocked back, (b) fear, (c) myopia and silos, and (d) overreaching. I now evidence the core category's development, first presenting *participants' 'voices'* (focused codes), then *my own 'voice'* (advanced memos). Last, I attend to the *theological tradition*. The resulting categories, concepts, and theory are my 'conceptual rendering' of participant responses.[27]

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[24] Sanne Akkerman and others, 'Auditing Quality of Research in Social Sciences', *Quality and Quantity,* 42 (2008), pp. 257–74 (pp. 272-73).

[25] Joe Rafferty, 'Managers' Forum', in *Managers' Forum* (Ashworth: Mersey Care NHS Foundation Trust, 2017).

[26] Pippa M462.

[27] Charmaz, p. 38.

Attention to Participants' 'Voices'

Despite some positive accounts, participants related many painful experiences. I most commonly coded feeling 'knocked back'.[28] Feeling knocked back extended beyond being asked to return later. It describes frequent reinforcement of low self-esteem through the continual experience of disadvantage, however seemingly trivial each instance. Participants across all five groups expressed disappointment with MHSs. Fear was widespread. Detention, compulsory medication, risk of aggression, availability of illicit substances, and enforced communal living challenged service users, carers, and staff alike. The category 'myopia' describes participants' sense that service priorities and theoretical formulations were unresponsive to service users' and carers' felt need.

Service users typically expressed feeling 'knocked back' when rejected by a fellow human being rather than by the system. Most assessed staff fairly. Peter, for instance, considered himself 'to have been very well treated in hospital' but saw service users as 'often sad and frustrated' and at risk of emotional harm.[29] Perry suggested that 'not feeling well and being unable to elicit positive responses can create a vicious circle'.[30] Pam found the staff 'warder-like'.[31] Patrick described MHSs as 'a form of oppression and violation of rights'.[32] He saw the 'mental health system […] using the myth of people not being able to look after themselves'.[33] Penny identified herself as 'vulnerable to drugs [*sic*] pushers on NHS premises'.[34]

Both Patrick and Peter implied that MHSs acted with limited understanding of service user stigmatization in wider society. Patrick described being "in the community but not in the

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[28] One hundred and eighty-six instances.

[29] C52; C264.

[30] C279.

[31] C382.

[32] C150.

[33] C146.

[34] C17.

community" and reported 'experiencing abuse like people spitting'.[35] Peter struggled 'with

living day-to-day and avoiding boredom'.[36] He said he did not know the name of his community

psychiatric nurse and experienced 'health service involvement as injection and six monthly

psychiatric reviews'.[37] His experience affords insight into why asking a service user to wait ten

minutes might leave them feeling knocked back.

Carers reported feelings of disconnection and fragmentation as most destructive.[38]

Christine found 'being dissed by [the] vicar mind-blowingly horrendous'.[39] Similarly, Craig

described "some very very unpleasant rabbis".[40] Sometimes MHS staff were seen to have failed

similarly, including chaplains.[41] Carla experienced staff 'varying from caring to not at all',

describing some as 'harsh'.[42] Connie reported having thirteen support workers in two years.[43]

Some participants questioned ward safety, Craig 'blaming aggression on doctors' inability to

communicate and find out about the patient'.[44] He expressed concern about 'bullying […] when

people [are] at their lowest or psychotic'.[45] Craig said a first admission could be 'a frightening

experience', suggesting 'patients [are] unsupported'.[46] Charlie remarked: 'It would be very

interesting to observe patients' understandings of what is going on'.[47]

Carers struggled with fear. Some fears were long-term, exposing vulnerabilities as when

a participant with visible disabilities described fearing hate crime.[48] Another said she expected

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[35] C44.

[36] C263.

[37] C296; C314.

[38] Cf. Stanley Hauerwas and William H. Willimon, *Resident Aliens: Life in the Christian Colony* (Nashville, TN: Abingdon Press, 1989), pp. 66-68.

[39] C270.

[40] C483; I cite this code without intending offence and apologize if I have caused such.

[41] Craig C477.

[42] C8; C14.

[43] C1150.

[44] C451.

[45] C219.

[46] C233.

[47] C13.

[48] Anonymized C85.

to die in the undertow of her son's illness and was unsure how she would deal with his death.[49]

Some fears reflected crises. Connie wondered 'how long [she] would be able to keep [her] son

out of prison in the face of [her] own [physical] illness'.[50] She was afraid when her son insulted

a Jewish doctor about the Holocaust.[51] Despair was often tangible, causing me to reflect:

'mental health problems can send shockwaves through a family that tear at weak points'.[52]

Staff with lived experience were frank about MHSs' limitations. Stephen (also a service

user) found 'little humanity in the crisis team'.[53] Serena suspected 'nurses may avoid

conversations where they might not have answers' and recognized 'a nurse's internal dialogue

and emotional strain'.[54] She reported 'time pressures on nurses as being the social process

causing them to avoid conversations'.[55] However, staff also recounted FC failings as when

Sharon described being 'told [her] own problems [were] too difficult for the [house] group'.[56]

Sharon significantly identified in MHSs 'a culture as much as a resources problem'.[57] Sally saw

'innovation as largely absent from NHS and church', describing the latter 'as enslaved to a

previously successful parochial model'.[58]

On myopia and silos, Sharon likened 'triumphalist theology to triumphalist medicine',

considering both rooted in 'discomfort in sitting with people rather than trying to fix them'.[59]

Stephen similarly saw staff as potentially 'becoming godlike when put into the powerful

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[49] Carla C269; C360.

[50] C931.

[51] C211.

[52] Connie M273.

[53] C48.

[54] C486; C535.

[55] Serena C502.

[56] C485.

[57] C121.

[58] C128; C149.

[59] C348; C347.

position' and likened 'domination to the days of slavery'.[60] Susan suggested 'we need to stop being fearful of each other'.[61]

Faith community leaders saw MHSs as fearful. Faye likened fear to 'a catapult, causing people to focus on [evidential] forms rather than care'.[62] Frank implied fear had a greater impact, suggesting 'comfort zones can become smaller and smaller when people act out of fear'.[63] He challenged what he saw as ridiculous enforcement of data protection.[64] Participants across the groups acknowledged the impact of fear on staff.

Organizational leader participants interacted with both MHSs and FCs. Oscar described the church as 'providing core support, even when other agencies are involved'.[65] Olivia considered Christian vocation important, feeling 'inspired to look after the poor and powerless'.[66] Ophelia echoed Olivia, seeing 'being Christian-led as distinctive [*sic*] from being faith-led'.[67] Ophelia, in turn, identified her project's strength in 'having [a] Western-trained priest and psychologist of the same nationality as asylum seekers'.[68] Pippa criticized the tendency of 'evangelical and [some] non-white churches' to dismiss MHSs and the latter's corresponding inclination to stigmatize and slight FCs.[69] Olivia drew on St Peter's being told 'not to call anyone unclean' (Acts 10.28), highlighting willingness to associate with others.[70]

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[60] C361; C397.

[61] C640.

[62] C402.

[63] C528.

[64] C208-10.

[65] C200.

[66] C36.

[67] C269.

[68] C1026.

[69] C207.

[70] M91.

For Odette, this included 'the necessity of long-term relationships in which people feel ready to invest'.[71] Oscar suggested chaplaincy was 'well-placed to start conversations'.[72]

Organizational leaders found both MHSs and FCs poorly prepared for the storm. Where Sharon had described 'a culture as much as a resources problem', Oscar went further, 'seeing the West as fixated on 400-year-old [Enlightenment] thinking'.[73] Oscar described people being 'harmed by science's revenge on religion'.[74]

Attention to my Own 'Voice'

I inferred that 'professionalism has created an aura around itself that [has] disabled others'.[75] This echoed Sharon's indictment of 'triumphalist theology' and 'triumphalist medicine' and her earlier observation about people 'feeling judged for failing to live their victory'.[76] I reflected that 'the comparison between triumphalist theology and [triumphalist] medicine gets to the heart of power and conceit'.[77] Both MHSs and FCs can gain 'a delusional sense that the world revolves around them' and end up 'disenfranchising [people] and creating sick roles'.[78]

I concluded that 'we need to be aware of [the] rhetoric […] that churches harm people as if MHSs don't also'.[79] Living in a psychiatric ward may be just as emotionally damaging as community isolation. I was struck by Craig's previously mentioned suggestion that a first admission could be 'a frightening experience' and his implied lack of support.[80] I saw parallels with a first FC attendance (recalling my visit to a large mosque).[81] I realized that atomized EBM

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[71] C100.

[72] C481.

[73] Sharon C121; Oscar C155.

[74] C283.

[75] Ophelia M857.

[76] C348; C334.

[77] Susan M147.

[78] Olivia M223; C340.

[79] Penny M17.

[80] C233.

[81] Though the worshippers made every effort to welcome me, I was fearful; Sharon M332.

and its hyper-spiritual FC equivalents are blind to broader overall experience.[82] A contrasting study attending to the wider context found that Experience-Based Co-Design improved cancer recovery rates.[83] Their findings supported the possibility that co-production might deliver notable improvements to MHSs (and possibly FCs).

I recalled Charlie's remark that 'it would be very interesting to observe patients' understandings of what is going on'.[84] I deduced that co-researching, co-designing, and co-delivering services could significantly address feeling knocked back.[85] I inferred that 'patients can forgive busyness but not lack of humanity'.[86] I concluded that 'withdrawal [in the face of feeling knocked back] is self-fulfilling and very dangerous', and that rejection instils fear.[87] I further thought that 'every time we lose sight of a person's humanity, we do them harm; every time we treat people as a means rather than an end, we damage them'.[88]

Reflecting on the codes 'myopia' and 'silo thinking', I inferred that without wider engagement, tunnel vision seems almost unavoidable. Both myopia and silo thinking are harmful and involve dissociation (in its psychiatric sense). Myopia — short-sightedness, inability to see beyond one's focus — is precisely my findings' charge against EBM. Similarly, tunnel vision does not recognize important matters on the periphery. When unrecognized, distorted perception risks rationalizing or even flaunting its own artefacts.[89] Dedicated practitioners rarely critique their own schools. For instance, the psychologist Kinderman's *A Prescription for Psychiatry* challenges that profession while seemingly oblivious to flaws within his own.

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[82] Kevern, The Grace, p. 206.

[83] King's Fund.

[84] C13.

[85] Raffay, Wood, and Todd.

[86] Pippa M449.

[87] Connie M941.

[88] Pippa M584.

[89] MacIntyre, p. 263.

A valuable insight comes from Forrest and associates' exploration of service user involvement in nurse education. They found that 'participants considered that students usually started out as 'naturally caring' but, once qualified, were 'corrupted' by working in the mental health system'.[90] I inferred that 'nurses' priorities [had switched] from bed to [trust] board' at least partly in response to the management-orientated Griffiths model of health service delivery.[91] I reflected: 'evidence-based practice chooses places where it can find evidence and leave[s] out humanity'.[92] I identified 'a self-reinforcing utilitarianism […] that is not only attracted to that which it can evidence but also narrows what it offers to that which can be evidenced, possibly in an ever-decreasing circle'.[93] I asked myself whether 'nurses and other health professionals have a relationship with those they work with [i.e. service users]' that is useful to the latter?[94]

Anyone can become disorientated in a storm. Myopia and tunnel vision only worsen the confusion.[95] Despite political pressures on MHSs, I suggest professionals' distancing from service user concerns has allowed many front-line staff to become swamped by the perfect storm of utilitarianism's ever-insistent self-rationalizing demands.[96] The resulting antifragile artefacts are inherently unstable, and the ensuing turbulence risks whipping the storm into a hurricane.[97] I wondered whether, as Francis suggests, service user concerns could restore equilibrium and, if so, what might best ensure this?[98] I found inspiration in the theological tradition.

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[90] Forrest and others, p. 53. We should not presume FCs to be immune from similar influences.

[91] Serena M188; Griffiths.

[92] Pippa M628.

[93] Ibid.

[94] Stephen M25.

[95] Cf. Matthew 6.22-23.

[96] MacIntyre, p. 64.

[97] Taleb, *Anti-Fragile*, p. 17.

[98] Francis, p. 7.

Attention to the Theological Tradition

My earlier suggestion that co-production began with Adam (Genesis 2.19) implies divine collaboration from the outset. Indeed, no sooner does the Old Testament declare God Creator than we learn that 'the Spirit of God was hovering over the waters'.[99] Even before God started co-producing with humankind, the Bible declares creation itself an expression of 'co-production' within the Godhead. In identifying 'co-production' within the Godhead, I am not making an eisegetical claim but rather repeating my earlier assertion (page 13) that Christians may understand co-production as a concept looking to our vocation as co-creators alongside the Trinity and people of goodwill.[100]

In this subsection, I *attend to the theological tradition*, following Leach's Step Four.[101] Throughout the rest of this thesis, I argue that, at its best, co-production reflects the Divine nature rather than the converse. In the 'Attention to the Theological Tradition' subsections, I bring Trinitarian theology to bear on the ideas presented by each chapter section's preceding 'voices'. In so doing, I prepare for chapter Six, where I integrate my fieldwork reflections with an overview of the Trinity to provide my thesis with its theological underpinning.

Returning, briefly to my statement that co-production echoes God's actions at the dawn of time and the beginning of human history, we may identify an ethical dimension from the outset, namely that creation 'was good' (Gen 1.12) but quickly became marred (Gen 3) when people acted independently of God. This pattern repeats throughout the Old Testament, where recurrent failure to honour God's covenants makes dismal reading. The New Testament opens with four accounts of God's remedy. John (1.1-4) unfolds by declaring Jesus co-creator. In Mark 4, Jesus strikingly displays his sovereignty over creation by stilling a storm. Not only did he save the disciples from shipwreck and death but caused them to ask: 'Who then is this, that even the wind and the sea obey him?' (4.41). Theologically, this was no isolated event nor even the

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[99] 'Holy Bible, New International Version - Anglicized', (Colorado Springs, CO: Biblica, 2011). Genesis 1.1-2.

[100] McFadyen, pp. 151-61.

[101] Leach, pp. 27-29.

climax of his ministry. The stilling of the storm foreshadowed the promise in Romans 8.18-29 that 'creation itself will be set free from its bondage to decay' (8.21). Creation and redemption are Trinitarian acts, overcoming the forces of chaos, often represented as a storm.

I am not suggesting that the economic Trinity provides the only divine insight to inform our understanding of co-production any more than I am suggesting that co-production is only about action or outcomes. On page 13, I observed that in my experience, co-production is foremost about relationships, a point also evident in Slay and Stephens' definition.[102] We may recognize in the ontological Trinity — three coequal Persons — unplumbable resources to prevent us from ever imagining that co-production might be a value-free tick box exercise.

In the next 'Attention to the Theological Tradition' section, I shall address theological issues that I have hitherto overlooked. In the words of McGrath: 'Our thoughts about God are bound to seem illogical and muddled, precisely because what they refer to lies beyond our full knowledge and understanding […] we need to open up our minds to the greatness of God, rather than reduce God to something we can cope with'.[103] Reductionism is my contention with EBM and precisely why Trinitarian theology is so apposite.

Heaney's *Skylight* expresses well the frustration my participants experienced with provided MHSs and their disappointment with the 'broken and demoralised system'.[104]

> You were the one for skylights. I opposed
> Cutting into the seasoned tongue-and-groove
> Of pitch pine. I liked it low and closed,
> Its claustrophobic, nest-up-in-the-roof
> Effect. I liked the snuff-dry feeling,
> The perfect, trunk-lid fit of the old ceiling.
> Under there, it was all hutch and hatch.
> The blue slates kept the heat like midnight thatch.

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[102] Slay and Stephens, p. 3.

[103] Alister E. McGrath, *Christian Theology: An Introduction*, 6th edn (Oxford: Wiley-Blackwell, 2017), p. 300.

[104] Schizophrenia Commission, p. 4.

But when the slates came off, extravagant

Sky entered and held surprise wide open.

For days I felt like an inhabitant

Of that house where the man sick of the palsy

Was lowered through the roof, had his sins forgiven,

Was healed, took up his bed and walked away.[105]

Citing Heaney's poem, I build my case that 'ordering more speed' is unlikely to help

MHSs survive the storm.[106] An altogether more radical approach is needed. Drawing on

Trinitarian theology will clarify our understanding of ethics, including the ethics of

co-production.[107]

Describing the core category as 'Surviving the Storm' reflects both individual

participant experience and doubt about future provision. Feeling knocked back and fear were

strong emotional responses, suggesting storm-tossed MHSs are taking water.[108] Myopia, silos,

and overreaching imply 'bondage to decay' and absence of psychological safety. Participants

found FCs ill-prepared and ill-equipped to respond yet considered them more resilient than

MHSs.

3.3   Faith Community Resilience: Core Category Two

The core category 'Faith Community Resilience' emerged as a recurrent theme.[109] It arose from

an awareness that both MHSs and FCs are under stress, despite FCs' richer, more time-

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[105] Heaney.

[106] Cameron, 'Titanic'; Schizophrenia Commission, p. 4.

[107] Christian readers will appreciate that I understand myself as searching God's purposes and nature revealed in creation.

[108] David Ford, *The Shape of Living: Spiritual Directions for Everyday Life* (London: Canterbury Press, 2012), p. xvi.

[109] The OED defines resilience as 'the capacity to recover quickly from difficulties; toughness'; Oxford University Press.

honoured, conceptual roots and often relatively less antifragile structures.[110] However, based on what I have said, we should not expect a quick recovery. We cannot assume the promised £20 billion NHS funding increase will prove a panacea.[111] In considering my second core category, and indeed the remaining seven, I again present *participants' 'voices'* (focused codes), then *my own 'voice'* (advanced memos), finally attending to the *theological tradition*.

Attention to Participants' 'Voices'

All participant groups found significant weaknesses in MHSs and FCs though most preferred faith-based approaches, seeing them as more compassionate.

Service user views of MHSs corroborated the Schizophrenia Commission's epithet of a 'broken and demoralised system'.[112] Peter, on an advanced care plan, made the saddest observation, being unable to name his community psychiatric nurse.[113] Pippa saw degradation coming about piecemeal through 'inaccessibility of college courses'.[114] Despite these weaknesses, participants recognized opportunities for MHS–FC collaboration. Perry found FCs 'very much involved with statutory services in some areas' (as in Street Pastors).[115] Pippa saw the 'Salvation Army as providing [a] very high level of support to very poorly people'.[116]

Carers found strengths and weaknesses all around. Charlie captured overall opinion, affirming 'the church's commitment over decades as compared with shrunk social provision'.[117] Christine, seeing 'cuts as endemic', thought providers were being stress-tested.[118] She described

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[110] Taleb, *Anti-Fragile*, p. 24.

[111] Laura Kuennsberg, 'Theresa May Is Asked Where NHS Cash Will Come From' (London: BBC, 2018).

[112] Schizophrenia Commission, p. 4.

[113] C296.

[114] C137.

[115] C164; Cf. Olivia C282.

[116] C529.

[117] C443.

[118] C824.

English MHSs as 'one of the worst in Europe'.[119] Susan alarmingly described 'staff getting carried away with "Crucify him"!'.[120]

Charlie implied that FCs commanded respect and confidence, resulting from generations of service within their neighbourhoods. Sally and Simon, among others, agreed.[121] For Christine, churches were 'offering deeper understanding than community social groups'.[122] She saw churches responding to local need rather than delivering theoretically framed policies.[123] Charlie saw the church 'picking up social provision in places where there is nothing else'.[124] Carers also criticized FCs. Craig described "horrific misdemeanours" in an FBO's hostel.[125] Claire found Christianity over-represented and considered some FCs 'unsuitable for providing services'.[126] She feared the country 'reverting to [dependence upon] philanthropy' with increasing 'lacunae in statutory provision'.

Staff participants saw FCs as having several advantages. Susan described MHS 'staff losing their humanity while risk assessments are barely in place'.[127] Sally named the NHS: "the most hidebound religion I've come across to date".[128] She saw 'innovation as largely absent from [both] NHS and church', describing the charitable sector as 'going down the tubes'.[129] Sharon suggested 'the NHS choice of business approaches has eclipsed human care'.[130] Susan suggested that, in churches, damage caused by frenetic activity was 'mitigated by their reservoir

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[119] C21.

[120] C200. Note: I checked that she was not raising safeguarding issues.

[121] Sally C64; Simon C74.

[122] C606.

[123] C606.

[124] C101.

[125] C919. Note: Again, I checked for safeguarding issues.

[126] C18; C273.

[127] C467.

[128] C16.

[129] Sally C128; C78.

[130] C87.

of humanity'.[131] Simon felt both MHSs and FCs had advantages, suggesting 'somewhere in the middle of the expert and the friend would be ideal'.[132]

The FC leaders contrasted what they saw as MHSs' exhaustion with their perception of greater capacity in FCs. Florence considered that the church had 'lots of unused assets from which people could benefit'.[133] Frank recommended a Boolean AND, saying: 'we need to recognize professional skill but equally affirm what ordinary people can offer in bringing reassurance and comfort'.[134] Fred, seeing 'collaboration as cheaper than crisis management', favoured 'energy and time being spent on strategic collaboration between [the] faith [sector] and statutory services'.[135] Fraser offered a practical example, suggesting 'a trust might ask a mosque to keep an eye on a service user'.[136] Fred anticipated 'recurring [NHS] scandals every five years with little genuine remedy due to the same solution being applied every time'.[137] He described one NHS chief executive as a "mechanic" and questioned his "entourage".[138] Fergus identified dangers in returning to a medieval scenario with mental health care being largely provided by FCs.[139]

The FBO leaders expressed concern about formulaic responses to human need. Odette saw: 'statutory services […] inflexibly responding to narrowly defined problems in communities'.[140] She considered MHSs' work among immigrants problematic, with staff 'needing a wide understanding of immigrants' culture and experience to avoid mistaken

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[131] C463.

[132] C52.

[133] C28.

[134] C61.

[135] C89; C87.

[136] C457.

[137] C167.

[138] C249; C255; Note: this was not Mersey Care's Chief Executive.

[139] C321; C473.

[140] C223.

attribution of difference to mental health issues'.[141] Odette saw 'mental health as full of myths' and asserted that 'professionals will not prevent a crisis'.[142]

Ophelia expressed a similar concern about FCs, describing 'a generation of clergy who think they are working because they're looking at their computer' and 'responding to pastoral issues by suggesting ChildLine'.[143] Ophelia saw 'Western-based faiths arrogantly believing God has equipped them to handle situations' and 'lack of trust [with]in Eastern-based faith groups'.[144] Oscar identified 'risk where churches cast out demons without learning about mental health'.[145] Olivia praised Alcoholics Anonymous and their approach, saying the 'sponsor isn't some lovely leader with a white coat. It's an alcoholic that's been able to stay off alcohol for [a] while'.[146]

Attention to my Own 'Voice'

In exploring MHS and FC resilience, I realized I was engaging in a delicate political process. This led me to use a strengths, weaknesses, opportunities, and threats (SWOT) framework to calibrate my responses, mitigate my mood filter, and seek balance.[147] Though I avoided Glaser's more positivist approach to GT, the distribution of codes within the SWOT framework merited comment. It suggested participants saw greater strength and opportunity in FCs than MHSs with slightly fewer weaknesses (see Table 4). Threats appeared evenly matched. I present these figures by participant group in Appendix F.

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[141] C175.

[142] C78; C121.

[143] C835; C839.

[144] C38; C40.

[145] C445.

[146] C325.

[147] Threats were to service user and carer welfare.

In considering threats, I reflected that MHS 'professionalization disempowers patients as well as FC ministers and volunteers. It may be arrogant and then collapses under the load that it has created for itself'.[148] This insight led me to conclude that MHSs' weaknesses might be inextricably bound to their positivist stance. I reflected that if 'problem-solving models fail to address loneliness', then the pressure on MHS beds may be 'a self-induced illness arising from deskilling the community'.[149] This uncomfortable assertion suggests that MHSs may be dysfunctional and that 'narrow definitions of success may fail to pick up failure'.[150] A tragic illustration of this effect is Grenfell Tower where complex interactions proved disastrous.[151]

	MHSs (%)	FCs (%)	Other (%)	Number of focused codes
Strengths	7	86	7	44
Weaknesses	45	40	15	133
Opportunities	2	51	47	59
Threats	21	14	65	28

Table 4 Distribution of Focused Codes within the SWOT Framework

Though a clinical trial may find an intervention more effective than its control, myopic researchers may be unaware that 'unwelcoming [ward] environments may be devastating for people with low self-esteem'.[152] Clinical trials are unlikely to grasp that 'the elimination of others from [giving] support creates an intolerable burden for the NHS and squanders professional resources'.[153] These others could include service users and carers engaged in co-production or the public more generally, including FC leaders.

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[148] Otis M141.

[149] Otis M155; M148.

[150] Odette M65.

[151] Gordon MacLeod, 'The Grenfell Tower Atrocity', *City,* 22 (2018), pp. 460-89.

[152] Otis M541.

[153] Otis M154.

In contrast to professionalism, co-production affirms everyone's 'vital' contribution and rejects the idea of 'Throw-Away People'.[154] An asset–based perspective on MHSs offers greater possibility of plentiful resources instead of overworked experts.

Research on stress suggests performance and learning decline rapidly beyond tolerable pressure, causing known solutions to replace creativity.[155] Pippa remarked that 'when stretched, both churches and NHS will do the things that promote their survival: narrow proselytism and number crunching'.[156] Sadly, 'stereotypes and prejudices may stand in the way of a very valuable resource'.[157]

Attention to the Theological Tradition

Personal resilience depends on protective factors, a significant one of which is participation in an FC.[158] Such resilience can transform staff members' awareness of their context, their role, and their relationship with service users and carers. Recognizing the other as made in God's image should lead beyond care to compassion.[159] McFadyen suggests it reflects a deeper reality:

> a person is conformed to Christ in making genuine response to the address of
> God and others […] In conformity to Christ one becomes a person for others,
> a centred and autonomous subject orientated to others who therefore stands
> within any particular relationship as an independent (though not totally closed)
> locus of communication. Conformity to Christ is never complete, and in any
> case, can never be held in isolation from others.[160]

Though we might read McFadyen's work as Christianized symbolic interactionism, he implies the reverse. He observes: 'the quality of life within the triune being of God, which is given and created in the Persons' dialogical interrelationship, overflows as God's externally directed

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[154] Slay and Stephens, p. 3; Cahn, pp. 87-99.

[155] Yerkes and Dodson; Martin Corbett, 'From Law to Folklore: Work Stress and the Yerkes-Dodson Law', *Journal of Managerial Psychology,* 30 (2015), pp. 741-52; Robert Mair, Kristen Onos, and Jacqueline Hembrook, 'Cognitive Activation by Central Thalamic Stimulation: The Yerkes-Dodson Law Revisited', *Dose-Response,* 9 (2011), pp. 313-31.

[156] M478.

[157] Susan M260.

[158] Koenig, pp. 49-77.

[159] Matthew 25.31-46.

[160] McFadyen, p. 120.

communication in creation–redemption'.[161] For McFadyen, full humanity reflects the divine perichoresis.[162]

However, before we conclude that models suited to emergency medicine are unsuitable for ourselves as beings made in the image of God, we need to address theological concerns about equating the perichoretic Trinity with the Social Trinity. Kilby questions the influence of Moltmann's *The Trinity and the Kingdom of God*.[163] Her objection is not so much to social analogies as to how they are used. She argues that they gloss over critical differences between patristic theology and contemporary terminology. In particular, she suggests they overlook the difference between Tertullian's (c.160-c.220) framing of the Latin word *persona* (rendering the Greek ὑπόστασις) and our psychology–imbued phrase 'person'.[164] She suggests we need not replace the word 'person' but rather resist '*some* features of the modern secular understanding of this notion', specifically its contemporary atomized conception.[165] I concur entirely in wanting to resist EBM's reductionist tendency to view service users and carers as divorced from their social context and its corresponding threats to sources of resilience, not least FCs.[166] I welcome Kilby's assertion that 'a proper understanding of the Trinity and of the Trinitarian perichoresis […] enables one to understand persons as by their very nature interactive, interdependent, in communion with one another.'[167] I suggest that mental health problems commonly result from this communion having been disrupted or abused.[168] Restoring emphasis on unity or the *persona* in Tertullian's sense of an actor's role would, I suggest, be more

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[161] Ibid., p. 29.

[162] Ibid., pp. 168-69. Note: Perichoresis is the mutual indwelling in the Trinity.

[163] Karen Kilby, 'Perichoresis and Projection: Problems with Social Doctrines of the Trinity', *New Blackfriars,* 81 (2000), pp. 432-45 (pp. 432-33); Jürgen Moltmann (London: SCM, 2000).

[164] McGrath, p. 304.

[165] Kilby, p. 434. Italics original.

[166] Peter Beresford, 'User Involvement, Research and Health Inequalities: Developing New Directions', *Health and Social Care in the Community,* 15 (2007), pp. 306-12 (p. 311).

[167] Kilby, p. 434.

[168] Swinton, p. 10.

accurately reflected in co-produced services rather than those delivered to atomistic individuals.[169]

In making these assertions, I have yet to address Kilby's more serious charge of projection (though she considers this endemic to theology).[170] My response is that my purpose is more humble than to propose any Trinitarian reformulation. As with my discussion of MacIntyre (page 31), I am merely drawing on resources, investing my energies in advancing co-production and the ethics of co-production rather than making Moltmann's more extensive assertions.[171] In terms of Kilby's question as to whether we are 'self-possessed and going out into relationships, or as entirely constituted by our relationships', for my purpose, I need do little more than reject both poles of the argument.[172] In rejecting EBM's atomization, I do not want to lose sight of personal agency. Instead, Slay and Stephens' 'vital contribution' gives everyone the responsibility to make reasonable eudaemonic effort wherever reasonably possible.[173]

We should not assume that the organizational recovery of MHSs or FCs is necessarily desirable. Full staffing and large congregations might seem reasonable goals, but my findings suggest that participants seek something other than perfected versions of current MHS–FC provision. The most disputed territory concerns the right to frame the discussion. Here both critical psychiatry and theology stand to make significant contributions.[174]

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[169] Kersten England, 'Health and Well-Being in Britain', in *On Rock or Sand: Firm Foundations for Britain's Future,* ed. by John Sentamu (London: SPCK, 2015), pp. 132-59 (pp. 141-42).

[170] Kilby, p. 439.

[171] Moltmann, *The Trinity,* passim.

[172] Kilby, p. 441.

[173] Slay and Stephens, p. 3. I prefer to think of 'fruitfulness' rather than necessarily paid employment.

[174] Astley, *Ordinary Theology*, p. 2.

3.4   Flair: Core Category Three

The potential for critical psychiatry and theology to make significant contributions is clear in my third core category. Several participants credited their recovery to 'Flair', defined by the OED as 'a special or instinctive aptitude or ability for doing something well'.[175] Participants named some staff members as having exceptional ability to support dramatic improvements. Significantly, they ascribed Flair to personal rather than professional qualities.[176] Flair recognizes unqualified staff — support workers, housekeepers, receptionists — as capable of making outstanding contributions. The core category suggests that FCs and the public can have more impact on people with mental health problems than professional rhetoric might imply.[177] Thus, my third core category contributes to Core Concept One.

Attention to Participants' 'Voices'

Because I gave precedence to service user and carer interviews, some conversations with them were less developed than with subsequent participant groups. However, GT's constant comparative method developed initial coding of Flair through later interviews to it becoming arguably the most significant core category.

Flair originated when a service user credited her breakthrough to a consultant's willingness to disclose his own lived experience of mental health. Though Pippa had a significant history of service use, she described this encounter as eclipsing the others.[178] I recorded: 'The consultant whose mother had had a breakdown did the [*sic*] right [in disclosing] and staff are either doing this or patients having to keep visiting until they encounter such a member of staff'.[179] Pippa's previous experiences of care provision seemed not simply ineffectual but harmful. She described: 'pretty horrid things […] being done to both patients and

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[175] Oxford University Press.

[176] Forrest and others.

[177] Kathryn Greene-McCreight, *Darkness Is My Only Companion: A Christian Response to Mental Illness*, Revised and Expanded edn (Grand Rapids, MI: Brazos Press, 2015), pp. 53-54.

[178] She may have been particularly receptive at the time (and a transference explanation might also be reasonable). However, later participants concurred with the code.

[179] Pippa M429.

staff'. She suggested that 'frenetic activity is the enemy in both church and hospital'.[180] We agreed that 'if relationship is massively important, the destruction of it compromises service quality'.[181] Unsurprisingly, Pippa expressed serious concern about staff turnover and burnout.[182]

Carers similarly valued Flair and struggled with its absence. Charlie described 'experiencing particularly bad and exceptional care within the same organization'.[183] He saw 'vocational leaders as there for the people they are caring for'.[184] He suggested that '"vocational people" need to "outbalance" those lacking vocation to avoid losing humanity'.[185] Connie who had felt 'unable to make sense of what was going on' during her son's breakdown described becoming an active Trust Member because of 'a lovely letter from a psychologist'.[186]

Some carers had adverse experiences. Carla found staff distant. She struggled 'to understand [her] son's mental health, deal with it, and understand staff too'.[187] Craig reported 'a general dearth of humanity, not just in a particular trust'.[188] He had tough words for both MHSs and FCs, asking 'how much are nurses and clergy pursuing their own interests in their relationships with patients?'.[189] Christine suggested 'we might consider similar hidden agendas within social services. Their motives might be the maintenance of law and order as much as care for the individual'.[190]

Staff mostly considered hope essential to mental well-being, Serena proposing 'it's not the thing in itself that is necessarily significant but rather the hope invested in it'.[191] Stephen

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[180] C806; C1153.

[181] C372.

[182] C394; C405.

[183] C337.

[184] C365.

[185] C346.

[186] C100; C974.

[187] C26.

[188] C515; cf. Schizophrenia Commission.

[189] C1022.

[190] C125.

[191] C364.

(also a service user) described 'experiencing transforming humanity from the consultant'.[192]

He recalled their 'self-disclosing' vulnerability providing the engine for his recovery.[193]

Stephen experienced churches having 'all the humanity, all the love, going the extra mile, all

that compassion, but not always'.[194] Similarly, Simon (also a carer), having felt 'very much like

a number', remembered his 'consultant as the […] person who showed me some genuine

compassion'.[195] He described 'finding hope in the consultant's affirmation of humanity'.[196]

Both Stephen and Simon considered their experiences hugely significant and transformative of

their clinical practice.

Some staff participants were critical of their colleagues. Susan described "seeing lots of

swine".[197] Sharon suggested that 'calling staff to be more compassionate may expose more of

their humanity'. She thought 'they need to be more patient-centred'.[198] However, she

recognized this might be contrary to their motivations or formation. Serena noted that staff

'turnover is one of the key features […] with the move from a vocational to a professional

model'.[199] Sharon saw 'MHSs as having disempowered ordinary people and excluded them

from [their own] care'.[200] She saw 'professionalism as having widened the gap'.[201] Sharon

suggested that 'staff lacking religious vocabulary may be unable to explore important

dimensions of life'.[202]

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[192] C23.

[193] C8; cf. Duncan and others, pp. 423-24.

[194] C109.

[195] C632.

[196] C600.

[197] C736.

[198] C287.

[199] C432.

[200] C666.

[201] C670.

[202] C110.

Faith leader participants described both Flair and harm. Florence identified 'remarkable improvements resulting from flair'.[203] Frank affirmed that 'people who have not had extensive training (such as cleaners) can make the difference to well-being and recovery'.[204] Florence (a former nurse) saw both 'hyper-religiosity and arrogant professionalism as setting themselves above the patient'.[205] Fraser saw 'engagement as requiring commitment from both sides'.[206] Faye confessed that her church 'drop-in works at [the] limit of [its] skill'.[207] Fergus, in contrast, expressed concern about MHSs, 'seeing a lot more things classed as mental health [than necessary]'.[208] Frank saw 'a double-edge', stating ironically: 'tablets solve the problem and there are people feeling unwanted'.[209]

A controversial issue is where organizations harm by categorizing people. Faye expressed concern at some FCs' tendency to do just that.[210] Similarly, MHSs constantly categorize people and clustering, 'at the opposite end of the spectrum from recovery [approaches]', may 'limit compassion'.[211] Frank was suspicious of 'generalizations' around clustering though, as I discuss in Section 5.3, it could support a co-produced stepped care type model.[212]

An FBO leader, Olivia, suggested that whether FC or MHS, 'quality of relationship appears to be transformational' though 'we tend to provide structures rather than relationships'.[213] Otis thought much 'basic care could be provided by people with training in

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[203] C214.

[204] C263.

[205] C216; C203.

[206] C377.

[207] Faye C150.

[208] C335.

[209] C134.

[210] C342.

[211] Sharon 667; Serena C573; Liam Trevithick, Jon Painter, and Patrick Keown, 'Mental Health Clustering and Diagnosis in Psychiatric in-Patients', *British Journal of Psychology Bulletin,* 39 (2015), pp. 119-23.

[212] C23; M118; National Institute for Health and Care Excellence, 'Commissioning Stepped Care for People with Common Mental Health Disorders' (London: NICE, 2011), (pp. 7-11).

[213] M22.

specific procedures'.[214] Oscar highlighted the absurdity of some common practices, thinking it 'crazy that asylum seekers no longer need safeguarding the moment they are granted asylum'.[215]

Otis considered 'pressure on NHS beds a self-induced illness arising from deskilling the community'.[216] He added: 'The elimination of others from [providing] support creates an intolerable burden for the NHS and squanders professional resources'.[217] Orla saw 'lack of support, loneliness, poverty, hopelessness, [and] unemployment as requiring addressing rather than [the] provision of tablets' and quoted a GP saying that 'lots of people [are] coming to him for loneliness'.[218] All participant groups valued Flair and expressed concern where its absence was notable. Their reflections moved me powerfully.

Attention to my Own 'Voice'

Despite being a chaplain with over fifteen years' experience, I was disturbed by gaps between staff members' best intents and service users' or carers' ideals. I reflected: 'It is unlikely that any service could provide as much care to a person as they might get from a partner or close relative, not least in bereavement'.[219]

I realized that MHSs evaluate treatment on specific measures or interventions, whereas FCs are expected to satisfy more widely. I inferred that 'if treatment were defined as the whole experience rather than purely the impact of medication, we might find a different emphasis'.[220] Taking an extreme example, I pondered that the durability of effect of electroconvulsive therapy might decrease if a service user felt rejected by nurses and bullied on the ward.[221] I concluded that recovery necessarily requires attention to both physical illness and emotional distress.[222]

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[214] C111.

[215] C567.

[216] C148.

[217] C154.

[218] C622; C642.

[219] Susan M623.

[220] Stephen M15.

[221] Craig C415; C217.

[222] Ford, pp. xv-xvi.

It seemed that the staff showing Flair were sensitive to the latter. I inferred that we ignore compassion at our peril.[223]

I only coded Flair twenty times but was struck by participants' enthusiasm for some staff members' exceptional ability to support dramatic improvements. From a theological perspective, I considered these 'kingdom moments'. Direct unhindered communication was undoubtedly precious but not necessarily replicable. It affirmed the art alongside the science of nursing.[224] I reflected that 'kindnesses such as flowers can bring much hope'.[225] This 'admittedly [mostly] anecdotal evidence suggests staff with lived experience may be more effective'.[226]

I considered the worth participants attached to Flair affirming. Quoting Frank: 'If ward cleaners can make the difference, then why shouldn't church members and leaders?'.[227] Affirming cleaners need not undermine qualified staff; indeed, Susan asserted that 'doctors and nurses genuinely want to be human'.[228] Staff with lived experience — Kara's mutable identities — may have privileged insight.[229]

The dramatic impact of Flair coupled with Orla's remark that many people visited her GP for loneliness suggested we might have overmedicalized human misery.[230] If we accept Ford's claim that they are dealing with 'multiple overwhelmings', we might suspect that many who use MHSs may not have an illness.[231] Alternatively, they may not consider that their primary problem.[232]

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[223] Francis, p. 18.

[224] Cf. Forrest and others, p. 53.

[225] Carla M632.

[226] Pippa M448.

[227] M263; cf. Nick Spencer and others, 'Religion and Well-Being: Assessing the Evidence' (London: Theos, 2016), pp. 6-7.

[228] C493.

[229] Susan M44.

[230] C622; C642.

[231] Ford, pp. xvi-xvii.

[232] Greene-McCreight, pp. 53-54; Swinton, p. 10; Sullivan, pp. 330-31.

I do not dispute that conditions like Alzheimer's disease and bipolar disorder appear to have largely biological causes but, even here, interventions responding purely to the biology will fail to achieve maximum recovery.[233] We may better understand the predominance of biological discourse when setting it within organizational theory, acknowledging (as mentioned in Section 2.2) 'the nature of power and influence' as 'the means by which the people of the organisation are linked to its purpose'.[234] From this perspective, a discourse's pervasiveness may relate more to its utility in enabling the dominant group to colonize others than to objective truth. Indeed, 'professions [including chaplaincy] jockey for status and opportunities for their members' advancement [often] without regard for patients' needs'.[235] I am not suggesting deliberate Machiavellianism but rather unawareness of (or disregard for) group dynamics.[236]

We would be naive were we to accept positivism's truth claims uncritically.[237] The 'exclusion of FCs from MHSs' may be none 'other in kind than the professional rivalry within the NHS'.[238] Despite professionalization's advantages, its wider impact is rarely considered. To repeat: 'Professionalization disempowers patients as well as [FC] ministers and volunteers. It […] collapses under the load it has created for itself'.[239] My findings suggest that Flair may debunk both positivist rhetoric and excessive professionalization. Flair may be little other than Rogers' core conditions or, using an older phrase, bedside manner.[240] I will later argue that 'loss of humanity [is] multifactorial' and that the 'institutional shell' is often 'empty'.[241]

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[233] Kitwood; Swinton, p. 10.

[234] Handy, p. 123.

[235] Otis M111; Goffman, *Asylums*, pp. 9-10.

[236] This will sometimes be applicable.

[237] Kendall and others, pp. 342-43.

[238] Frank M200.

[239] Otis M141.

[240] Carl R. Rogers, 'The Necessary and Sufficient Conditions of Therapeutic Personality Change', *Psychotherapy: Theory, Research, Practice, Training,* 44 (2007), pp. 240-48 (pp. 242-43).

[241] Craig C314; C312.

While MHSs 'have certainly created a framework necessitating their existing', Flair exposes their Achilles heel.[242] It provides admittedly tentative evidence that a change of tack might significantly improve recovery.[243] Flair's existence shows that mental health wards need not be 'emotional deserts'.[244] It suggests that rebalancing the technical with the human (fact with value) promises more effective and more humane services. Perhaps Sharon's identification of 'love as the fundamental thing of Christianity', despite the church's historic failings, provides a pointer towards a better understanding.[245] Indeed my reflection that 'heightened spiritual awareness and cultural identity [might largely be] reactance to institutionalization' concurs.[246] Surely, 'the professional model, […] when it destroys the dignity of the patient is theologically flawed'.[247]

I want to apply the Schizophrenia Commission's epithet 'broken and demoralised system' to MHSs and many FCs.[248] With the notable exception of individual Flair and localized excellence, participants found provision mostly inadequate, echoing Government reports on MHSs.[249] We may wonder whether 'statutory [, voluntary and faith-based] organizations may aspire to the impossible [and whether] professional solutions (with commensurate salaries) may be unworkable'?[250] We may need to focus less on expensive technical expertise and instead rediscover the worth of more humble roles, including 'ward cleaners […] church members and leaders'.[251]

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[242] Susan M392.

[243] Murphy Halliburton, 'The Importance of a Pleasant Process of Treatment: Lessons on Healing from South India', *Culture, Medicine and Psychiatry,* 27 (2003), pp. 161-86.

[244] Craig M582.

[245] C661.

[246] Fergus M16.

[247] Pippa M732.

[248] Schizophrenia Commission, p. 4.

[249] James Morris, 'Parity in Progress?' (London: All Party Parliamentary Group on Mental Health, 2015), p. 5.

[250] Ophelia M823.

[251] Frank M263; cf. Spencer and others, pp. 6-7.

Attention to the Theological Tradition

Flair, described as 'the politics of manna, not Mammon' is necessarily creative, relational, and transformative.[252] Transcending *homo incurvatus in se*, Flair potentially replaces care with compassion. It transforms giver and receiver, bringing them into communion with one another. More important than whether Flair is Rogers repackaged, is participants' sense — reminiscent of I Corinthians 13 — that expertise without compassion is ineffective. [253]

Moltmann alerts us to the ease with which compassion can become overlooked, and its absence become the norm:

> Where Jesus is, there is life. There is abundant life, vigorous life, loved life, and eternal life. There is life-before-death. I find it deeply disturbing and unsettling whenever I think about how we have become accustomed to death: to the death of the soul, to death on the street, to death through violence — to death-before-life. "The worst thing is that one gradually becomes used to it." That's the way a friend in New York summed up his reaction to the growing crime rate as we were discussing a recent incident.[254]

Noting Kilby's provisos elaborated in the previous 'Attention to the Theological Tradition' subsection, I propose that relationships within (and emanating from) the Trinity offer a pattern and *telos* for healing. [255] Such relationships contrast with EBM's intended objective stance. The ethics of co-production requires that agency should be respected.[256] Respecting agency empowers service users to co-create their well-being and disallows delivered services. We might expect co-produced services reflecting our being in *Imago Dei*, to be more effective.[257]

Rublev's *Trinity* extends an open, unbounded invitation reminiscent of the 'art' in Peplau's 'art and science of nursing' (or indeed Flair).[258] This hospitality accepts others

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[252] Denise Ashworth, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool, 2017).

[253] Rogers, pp. 242-43.

[254] Jürgen Moltmann, *The Open Church: Invitation to a Messianic Lifestyle* (London: SCM Press, 1978), p. 19.

[255] Kilby, p. 434.

[256] Except where capacity is lacking; Seedhouse, pp. 149-51.

[257] McFadyen, pp. 30-31.

[258] Peplau, pp. 8-9.

unconditionally, inviting previously unexpected possibilities. It brings life in a way that 'thin, and cold, and [often] very dead' theories cannot.[259] Perichoresis offers a fuller understanding than Slay and Stephens' distinct groups' summative contributions. Perichoresis supports Kara's 'mutable' identities and values the synergy of service user, carer, and staff perspectives.[260] The kind of mutual learning we see between Jesus and the Syrophoenician woman (Mark 7.25-30) transcends The Triangle of Care and places compassionate relationships at the heart of well-being.[261] Were service users, carers, and staff to co-evaluate these relationships, their approach might gain precedence over the bureaucratic solutions commonly favoured by positivist approaches.

We need not relegate science but may need to recognize that — paraphrasing St Paul — science without love cannot make whole.[262] Of itself, positivism risks stigmatizing further. In the admittedly harsh words of a service user commenting on outcome measures, 'there's no standardized good, just standardized rubbish'.[263] As we consider the future, I propose that we explore an approach rooted in co-production that appreciates all partners' 'vital' contributions. My proposal invites everyone to up their game, whether service user, carer, staff, FC, or FBO leader.

Conclusions

In this chapter, I have shown how the three supporting core categories formed Core Concept One All Hands on Deck and addressed my first RQ: 'Do stakeholders consider that greater cooperation between MHSs and FCs would benefit service users and carers?'.

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[259] Wilfred Owen, *The Poems of Wilfred Owen (Wordsworth Poetry Library)* (Ware: Wordsworth Editions Limited, 1994), p. 32.

[260] Kara, p. 131.

[261] Worthington, Rooney, and Hannan.

[262] I Corinthians 13.

[263] Anonymized, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool, 2017).

My second RQ explores what participants would consider safe and effective protocols. My second core concept suggests that MHSs and FCs might become Critical Friends, protecting those they serve (and each other) from their respective vulnerabilities. However, we need to accept that 'mutual fear between MHSs and FCs' is commonplace, 'hindering partnership working'.[264]

The notion of Critical Friends, my second core concept, with its three core categories, forms the structure of the next chapter. I begin by developing the idea of complementarity (that emerged in the latter part of this chapter) as I consider compassion and expertise.

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[264] Ophelia C154; Sally C24.

4   Critical Friends: Core Concept Two

In the last chapter, I explained how Core Concept One All Hands on Deck emerged from the interview data.[1] I reported that the participants overwhelmingly affirmed my first RQ. All but one considered that greater cooperation between MHSs and FCs would help service users and carers.

In this chapter, I address my second RQ. However, rather than merely describe what participants *would consider safe and effective protocols*, GT's continuous comparative method yielded insights into MHS and FC strengths and vulnerabilities. Safeguarding emerged as a critical opportunity for exploring collaboration and building safe and effective protocols.

Core Concept Two 'Critical Friends' arose from three GT core categories (forming the chapter sections). Section 4.1 examines 'Expertise versus Compassion', participants' identified trade-off between MHSs and FCs. It suggests complementary strengths and assigns the differences to their underpinning philosophies. Section 4.2 explores their consequent 'Vulnerabilities'. Section 4.3 names safeguarding as common ground for developing cooperation and suggests that MHSs and FCs might collaborate to mutual advantage. The shorter last section comprises an excursus describing two interesting FBO examples of good practice. More immediately, continuing with Leach's action–reflection method (see Section 1.3), I consider Core Category Four and explain how the Critical Friends concept emerged.[2]

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[1] Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (London: Weidenfeld & Nicolson, 1968), p. 72.

[2] Leach, p. 31; Arthur L. Costa and Bena Kallick, 'Through the Lens of a Critical Friend', *Educational Leadership,* 51 (1993), pp. 49-51.

4.1   Expertise versus Compassion: Core Category Four

The category Expertise versus Compassion emerged when a service user described 'valuing an evidence-based model but not wanting to lose out on [the] art of nursing'.[3] Pippa's comment suggested that participants' greater affection for FCs might resonate with this 'art'. Further interviews led me to infer that single-minded focus on expertise (or compassion) might be counterproductive. Oscar suggested the polarization between MHSs and FCs originated in the Enlightenment.[4] Attending to *the theological tradition*, I pick up this theme. In doing so, I find useful links between I Corinthians 12-13, co-production, and asset–based approaches.[5] I theorized that MHSs and FCs might protect each other from unsafe practices. This led me to consider their particular vulnerabilities and to Core Category Five. We first attend to participants' 'voices'.

Attention to Participants' 'Voices'

Participants suggested a trade-off between MHS expertise and FC compassion. Most identified MHSs as expert yet often lacking compassion. They described FCs as more humane, though sometimes out of their depth. The participants spoke frankly, some recounting experiences that were neither expert not compassionate.[6] Elaborating *participants' 'voices'* (Leach's Step One) group by group, I show how the focused codes resulted in the Expertise versus Compassion category.[7]

Beginning with service users, Pippa's 'valuing an evidence-based model but not wishing to lose out on [the] art of nursing' suggests why most participants praised FCs more than MHSs.[8] Her statement clarifies Pam's observation that 'the church has more ability to make

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[3] Pippa C266.

[4] C153-5.

[5] Slay and Stephens; Fiona Garven, Jennifer McLean, and Lisa Pattoni, *Asset-Based Approaches: Their Rise, Role and Reality* (Edinburgh: Dunedin, 2016).

[6] Though these potentially obscure my argument, I have included them as they deserve consideration.

[7] Leach, pp. 24-25.

[8] C266.

people better than the hospital'.[9] It makes sense of the significance Patrick attached to 'having received hope from nice [church] people' whom he considered 'friends'.[10] Pippa's agreeing that a 'minister may have a better relationship than a nurse' was illustrated by Peter — on an advanced care plan — who could not name his community psychiatric nurse.[11]

Penny described 'being mistreated by a member of staff' but 'valuing the care of a particular nurse'.[12] Her presentation made for difficulties as when she asserted that she 'would begin by locking staff up if in charge'.[13] However, her remark that 'churches can sometimes "mess up your head"' gave pause for thought.[14] Patrick questioned psychiatric practice, seeing "a lot of so-called mental illness" as "a normal reaction to an abnormal class-ridden, very unequal, and very offensive society where money speaks".[15] Overall, service users treasured the compassion they found in FCs.

Carers voiced opposing opinions about FCs. Those most critical were similarly disparaging of MHSs. Christine described feeling 'excluded [from the church] due to lack of [her own] time and opportunity' yet acknowledged 'an absence of other community resources'.[16] Claire opposed FC involvement ideologically, voicing a dilemma she blamed on the Government's having "degraded" social care.[17] She experienced 'religion as punitive or exclusive' and observed 'religious groups […] using care to evangelize'.[18] Nevertheless, Claire admitted that 'faith-based support [had] been helpful to [her] son'.[19]

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[9] C197.

[10] C246; C122; C124.

[11] C335; C296.

[12] C54; C30.

[13] C199,

[14] C199.

[15] C163.

[16] C190; C167.

[17] Claire C181.

[18] C163; C295.

[19] C15.

Other carers described exceptional FC care. Carla found 'the priest very good and a source of hope', especially when he 'found [her] son [sitting] in [the] snow with no top on'.[20] Connie had considered her 'priest very supportive, spending the night in Accident and Emergency'.[21] She found him '"ever so good" in […] ensuring [they] received care', providing compassion and access to otherwise unavailable expertise.[22] Craig suggested 'MHSs and FCs "should not be separated in any shape or form"'.[23] Carers related different experiences and attitudes but considered compassion essential.

Staff participants valued humanity, the majority using this word as equivalent to compassion. Two, with lived experience, gave moving accounts. Simon described 'the crisis team as "terrible" and devoid of humanity'. He found 'hope in the consultant's affirmation of humanity'.[24] Crediting his 'referral to [the] consultant's mother having had a breakdown', Simon saw his consultant as the first person who showed "some genuine compassion".[25] Stephen, similarly, reported 'experiencing transforming humanity from the consultant', crediting his son's recovery to their 'self-disclosing'.[26] Sharon saw 'inevitable improvements where genuine listening takes place'.[27]

Stephen described the church 'as fantastic', seeing 'masses of humanity' and finding that 'practical humanity really helped'.[28] He likened this to 'Jesus's asking people "Who are you, what is your name?" [cf. John 20.16], rather than focusing on the condition'.[29] He affirmed the importance of connecting with an individual and enabling them to harness their inner resilience. Sharon saw 'love as the fundamental thing of Christianity' while Simon warned that

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[20] C346; C171.

[21] C171; C62.

[22] C13.

[23] C5.

[24] C591; C600.

[25] C547; C632.

[26] C23; C8.

[27] C146.

[28] C25; C101; C35.

[29] C81.

churches needed to 'stop doing *to* people and be friends *with* them in community'.[30] All staff participants supported closer working with FCs. They saw compassion as affirming humanity.

Faith community leaders placed themselves firmly on the side of compassion, considering their role vocational rather than expert. Faye thought FCs made 'a distinctive but [personally] costly contribution' with Frank seeing them "going in again where nobody else wants to".[31] He described FC leaders spending 'a great deal of time conducting pastoral visits', resulting in their being closer to communities than MHSs.[32] Fred, saw 'the necessity for a different breed of person [in MHSs]', identifying 'personal ethics as providing a stronger safeguard than [organizational] frameworks'.[33] Fraser suggested MHSs might need 'to communicate genuine commitment'.[34] The FC leaders identified weaknesses in MHSs' single-minded focus on expertise.

The FC leaders were, however, not lacking generic expertise. They showed far greater respect for autonomy than MHS staff might assume (let alone necessarily practise). Florence stressed 'the importance of allowing people to decide the next step for themselves' and suggested 'co-production should follow immediately after stabilization' of mental health.[35] FC leader participants — Christian, Jewish, and Muslim — wished to 'collaborate [with MHSs] in a warmer, more skilful manner'.[36]

The FBO leaders saw compassion as central to the gospel. Ophelia radiated compassion, not least when she described her distress at mobile phone 'footage of child asylum seekers' suffering'.[37] She deliberately marketed her outreach as a well-being drop-in rather than as

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[30] C661. My italics.

[31] C251; C134.

[32] Frank C493.

[33] C187; C70.

[34] C101.

[35] C216; C236.

[36] Fred C417.

[37] C755.

providing mental health care.[38] Ophelia had a rounded view of compassion, 'seeing the value in sharing a cup of tea'.[39] She found people 'more likely to be able to talk in church than on a ward'.[40]

Oscar described an abused asylum seeker's recovery after Christian counselling, alleging MHS staff had previously told him: "calm down and don't think about it".[41] Oscar's project was holistic, offering both acceptance and inclusion. It supplied a vocationally–grounded service that affirmed and cherished service users and undoubtedly had much to teach MHSs. His seeing 'the West as fixated on 400-year old thinking' led me to explore his suggestion the divergence between MHSs and FCs had its origins in the Enlightenment (see Section 2.2).[42] The FBO leader participants — all Christians — saw love, rooted in Scripture, as the heart of their calling.

Overall, participants named MHSs as more expert and FCs as more compassionate, reflecting emphases on professionalism and vocation respectively. Service user participants especially favoured compassion, most considering FCs more positively than MHSs. Carers considered it essential to effective services. Staff saw compassion as affirming humanity. Faith community leaders were keen to collaborate, seeing their role as chiefly vocational and love as central. Organizational leaders linked compassion with gospel mandates.

Returning to Pippa's 'valuing an evidence-based model but not wishing to lose out on [the] art of nursing', I pondered what social processes might be driving MHSs.[43] I inferred that effective care might be jeopardized when either expertise or compassion falls below an acceptable threshold.

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[38] C56.

[39] C628.

[40] C640.

[41] C28; C26.

[42] C153-5.

[43] C266.

Attention to my Own 'Voice'

My advanced memos located *my own 'voice'* (Leach's Step Three).[44] Inspired by informed GT, I considered my prior (and concurrent) research as proximate and useful to the present study. I avoided a 'naïve [*sic*] empiricism [that] fails to recognize the embeddedness of the researcher within a historical, ideological and socio-cultural context'.[45] Instead, I identified the sensitizing concept behind Expertise versus Compassion as originating in my 2012 master's research.[46] It crystallized when service user participants in GT research I conducted in 2015 impressed on me the significance they attached to living by their faith values.[47] What struck me was their mature thinking and the extent to which they thought FCs offered something distinctive and invaluable. The current interviews suggested that MHSs' and FCs' different philosophies were driving an emphasis on expertise or compassion respectively.

My present study sheds fresh light on my 'Perfect Storm Theory' with Serena highlighting 'a nurse's internal dialogue and emotional strain'.[48] I pondered whether 'nurses' discomfort about getting close to patients [might be] restricted to physical contact or whether they [sometimes] avoid emotional contact as well?'.[49]

As a chaplain, I recognize that staff find engagement demanding yet it seems to be what patients value (as I recently discovered myself when adjusting to a life-threatening condition).[50] I noted: 'patients can forgive busyness but not lack of humanity'.[51] Though counterintuitive to a utilitarian, my recent findings suggest that tipping the balance towards compassion could be

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[44] Leach, pp. 26-27.

[45] Thornberg, p. 246.

[46] Raffay, Are our Practices?, pp. 74-76.

[47] Raffay, Wood, and Todd, pp. 5-6.

[48] Raffay, Are our Practices?, p. 74; C535.

[49] Stephen M88.

[50] Forrest and others, pp. 52-53.

[51] Pippa M499; Duncan Randall and Mick McKeown, 'Editorial: Failure to Care: Nursing in a State of Liquid Modernity?', *Journal of Clinical Nursing,* 23 (2014), pp. 766-7.

expected to increase MHSs' effectiveness.[52] Emphasis on compassion reflects FCs' relative favour to which we now turn.

Though FCs also face increasing challenges — with many adopting management methods — their daily diet of Scripture hopefully inspires compassion.[53] Indeed, Susan suggested that "the impact of frenetic activity in churches [is] mitigated by their reservoir of humanity".[54] Sadly, religion of itself does not guarantee compassion, as with Craig's "very very unpleasant rabbis".[55] I reflected that 'we find an interesting comparison between religious people who believe they know what's right for people and medics [and other staff] who have the same attitude'.[56] However objectively right those people might be on occasion, their lack of compassion does harm and risks creating hostility.

My findings suggest a sinister influence behind the felt leaching of compassion from MHSs. Fred expressed severe concerns about senior NHS managers, describing them as more intelligent than their predecessors but lacking 'sufficient understanding of patients'.[57] I inferred that managers' 'understanding of macroeconomics may fail to protect patients from utilitarian winds'.[58] I questioned whether 'the erosion of care at senior management level may be acceptable provided safeguards exist in relevant parts of the organization'.[59]

I inferred that MHSs' and FCs' different core philosophies underpinned their respective emphasis on expertise or compassion. Though clergy often feel marginalized by MHSs, they may be more resilient.[60] FCs, however, do not have a monopoly on virtue. I reflected: 'Whether church or MHSs, quality of relationship seems transformational. We tend to provide structures

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[52] Julian Raffay, 'How Staff and Patient Experience Shapes Our Perception of Spiritual Care in a Psychiatric Setting', *Journal of Nursing Management,* 22 (2014), pp. 940-50 (p. 941).

[53] Stephen Green, 'Talent Management for Future Leaders and Leadership Development for Bishops and Deans: A New Approach' (London: Archbishops and the Development and Appointments Group, 2014).

[54] C463.

[55] C483.

[56] Florence M264.

[57] C208.

[58] Fred M258.

[59] Fred M258; M199; Francis, p. 18.

[60] Wood, Watson, and Hayter, pp. 780-81.

rather than relationships'.[61] This is not to propose dispensing with expertise but to recognize that imbalance compromises care, regardless of its source.[62] Indeed, 'we might consider what we mean by care when it doesn't have a human face'.[63] Compassionless care may be as damaging as inept care.[64]

In Jesus's meeting with the Syrophoenician woman (Mark 7.24-30), Marsh identifies an approach comparable with Thornberg's abductive reasoning.[65] He describes how 'truth-telling happened between Jesus and one of his interlocutors'.[66] I now consider the theological tradition in the same spirit.

Attention to the Theological Tradition

Compassion has deep roots in both medical and FC traditions. Contemporary Christian apologists, including Hauerwas, Moltmann, Nouwen, Swinton, and Vanier are influential proponents.[67] Many of them draw inspiration from social conceptualizations of the Trinity. In contrast, MHSs — not least since Griffiths — are building services on more utilitarian foundations.[68] Reorganizations, coupled with professionalization and declining vocation in MHSs, may be eroding user experience.[69]

The consequences of ignoring user experience are powerfully illustrated by Owen's war poem *Maundy Thursday* that distinguishes what is offered from what is needed.[70] Just as Owen reached for the server-lad's hand rather than the crucifix, I found participants grasping for

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[61] Olivia M22.

[62] Forrest and others, p. 53.

[63] Charlie M323.

[64] Francis, p. 83.

[65] Clive Marsh, *Christ in Practice: A Christology of Everday Life* (London: Darton, Longman and Todd, 2006), p. 35.

[66] Ibid.

[67] Moltmann, *The Open Church*; Henri Nouwen, *The Wounded Healer: Ministry in Contemporary Society* (Garden City, NY: Doubleday, 1979).

[68] Griffiths.

[69] Rowan Williams, *Lost Icons: Reflections on Cultural Bereavement* (London: Continuum, 2003), pp. 138-39; Baxter, Mugglestone, and Maher, p. 10.

[70] Owen, p. 32.

humanity, often finding clinical interventions 'thin, and cold, and very dead'.[71] Their statements corroborated Forrest and associates' observation that 'if a nurse [or another member of staff] cannot function at the 'human' end of the [professional–human] continuum there cannot be progress towards professional help'.[72] Care may sustain life, but compassion inspires recovery.

Moltmann argued that alienation from significant others redoubles people's pain.[73] He contrasted 'abundant' Christian life in misfortune with habituation and despair.[74] His insight explains Orla's affirmation of the ordinary church fete 'as really helping people "sitting in this lonely world"'.[75] Similarly, Oscar considered EBM deficient (and embedded in a more extensive cultural deficiency).[76] He identified 'Chinese medicine as recognizing what the West fails to see'.[77] It may be that 'the poorer [western] compassion becomes, the less happy people are likely to be with an evidence-based paradigm'.[78] While people cry out for humanity, wards risk becoming 'emotional deserts'.[79]

When we trace the divergence between expertise and compassion back to the Enlightenment, the current polarization appears to disadvantage both service users and carers, not to mention MHSs and FCs.[80] Vanier's L'Arche, for instance, shows that expertise and compassion can be reintegrated.[81] L'Arche communities involve professionals as needed — and typically have professionals on their staff — but their primary inspiration is Jesus (or another

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[71] Ibid.

[72] Forrest and others, p. 53.

[73] Moltmann, *The Open Church*, p. 29.

[74] Ibid., p. 19.

[75] C688.

[76] Banicki, p. 23. Boaventura de Sousa Santos, *Epistemologies of the South: Justice against Epistemicide* (London: Routledge, 2016), p. 19.

[77] C153-5.

[78] Oscar M255.

[79] Craig M582.

[80] After Oscar C153-5.

[81] Jean Vanier, *The Challenge of L'Arche* (London: Darton, Longman, and Todd, 1982); Hans S. Reinders, *The Paradox of Disability: Responses to Jean Vanier and L'Arche Communities from Theology and the Sciences* (Grand Rapids: Eerdmans, 2010).

member of the Trinity). They provide evidence that MHS–FC collaboration can be both

effective and iconic.

Rublev's *Trinity*, also known as *The Hospitality of Abraham*, can be interpreted as

depicting either the Godhead or the angels who visited Abraham at Mamre (Genesis 18.1-8).[82]

Significantly, in this second interpretation, Abraham blesses the three angels by washing their

feet and providing them with graciously accepted sustenance.[83] Rublev's *Hospitality* reveals

mutuality of regard, an open invitation to share in the table fellowship.[84] All are welcome.

Within such an approach, skilled MHS practitioners have their proper place alongside FC

leaders.

Parish Nursing Ministries UK offers another useful template for collaboration.[85]

Similarly, Street Pastors — bringing compassion alongside police expertise — provide hope to

people in the community, many of whom experience mental health problems.[86] How tragic that

we so often replace Rublev's graceful image with the ethically questionable defensive and

territorial politics of Mammon, far removed from anything resembling the divine perichoresis.

While MHSs have embraced utilitarianism, many FCs have taken the other

Enlightenment path and retreated into the gaps, lessening their contribution to society.

Thankfully, there are still countless examples where FCs care for people with "no one else to

walk with them".[87] Despite instances of historic abuse and neglect, many offer outstanding

expert compassionate care.

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[82] Tony Castle, *Gateway to the Trinity: Meditations on Rublev's Icon* (Slough: St. Paul, 1988), pp. 17-28.

[83] Rublev.

[84] Paul Bayes, *The Table: Knowing Jesus: Prayer, Friendship, Justice* (London: Darton,Longman & Todd, 2019), pp. 1-5.

[85] Parish Nursing, 'Parish Nursing' (Peterborough: Parish Nursing Ministries UK, 2018).

[86] Perry M270.

[87] Olivia C146.

My theological analysis corroborates my research findings, suggesting that compassion is the moral compass misplaced in the 'perfect storm'.[88] Lacking the centrality of compassion, service users, carers, and staff risk becoming subordinated to organizational objectives.[89] The intensity of the distress they sensed in MHSs warranted the term 'storm'.[90]

Participants' 'voices' revealed a general affection for FCs, broadly echoing my experience. Having suggested that a single-minded focus on expertise or compassion may result in vulnerabilities, I now explore participants' thoughts about MHSs' and FCs' relative susceptibilities.

4.2   Vulnerabilities: Core Category Five

The core category 'Vulnerabilities' emerged in conversation with an NHS-employed FC leader. Fred saw 'personal ethics [...] providing a stronger safeguard than [organizational] frameworks' and identified a 'lack of effective integration between policies and their implementation'.[91] His insight led me to consider how MHSs and FCs might respond under increased stress or if the current economic headwinds were to continue unabated. Understood thus, vulnerability is the risk of failing to 'deliver the quality of treatment that is needed for people to recover'.[92]

Building on the last section, I explore the idea that expertise cannot be expert or compassion compassionate without their complement. I propose that "MHSs and FCs are both weakened if they seek to exist without each another [*sic*]".[93] Again, using Leach's method, I attend to *participants' 'voices'*, then *my own*, and finally the *theological tradition*. The suggestion that FCs are weakened without MHSs is intensely challenging to certain theologies.

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[88] Raffay, pp. 74-75.

[89] Francis, p. 3.

[90] A storm is force 10 (out of a maximum of 12) on the Beaufort scale.

[91] C70; C93.

[92] Schizophrenia Commission, p. 3.

[93] Fred C101.

I, therefore, address this issue before exploring Core Category Six, Critical Friends for Safeguarding.

Attention to Participants' 'Voices'

Service user participants associated failure more closely with MHSs than FCs. Some carers felt unable to rely on either. Staff blamed NHS systems, values, and culture for not delivering. They also considered triumphalist churches harmful. Most of the FC leaders appeared open about their limitations. They had poor opinions of MHSs, perhaps because they experienced exclusion.[94] The least favourable remarks came from FBO leaders who struggled with MHSs' non-cooperation. I now explore the participant groups in turn.

Service users found staff vulnerable to being 'warder-like'.[95] They considered this harmed those with low self-esteem, including Peter who hoped 'to be able to interact, laugh, and join in activities'.[96] Perry proposed that 'not feeling well and being unable to elicit positive responses can create a vicious circle'.[97] He suggested that 'matters important to service users need to be incorporated into staff training'.[98]

Pippa saw 'clinicians as focusing on the problem rather than the person' and agreed that 'redefining treatment as the whole experience would be beneficial'.[99] Perry was more dismissive, describing MHSs as 'insufficient for well-being'.[100] Overall, Pam considered 'the hospital as failing in [its] duty of care'.[101] She met "quite a lot of nurses and doctors who see themselves as the superior one" and said she preferred 'a less skilled [compassionate] practitioner to an arrogant one'.[102] Pippa suggested, "staff sometimes imagine they're the only

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[94] Wood, Watson, and Hayter, p. 94.

[95] Pam c382.

[96] C352.

[97] C279.

[98] C144.

[99] C28; C48.

[100] C22; cf. Schizophrenia Commission, p. 4.

[101] C263.

[102] C362; C365.

game in town".[103] Her remark was concerning, given Penny's opinion that MHSs were 'visibly deteriorating in extent and quality'.[104] Service user participants said little about FC vulnerabilities, though Pippa saw 'some churches as reluctant to talk about mental health stigma'.[105] She found 'the evangelical and non-white churches particularly problematic'.[106] Penny questioned 'God's seeming lack of assistance'.[107]

　　　　Some of the carers gave harrowing accounts. Connie described 'smelling [her schizophrenic] son's flesh on the cross on Good Friday'.[108] Another carer reported discovering her 'son in a terrible state with skin [literally] peeled off his hands', saying "I'm Jesus, I've got the hands of Jesus".[109] For most, the challenge was stigma, isolation, and exhaustion. Experiencing both acute and chronic distress, several of the carers found MHSs and FCs unable to meet their needs. Christine felt 'let down by community services', feeling that 'her son should never have been discharged'.[110] She felt 'powerless in the face of a brick wall of confidentiality' and found the 'experience of invasive psychiatry "just horrendous"'.[111] Craig found 'lack of humanity […] customary' in MHSs.[112] Christine, having imagined 'the vicar as a professional familiar with trauma', found 'being dissed […] "mind-blowingly horrendous"'.[113] Despite this, she saw 'churches as offering deeper understanding than other community social groups'.[114]

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[103] C552.

[104] C54; C16.

[105] C204.

[106] C207; C204.

[107] C283.

[108] C1085.

[109] Anonymized C149; C152.

[110] C72; C86.

[111] C99.

[112] C483; C522.

[113] C314; C270.

[114] C522; C606.

Several carers felt unable to count on either MHS staff or FC leaders. Charlie saw 'the NHS as failing "when the humanity is taken out of it"'.[115] He identified 'low staff morale as degrading humanity' and suggested that 'staff who don't feel valued won't value others'.[116] Similarly, he saw 'clergy who feel uncared for failing to care in turn'.[117] Claire saw 'non-compliance with procedures as endemic' and identified 'religious groups as preying on the vulnerable to promote their faith'.[118]

Staff related MHSs' vulnerabilities to dehumanization and FCs' to lack of skill. Stephen saw 'staff starting out wanting to treat people with compassion but ending up on a conveyor belt'.[119] Serena understood 'relationship as [being] lost in the pursuit of evidence-based practice' and identified 'a loss of expertise around one-to-ones'.[120] She suggested MHSs 'have moved far away from relating to a patient's thoughts and feelings'.[121] She saw 'Payment by Results as having influenced nurses' attitudes and behaviour'.[122] Sharon identified 'staff as lacking insight into the dilemmas and difficulties faced by patients'.[123] Susan thought 'we should look on [*sic*] people with compassion and not get caught up with the mob saying "Crucify"'.[124] Sharon desired 'a fundamental break with measurements when it comes to time for patients' and saw 'staff as lacking [relevant] skill'.[125]

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[115] C310.

[116] C316-318.

[117] C319.

[118] C100.

[119] C48; C71.

[120] C453; C244. Note: a service user on one-to-one observation will have a staff member assigned to constantly observe their actions.

[121] C460.

[122] C558; Barry L. Speak, Paula Hay, and Steven J. Muncer, 'HoNOS - Their Utility for Payment by Results in Mental Health', *International Journal of Health Care Quality Assurance,* 28 (2015), pp. 115-28.

[123] C13.

[124] C231.

[125] C144.

Sharon saw 'churches as being "very ill-informed" about mental health' and wondered why they 'don't talk about mental health problems'.[126] Simon considered churches 'unable to cope with the unexpected'.[127] Sharon identified 'triumphalism' as harming people and 'failure to live victoriously as leaving a sense of "doing something wrong"'.[128] She compared 'triumphalist theology with Facebook' posts.[129] Simon similarly likened the church to Facebook 'promoting the happy stuff'.[130] Susan saw 'a lot of frenetic activity in clergy and church'.[131] Simon suggested 'somewhere in the middle of the expert and the friend would be ideal'.[132] Susan argued that 'both church and NHS need to get on with being about people'.[133]

Among FC leaders, Fred, familiar with the NHS, observed 'a lack of ethics in secular practice'.[134] He identified 'the necessity for a different breed of person' and strongly agreed with my tentative submission that the abuse at 'Winterbourne View might not have happened had people valued people with learning disabilities'.[135] He observed 'recurring scandals every five years with little genuine remedy due to the same solution being applied every time'.[136] Fred asserted that despite 'new policies, procedures, and projects, the solutions are the same in essence and have never worked'.[137] He was 'not expecting real change'.[138] Faye offered insight into basic social processes. She saw 'fear as "a catapult", causing people to focus on [paper]

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[126] C167; C215.

[127] C138.

[128] C332; C328.

[129] C358.

[130] C24.

[131] C461.

[132] C56.

[133] C672.

[134] C358.

[135] C187; C282; Department of Health, 'Transforming Care: A National Response to Winterbourne View Hospital' (London: Department of Health, 2012).

[136] C167.

[137] C175.

[138] C175; C178.

forms rather than care', like 'attending to the smoke alarm rather than the fire'.[139] Frank, similarly, suggested that 'professional groups often act out of professional self-interest'.[140]

Fergus considered 'it hugely important that MHSs understand patients' cultural and religious backgrounds' and suggested 'synagogues would best be helped by services' understanding adherents' needs'.[141] He saw FCs 'requiring far greater training before taking up mental health provision'.[142] Faye sensed she 'could have handled situations better' in running a drop-in centre, 'acknowledging financial drivers for providing the project'.[143] Fraser considered 'mosques as particularly in need of mental health support'.[144] He recognized 'lack of awareness of mental health by those only familiar with the mosque'.[145]

Organizational leaders were less generous to MHSs than clergy, possibly because a greater share of their work involved direct contact with service users. Odette saw 'the church as having greater understanding and commitment to communities' and identified 'the necessity of long-term relationships in which people feel ready to invest'.[146] She saw great strength in FC leaders 'being present twenty-four-seven' but also identified 'a double-edged sword', risking 'dependency relationships'.[147] Olivia, 'recognizing professionals will not prevent a crisis', believed 'the church to have a role, even if the NHS were fully funded'.[148] Oscar attributed 'non-cooperation to risk avoidance or empire building'.[149]

Participants found both protective factors and vulnerabilities underlying MHS and FC philosophies. The findings support my claim that expertise cannot be expert or compassion

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[139] C402; C408.

[140] C180.

[141] C8; C663.

[142] C475.

[143] C48; C244.

[144] C8.

[145] C287.

[146] C102; C100.

[147] C120; C122.

[148] C121; C133.

[149] C457.

compassionate without their complement. Most participants considered FCs more resilient. That has been my experience as I elaborate below.

Attention to my Own 'Voice'

Participants' openness caused me to self-reflect. Many revealed 'mutable identities': staff who had used services or were carers, a carer who had been a social worker, FC leaders with nursing backgrounds, and a chaplain.[150] I consider myself an FC leader and professional, someone with my own previously indifferent mental health. I have at times struggled to keep my ship afloat and sometimes had unrealistic expectations of FCs. As a social worker and then vicar, I have experienced frustration with MHSs' weaknesses and shortfalls in provision. I have undoubtedly disappointed many seeking help.

In considering my own 'voice', I explore MHSs then FCs, and finally the wider social context. In doing so, I consider Fred's suggestion that "MHSs and FCs are both weakened if they seek to exist without each another [*sic*]".[151]

Fred's view of 'personal ethics [...] providing a stronger safeguard than [organizational] frameworks' corroborates my Perfect Storm Theory (see Section 2.2).[152] Ethics potentially offers staff a compass in the storm, enabling them to avoid the 'Combine's' frenetic and urgent demands for evidence.[153] From my position as chaplain, I see trust boards and directors becoming increasingly remote to matrons and ward managers.[154] Responding to *Sustainability and Transformation Plans*, mergers, *The Five Year Forward View*, and similar initiatives consumes their energies.[155] Ward managers struggle with staffing while conducting work previously done by matrons. Front-line staff find themselves pressed to achieve 'outstanding' in

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[150] Susan M44; Kara, p. 131; cf. Christopher Swift, *Hospital Chaplaincy in the Twenty-First Century: The Crisis of Spiritual Care in the NHS* (Farnham: Ashgate, 2009), p. 173.

[151] C101.

[152] C70.

[153] Ken Kesey, *One Flew over the Cuckoo's Nest: A Novel* (London: Penguin, 2005).

[154] Julian Raffay, 'Checkmate for Chaplains', *Mental Health Chaplains' Newsletter*, Summer (2009).

[155] Louise Shepherd, 'Cheshire and Merseyside Sustainability and Transformation Plan' (Leeds: NHS England, 2016); Mental Health Taskforce, 'The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England' ([Leeds]: NHS England, 2016).

Care Quality Commission ratings. They become prisoners of perception while service users and carers wonder what is happening. These vulnerabilities were evident to a carer 'listening to patients describing a suicide [on a ward] and wondering whether anyone was on duty'.[156] He quoted them saying: "We can do whatever we want, we can get away with anything we want; we can bring whatever onto the ward".[157] The weaknesses Francis condemned seem ever-present.[158]

I thought 'it appears almost unreasonable to expect over-busy people to be able to down tools', ignore their mortgages, and show compassion.[159] However, if compassion is what people need, the system may fail them. Paloutzian notes:

> Simply put, when it comes to patient comfort, it is the patient that calls the shots. We would argue, too, that the priority that is given to this should increase as the severity of the disease or disorder that the patient is suffering [from] increases.[160]

I suggest chronicity should be considered alongside severity. I inferred that MHSs are vulnerable to 'utilitarianism's logic [that] seems to screw everything up, like a poisoned chalice'.[161]

Faith communities, being diverse, range from effective (for example, The Salvation Army) to problematic — in the case of some 'extremely evangelical churches' — to violent extremist.[162] One carer described 'the history of many religious organizations as discreditable'.[163] I reflected that when FCs (and MHSs) abuse power, they do so at the expense

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[156] Anonymized C596; C598.

[157] Anonymized C598.

[158] Francis, p. 3.

[159] Susan M74.

[160] 'Spiritual Well-Being Scale: Mental and Physical Health Relationships', in *Oxford Textbook of Spirituality in Healthcare,* ed. by Mark Cobb, Christina Puchalski, and Bruce Rumbold (Oxford: Oxford University Press, 2012), pp. 353-58 (p. 357).

[161] Craig M1215.

[162] Sharon M661; Susan C703.

[163] Claire C121.

of their most vulnerable members. Paradoxically, FCs' flexibility is their very strength.[164]

Assuming necessary boundaries to behaviour, 'FCs potentially offer better solutions to being

unloved than MHSs'.[165] The 'challenge of safeguarding may be to propose a better system'.[166]

FCs can raise MHSs beyond their obsession with regulation, but they may need grounding

themselves. I inferred that 'having faith and [knowledge of] mental health provides stereo

vision, allowing perception that would be impossible with either alone'.[167]

Faith communities may be most vulnerable when they detach from other sectors. They

too risk becoming prisoners of perception, 'preying on the vulnerable to promote their faith'.[168]

In Serena's words, 'everybody's got a dirty shirt, and we need better cross-fertilization, not least

in safeguarding training'.[169]

The Principle of Subsidiarity questions: 'Who should have ultimate responsibility for

people with mental health problems? The services or the community?'[170] Russell argued: "The

more we do top-down interventions to people, the more we erode associational life".[171] His

remarks echoed my previously quoted memo: 'Professionalization disempowers patients as well

as ministers and volunteers. It may be arrogant and then collapses under the load that it has

created for itself'.[172]

Traditional deficit-based service delivery 'creates dependency and invalidates

resources, thus becoming much more expensive to deliver'.[173] Russell declared:

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[164]Raffay, The Francis Report, pp. 25-26.

[165] Sharon M699.

[166] Oscar M570.

[167] Orla M23.

[168] Claire C100; Fergus C111.

[169] C385.

[170] Pope Pius XI, 'Quadragesimo Anno: Encyclical of Pope Pius XI.' (Vatican: Libreria Editrice Vaticana, 1931). para. 80; Orla M94.

[171] Cormac Russell, 'Asset Based Community Development', in *Releasing the Power of Citizens and Communities: The Era of Social and Collaborative Leadership in Health and our Wider System* (Leyland: Northwest Leadership Academy, 2017).

[172] Otis M141; Susan M392.

[173] Pippa C358; Cahn, pp. 87-99.

> Forty percent of people who engage with the NHS are lonely. The best solution is to build community. One of the ways to do it is to treat people like producers rather than consumers. When we go into neighbourhoods, we find them doing lots of things that may not hit our KPIs [key performance indicators] but are to do with health.[174]

Stodd suggested 'the fundamental structure of our society is evolving. How we communicate, and indeed, how we think, is in flux'.[175] In consequence, our 'silos are a form of self-limitation and impoverishment'.[176] Critical Friends may afford the best protection from MHS–FC vulnerabilities.

Neither competence and inhumanity nor humanity and incompetence is conducive to recovery. 'When the NHS has a problem, it becomes devoid of humanity'.[177] 'When the church has a problem, it becomes totalitarian and seeks to convert people'.[178] These remarks support my earlier contention that "MHSs and FCs are both weakened if they seek to exist without each other [*sic*]".[179]

Attention to the Theological Tradition

My phrase 'neither competence and inhumanity nor humanity and incompetence is conducive to recovery' (in the previous paragraph) echoes patristic understandings of the Trinity. The Doctrine developed in the face of emerging heresies. From a patristic perspective, heresies were counterfeits, inferior or distorted perceptions of God.[180] Typical of counterfeits, they may have immediate appeal but are nevertheless inadequate, short-selling their recipients.

In contrast, like Rublev's icon, the Doctrine of the Trinity, searches the divine mystery to make a matchless or pinnacle statement about God's nature and glory. Part of the doctrine's

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[174] Russell.

[175] Julian Stodd, *The Social Leadership Handbook*, 2nd edn (Bournemouth: Sea Salt Learning, 2016), p. 15.

[176] Ophelia M466.

[177] Pippa M473.

[178] Pippa C467.

[179] Fred C101.

[180] McGrath, p. 303.

elegance is that it holds together the tension between God being three persons, yet in perfect unity.[181] Attempts at more straightforward explanations may avert complexity yet fall short. We may illustrate by analogy with Aristotelean virtue theory. MacIntyre writes: 'For each virtue […] there are two corresponding vices. And what it is to fall into a vice cannot be adequately specified regardless of circumstances: the very same action which would in one situation be liberality could in another be prodigality and in a third meanness'.[182]

I suggest that neither end of the expertise–compassion MHS–FC spectrum reflects our being in *Imago Dei*.[183] I wrote: 'The professional model, at least when it destroys the dignity of the patient, is theologically flawed'.[184] Utilitarianism may claim just distribution of healthcare and appear successful.[185] However, it diverts resources from the front-line to compile the necessary metrics and pays an army of administrators and auditors to dole out what remains. These technocrats have a clear interest in the 'pseudo-concept available for a variety of ideological uses'.[186] At the bottom of the food chain, the service users and carers are sold short.

At the 'expertise' end of the spectrum, classic EBM — based on the self-defining supposed gold standard of randomized controlled trials — narrows the range of legitimate debate. Salvador-Carulla and associates, not to mention Banicki and de Sousa Santos (see Section 2.2), argue that EBM's epistemology is insufficient, at least in MHS provision.[187] I have already suggested that EBM sanctions the nosological colonization of human distress. Though EBM may have immediate appeal, by analogy with patristic theology and at risk of being offensive it might be deemed heresy, a counterfeit, short-selling its recipients.

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[181] Kilby, pp. 433-35.

[182] MacIntyre, p. 154.

[183] McFadyen, pp. 30-31.

[184] Pippa M732.

[185] Beauchamp and Childress, pp. 249-55.

[186] MacIntyre, p. 64.

[187] Salvador-Carulla, Lukersmith, and Sullivan, p. 106; Banicki, p. 23; de Sousa Santos, p. 19.

However, it is not only EBM that may be considered problematic. I find Brueggemann's 'redescription' similarly disturbing. Its epistemological circularity (see page 47) should be apparent:

> I propose that what we are doing in Scripture study, reading, and hearing is that we are redescribing the world, that is, constructing it alternatively. The "re" in "redescription" means that the church is restless with the current, dominant description of reality because that description does not square with the facts on the ground. Thus every time the church takes up Scripture, it undertakes a serious challenge to dominant characterizations of our social world. It dares to propose an alternative reading of the world.[188]

Brueggemann places the theologian as arbiter (in contrast with Jesus's interaction with the Syrophoenician woman (Mark 7.24-30)). Further, Brueggemann's approach overlooks the church's moral failures. Theologically, I affirm the work of the Spirit in discernment yet admit that church failures, including the Anglican mishandling of the Bishop Ball case and the Roman Catholic Magdalene Laundries, disallow high-handed criticism of NHS failures.[189]

At the compassion end of the spectrum, I am not advocating *All You Need is Love,* otherworldly region, or ill-informed offers of healing.[190] Though such approaches were not evidenced by Wood and associates' or Wonders' participants, there is no denying that they can be harmful, as in the Victoria Climbié tragedy.[191]

Continuing perichoretic reflection enriches our understanding of ethics and co-production. In likening stakeholders' 'vital' contributions to the persons of the Trinity, we continue to 'thicken' Slay and Stephens' description and obstruct influential people from imposing impoverished epistemologies, however immediately appealing they may make them.[192]

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[188] Walter Brueggemann, *Redescribing Reality: What We Do When We Read the Bible* (London: SCM Press, 2009), p. 4.

[189] Hattie Williams, 'Bishops Were 'Perfect Accomplices' for 'Nauseating' Peter Ball, IICSA Hears' (London: Church Times, 2018); Stephen Frears, 'Philomena' (Venice: Pathé, 2013).

[190] John Lennon and Paul McCartney, 'All You Need Is Love' (London: Parlophone, 1967).

[191] Wood, Watson, and Hayter, p. 775; Wonders, pp. 85-86; Lord Laming, 'The Victoria Climbié Inquiry' (Norwich: HMSO, 2003).

[192] Slay and Stephens, p. 3; Geertz, pp. 6-10.

Ophelia identified "a very narrow but very deep chasm between churches and statutory provision that neither wants to cross".[193] If 'having faith and [knowledge of] mental health provides stereo vision, allowing perception that would be impossible with either alone', we do better together.[194] In this chapter's next section, I suggest safeguarding as an area where collaboration could enable the relative strengths of MHSs and FCs to mitigate their own vulnerabilities.

4.3   Critical Friends for Safeguarding: Core Category Six

It was a staff member, Susan, who identified the relevance of 'Critical Friends for Safeguarding'.[195] She advised that 'shared learning would be massively, hugely important', a readily achievable first step towards closer collaboration.[196] She suggested that shared learning could provide both MHSs and FCs with a 'fresh look', helping bridge the "very deep chasm", and potentially improving quality.[197] Shared learning could be invaluable around safeguarding and information governance.

I have (with one notable exception) found MHS safeguarding training uninterested, and scarcely more than a protocol for protecting the organization from litigation. By contrast, I have experienced the church's training, rooted in ethics, as altogether better.[198] However, MHSs are stronger on information governance, with most participants 'valuing NHS confidentiality'.[199]

Learning together would break down 'prejudice and stereotyping' by exploring the 'pros, cons, challenges, and dreams' of each other's approaches and personnel.[200] Introducing joint safeguarding training need entail little more than extending current multi-agency practice,

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[193] C986.

[194] Orla C23.

[195] C405.

[196] C405; C360.

[197] C424; C986.

[198] I recognize others may have quite dissimilar experience.

[199] Sharon C495.

[200] Pippa 1040; Susan C398.

already separately familiar to both MHSs and FCs.[201] Ultimately, 'joint working would […] identify and seek to respond to gaps rather than each service respond ad hoc to individuals'.[202] Collaboration might extend to voluntary and private sector providers. I now consider these matters, exploring Critical Friends using my standard structure.

Attention to Participants' 'Voices'

Participants were far from naive about recurring problems in MHSs and FCs alike. Human fallibility framed much of the discussion, with Ophelia describing "everyone [as] contaminated: bent coppers, bent lawyers".[203] Tragically, most organizations, besides MHSs and FCs have their safeguarding failures. Recognizing "everyone has a dirty shirt" offers an opportunity to use 'complementary' skill sets to address systemic weaknesses.[204] Ideally, each would encourage the other towards their highest values.

Little service user material emerged on Critical Friends. Pippa saw 'the church community as able to help the NHS recognize the crisis is happening'.[205] In seeing 'FCs' knowledge of the person as invaluable yet insufficient in crisis', she implied that safeguarding might require more than working through a flow chart.[206] Her observation suggests critical distance from professional role expectations — whether as nurse or vicar — might be required. Indeed, if nurses are 'constantly firefighting' and FCs are 'offering far more than firefighting', FCs have the better offer.[207] Where FCs are 'lacking basic awareness and training', they could be taught to 'work in [the] same manner as [the] third sector', 'requiring guaranteed confidentiality'.[208] Patrick suggested something similar, 'desiring the church to have talented

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[201] Susan C277.

[202] Orla M533.

[203] C929.

[204] Fred C80; Oscar C140.

[205] C358.

[206] C352.

[207] C349, C351.

[208] C193; C159; C161.

people who "could help you to look after yourself"'.[209] The Jimmy Savile Investigations suggested that both MHSs and FCs may have blind confidence in their 'cultures, behaviours and governance arrangements'.[210]

Among carers, Charlie argued that 'bringing MHSs and FCs together must not dilute [the] distinctiveness of both'.[211] He considered carers at risk, portraying the 'NHS as failing "when the humanity is taken out of it"' and describing "clergy who feel uncared for failing to care in turn".[212] As previously mentioned, Charlie suggested '"vocational people" need to "outbalance" those lacking vocation to avoid losing humanity'.[213] Supremely for co-production, he saw 'lived experience as igniting' compassion.[214]

Claire, who had extensive knowledge of services did not see the 'the provision of policies as guaranteeing safe practice'.[215] Rather, she recognized 'non-compliance with procedures as endemic'.[216] Describing 'Tesco [supermarket] as unconcerned', Claire had little confidence in the private sector. More positively, she named 'standards as potentially relevant to safe care'.[217]

Serena, a staff member, was ambivalent about standards, seeing 'relationship as lost in the pursuit of evidence-based practice'.[218] She suggested 'we have moved far away from relating to a patient's thoughts and feelings'.[219] She acknowledged 'deep-rooted issues in our

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[209] C240.

[210] Kate Lampard and Ed Marsden, 'Themes and Lessons Learnt from NHS Investigations into Matters Relating to Jimmy Savile' (London: Department of Health, 2015), p. 12.

[211] C410.

[212] C310; C319.

[213] C346.

[214] C602.

[215] C112.

[216] C112; C109.

[217] C325; the context suggests she had in mind something akin to the Care Quality Commission's standards. Care Quality Commission, 'The Essential Standards' (London: Care Quality Commission, 2015).

[218] C453.

[219] C460.

understanding of care' and saw mental health 'clustering as being at the opposite end of the spectrum from recovery'.[220]

Stephen saw churches 'having all the humanity, all the love, going the extra mile, all that [*sic*] compassion, but not always'.[221] In saying, 'not always', he usefully recognized 'both churches and [mental] health services as non-homogeneous'.[222] If Sally was right in 'seeing innovation as largely absent from NHS and church', hopefully each has sufficient strength to guard the other?[223] She suggested 'challenges and opportunities need to be presented at top levels of both church and NHS'.[224] Sally saw 'transformation as needing "a Moses vision of the promised land"'.[225] She saw critical friendship as more effective than compulsion.

Fred, an FC leader, suggested 'we need to come back to the true form of our FCs'.[226] He believed MHS staff 'want to engage in a more ethical, radical way' and saw 'Christianity as able to give them something working for the NHS cannot'.[227] However, he also identified 'the problem of the institutional blind eye and chaplains becoming part of the problem'.[228] His solution lay in greater attention to staff selection 'as standards can be worked around'.[229] He identified personal ethics as 'providing a stronger safeguard than [organizational] frameworks' yet regarded 'safeguards and standards as essential to quality assurance'.[230]

Fraser recognized 'mosques as particularly in need of mental health support' yet also saw them as 'safeguarding people'.[231] In a phrase reminiscent of Peplau's 'art and science of

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[220] C573.

[221] C109.

[222] Ibid.; C726.

[223] C128.

[224] C173.

[225] C225.

[226] C398.

[227] C369; C371.

[228] C141.

[229] C68.

[230] C70; C76.

[231] C8; C130.

nursing', Frank interestingly suggested 'we can compare the sensitive use of liturgy with the humanizing of legislation'.[232] Here we see how FCs and MHSs could help each other as Critical Friends for Safeguarding. Overall, FC leaders agreed 'everyone has a dirty shirt'.[233]

From an FBO leader perspective, Odette echoed Charlie, suggesting 'MHSs and FCs should work closely [together] but also keep apart'.[234] Part of her rationale was that service users 'may wish to keep their lives separate'.[235] She was especially perceptive about complementarity, 'believing the NHS need[s] to see how clergy develop relationships' and that 'the NHS can teach faith leaders the boundaries of relationships'.[236] Indeed, she saw meaningful 'relationships as central to safeguarding'.[237]

Olivia specifically introduced 'safeguarding training as offering a model'.[238] 'Identifying good links with [the] safeguarding team' and seeing in her community 'a chain of incest and poverty and mental health problems with no one to break the chain', she felt called to action.[239] Olivia saw 'churches and MHSs as having a responsibility to make connections with each other'.[240] Oscar acknowledged this may not always be easy, 'acknowledging the church didn't make good use of their historical power' yet he observed 'people [being] harmed by science's revenge on religion'.[241] Orla was keen 'to challenge entrenched positions', seeing 'relationship and getting to know each other as vital' and 'trust as central'.[242] She affirmed 'faith and mental health [insights] as equipping people to understand what they're

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[232] C232; Peplau, pp. 8-9.

[233] Fred C80.

[234] Odette C8.

[235] C9.

[236] C130; C132.

[237] C47.

[238] C272.

[239] C195; C41.

[240] C260.

[241] C275; C283.

[242] C54; C63; C65.

experiencing'.[243] Orla saw 'mental health professionals as out of their depth in some areas'.[244] She perceived 'FCs and MHSs as having complementary roles'.[245]

A staff member proposed the idea of MHS and FCs becoming Critical Friends and an FBO leader saw potential in safeguarding training as a way forward. Participants considered MHSs and FCs complementary, but most were keen they should remain distinct, not least to preserve critical distance.

Attention to my Own 'Voice'

In attending to my own 'voice', I rework and elaborate some earlier material, complementing participants' perspectives with more autobiographical content. I do so to shed light on the organizational complexities that my research addresses.

To explain my work's sensitizing concepts, I go back to before 2007 when I was a vicar in an economically disadvantaged steelworking community. Having served in the NHS, it was second nature for me to engage MHSs.[246] On several occasions, when individual pastoral need exceeded my abilities, I attempted both primary and secondary care referrals. However, my experiences were so bad, I ended up taking people to Accident and Emergency as a last resort.

I first met the term Critical Friends as a school governor where it served to support school improvement. I did not appreciate how formative it would become. In the spirit of informed GT, I incorporated this educational phrase into the core category.[247]

In 2007, my local Trust advertised a for mental health chaplain. Shortly after my appointment, I met three local researchers exploring the boundary between MHSs and FCs: Walsh, Wonders, and Wood (see Section 2.1). Later discussions resulted in mental health training around Sheffield Diocese. In 2010, I set up the Mental Health Working Team of

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[243] C17.

[244] C31.

[245] C5.

[246] My parish experience offered the backdrop for my encounters as a chaplain.

[247] Thornberg, pp. 244-45.

Sheffield Diocese's Faith and Justice Board. It continues to promote mental health awareness in FCs and knowledge of spirituality in MHSs. Delivering the training, I dutifully recommended people to report safeguarding concerns to South Yorkshire Police and Doncaster County Council. I found their later reported failings distressing.[248] The experience led me to reject rhetoric suggesting historic abuse was the preserve of FCs alone.

Memos from the present study incorporate these ideas. Reflecting on Walsh's research, I pondered: "Do nurses, and other health professionals actually have a relationship with those they work with?".[249] To the extent they do not, clergy perspectives may be invaluable. More generally, I considered 'Jesus's whole-person focus may be critical. The moment we move away from it, we are reifying or dehumanizing', a clear risk with narrow approaches to evidence-based practice.[250] Here we must check the log in our eye (Matthew 7.3), being sure to discern as well as teach.

Having studied management and seen it spread through churches (for good and ill), I accept that we should not view utilitarianism as MHSs' problem alone. Indeed, *The Kairos Report* challenges Western churches' collusion with power and wealth.[251] Becoming Critical Friends with MHSs might address some FC weaknesses but is no panacea. I prefer the inclusivity of Kelly and Swinton's vision of 'chaplains working as agents of transformation collaboratively with other health and social care disciplines and agencies, including FCs, to help others to utilize their assets to promote individual and collective well-being'.[252]

I have shared how my own experience, working first as a vicar then as a chaplain, led to the sensitizing concept that emerged as 'Critical Friends for Safeguarding'. In the next subsection, I develop these ideas, attending to the theological tradition.

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[248] John Drew, 'Drew Review: An Independent Review of South Yorkshire Police's Handling of Child Sexual Exploitation (1997 – 2016)' ([n.p.]: [n. pub.], 2016).

[249] Stephen M25.

[250] Pippa M579. Citing this memo, I am not suggesting non-Christians inevitably reify or dehumanize.

[251] Catholic Institute for International Relations.

[252] Ewan Kelly and John Swinton, *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care* (London: Jessica Kingsley, 2020).

Attention to the Theological Tradition

In this subsection, I elaborate on how MHSs and FCs might recognize their need for each other's critical friendship. I begin by naming both as wounded healers.[253] The biblical concept of ἁμαρτια (sin or missing the target) helps us understand prospective fact–value partnerships. Though MHSs aspire to restore health and the Abrahamic faiths claim to promote shalom, they often miss the mark; MHSs risk becoming empty shells.[254] Similarly, FCs quickly go off-mission, failing to reflect the love at the heart of the Trinity.

Child abuse scandals undermine church authority. Care failures and exploitation rock the NHS and other institutions, including the House of Commons.[255] Both MHSs and FCs are struggling, disfigured by their 'dirty shirts', unable to meet expectations.[256] I suggest — not excusing these crimes — that they have been scapegoated. I rest this assertion on Shooter's claim that 'by the age of 18 around 25 per cent of girls and 10 per cent of boys have been victims of sexual abuse'.[257] Both MHSs and FCs strive to address wider society's failings yet are reprimanded when they fail. From the perspective of the (admittedly harsh) Calvinist doctrine of Total Depravity, what is remarkable is the expectation they might be infallible.

Just as Saint Paul declared that 'the members of the body that seem to be weaker are indispensable' (I Corinthians 12.22), co-production asserts their 'vital' contribution.[258] Co-produced systems, properly designed and implemented, could incorporate self-regulation to prevent abuse, stigma, disadvantage, and rejection. A critical ethical question is not whether MHSs or FCs deliver their aims, but whether they do good or cause harm.[259] Reference to 'a

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[253] Nouwen.

[254] Charlie C312.

[255] Marsh, p. 17; Francis, pp. 3-5, 8; Nick Triggle, 'Shipman, Bristol, Stafford, Morecambe Bay - and Now Gosport' (BBC News, 2018); Laura Cox, 'The Bullying and Harassment of House of Commons Staff: Independent Inquiry Report' ([n.p.]: [n. pub.], 2018).

[256] Fred C80.

[257] Susan Shooter, *How Survivors of Abuse Relate to God: The Authentic Spirituality of the Annihilated Soul* (Abingdon: Ashgate, 2012), p. 2.

[258] Slay and Stephens, p. 3.

[259] Francis, p. 4.

perfect storm' suggests MHSs are far from healthy.[260] It signals that the system itself may be diseased, harming service users, carers, and staff alike.

Moltmann suggests we need to rediscover our passion for life, 'recognizing [that deep] attitude change [is] needed in church as well as beyond'.[261] Hauerwas and Willimon suggest an identity crisis:

> From a Christian point of view, the world needs the church, not to help the world run more smoothly or to make the world a better or safer place for Christians to live. Rather, the world needs the church because, without the church, the world does not know who it is.[262]

My findings indicate that FCs should not respond piecemeal to governmental plans or display the ecclesial self-interest Sentamu condemns.[263] Neither will achieve the Wilberforce-type reforms my results imply service users and carers (among others) want.[264] Hauerwas and Willimon raise the bar:

> An accommodationist church, so intent on running errands for the world, is giving the world less and less in which to disbelieve. […] At every turn, the church must ask itself, Does [*sic*] it really make any difference, in our life together, in what we do, that in Jesus Christ God is reconciling the world to himself?[265]

Co-production, ethics, and Trinitarian theology invite critical reflection on Government policies based on the 'merciless language of non-madness' that colonize recovery without admitting Freirean insights.[266]

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[260] Raffay, Are our Practices?, p. 74.

[261] Moltmann, *The Open Church*, pp. 19-26.

[262] p. 94.

[263] Shepherd; Sustainability and Transformation Plan; John Sentamu, 'Conclusion: Firm Foundations for Britain's Future', in *On Rock or Sand: Firm Foundations for Britain's Future,* ed. by John Sentamu (London: SPCK, 2015), pp. 236-58 (p. 242).

[264] Hague, pp. 178-83.

[265] pp. 94-95.

[266] Foucault, *Madness*, p. xi.; Freire, p. 40.

The Jesus prefigured in Mary's Song, revealed in Cana, and present with Mary and Martha was altogether more radical.[267] Sally expressed a need for *Skylight*-like change, 'seeing [the] transformation as requiring a Moses vision of the promised land'.[268] Provided MHSs and, all too often, FCs lack passion for life and bear little resemblance to either the purposes or the life of the Trinitarian God.[269] Utilitarian frameworks may claim to use resources effectively, but if 'confronting stigma is central to social inclusion', they fall far short.[270]

In this section, I have argued that the three core categories Expertise versus Compassion, Vulnerabilities, and Critical Friends for Safeguarding form the core concept Critical Friends. Theologically, the church (and other FCs) have a ministry of reconciliation to bridge Ophelia's "very deep chasm".[271] Shared learning could be a readily achievable first step.

4.4   Excursus: On the Path to Blessing

As examples of what could follow, I next outline two projects based on principles akin to those I explore in my thesis. For confidentiality, these case studies deliberately do not include previously mentioned participants. Though I have met the project leaders, this section's content is mostly available on their websites. Both leaders embrace co-production and bring people together for mutual support.

Renew Wellbeing: Case Study One

The first project, Renew Wellbeing seeks to address the 'tsunami of mental ill health facing this nation'.[272] Renew Wellbeing 'helps churches open spaces of welcome and inclusion in

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[267] Luke 1.46-55; John 2.1-11; Luke 10.38-42.

[268] Heaney; C225.

[269] Moltmann, *The Open Church*, pp. 19-26.

[270] Perry C303; cf. Connie C957; Welby, p. 30.

[271] C986.

[272] Ruth Rice, 'Renew You' (Nottingham: Renew Wellbeing, 2018).

partnership with mental health teams to improve mental and emotional well-being'.[273]

A Registered Charity in its second year, its striking clarity of purpose is achievable by most FCs:

> Renew spaces are simple cafe style spaces run by local churches where hobbies and activities are shared or co-produced. Each cafe space is attached to a quiet room or prayer space where inner habits of wellbeing are shared. Each church partners with a mental health professional […] to ensure good inclusive practices for safe spaces where its [*sic*] OK not to be OK can be sustained.

Three points deserve elaboration. First, is the emphasis on 'hobbies and activities', encouraging creativity that focuses on people's assets rather than perceived deficits. Second, simple, gentle, inclusive prayer is at the heart of the project. This is unapologetically, though far from aggressively, Christian. In being thus, it addresses the isolation so commonly devastating for people with mental health problems.[274] Third, the charity asks churches to partner with mental health professionals. The church members offer compassion and support; the latter supply the necessary expertise. Renew Spaces provide a template for collaboration, potentially influencing the wider church and MHSs alike.

The charity presents a simple yet effective model, offering training, and support. It works to three principles:

1) being present: 'run by a local church who give their time and share hobbies and skills in a homely welcoming space'[275]

2) being in partnership: forming 'good partnerships with statutory services'[276]

3) being prayerful: establishing 'a rhythm of quiet prayer' and opening 'these habits to their community'.[277]

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[273] Ruth Rice, 'What We Do' (Nottingham: Renew Wellbeing, 2018).

[274] Swinton, p. 10.

[275] Ruth Rice, 'What We Do' (Nottingham: Renew Wellbeing, 2018)

[276] Ibid.

[277] Ibid.

We may recognize Rice's gifting as a teacher and Baptist pastor reflected in her non-technical communication. She nurtures MHSs' and FCs' vital contributions, seeing churches as places of prayerful welcome and hospitality, fostering recovery and preventing relapse. Her approach combats stigma and disempowerment by professionals. It supplies a lean structure that enables FCs to rediscover confidence in making a distinctive contribution.[278]

Rice suggested Wellbeing Renew Spaces may best suit people with mild to moderate mental health problems.[279] For most FCs, this is undoubtedly the best place to start. Participation can prevent spiralling loss of self-confidence, isolation, and depression. It could form a pathway back into the community, potentially leading to employment where fitting. With growing experience and greater collaboration, Renew Spaces might venture to include people with more severe problems (in remission) as elaborated in Section 5.3.

Strawberry Field: Case Study Two

My second project, Strawberry Field, is an eight-million-pound investment beyond the reach of many FCs.[280] Capitalizing on the fiftieth anniversary of the Beatles' song named after the eponymous derelict children's home, The Salvation Army aims to 'to weave together educational, cultural, heritage and spiritual exploration in one bold, imaginative plan'.[281]

Alongside the visitor centre depicting John Lennon's difficult childhood will be a work-experience opportunity for marginalized people. This project discerns Salvation Army assets: a building and land with significant heritage value alongside expertise in working with marginalized people, enabling cross-subsidy of otherwise unaffordable recovery pathways. Strawberry Field will place previously stigmatized people at the heart of a significant contribution to Liverpool's tourism industry. Drawing on trainees' creativity as assets will serve the wider city.

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[278] Westwood, James-Moore, and Cooke.

[279] Ruth Rice, 'Authorized Personal Conversation', ed. by Julian Raffay (Chester, 2018).

[280] Louise Brown, 'Forever Strawberry Field' (Liverpool: The Salvation Army, 2018).

[281] Louise Brown, 'The Vision' (Liverpool: The Salvation Army, 2018).

In selecting Strawberry Field, I have deliberately chosen a project working with people with learning disabilities (an area where approaches with affinity to co-production are often more advanced than in MHSs).[282] In doing so, I suggest my findings could be relevant beyond MHSs. Indeed, co-production has been explored extensively in public policy.[283]

Strawberry Field is underpinned by vibrant Christian faith, fusing fact and value. It has the potential to help neighbouring FCs return to Fred's 'true form'.[284] Brown caused me to wonder how the project differed from more 'hidebound' and lukewarm churches.[285] I asked myself "what is it that might enable us to […] reach out to someone in need?".[286] Sandford proposed 'confidence to overcome our fear of what we do not understand' and 'focus on love as the prime motivation'.[287] Such love will, like action research, seek ways of achieving practical change. It will affirm people as assets rather than lament their deficits. Strawberry Field, like Renew Wellbeing, is a true fresh expression, transcending Owen's 'thin, and cold, and very dead' institutions.[288]

Both Renew Wellbeing and Strawberry Field harness MHSs' and FCs' strengths while addressing their weaknesses through partnership. There could be innumerable Wellbeing Renew Spaces in a region, while Strawberry Field's particularity invites other MHS–FC partnerships to 'co-identify' their particularity. In creating an adverse climate for structural megaliths,

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[282] Cindy Chan and others, 'Narratives of Adults with a Learning Disability and Autism Living within a Secure Forensic Setting', *Good Autism Practice,* 18 (2017), pp. 58-71.

[283] Catherine Durose and Liz Richardson, *Designing Public Policy for Co-Production: Theory, Practice and Change* (Bristol: Policy Press, 2016); Mariagrazia Fugini, Enrico Bracci, and Mariafrancesca Sicilia, 'Co-Production in the Public Sector: Experiences and Challenges' (London: Springer, 2016).

[284] C398.

[285] Sally C16.

[286] Cf. Luke 10.25-37; Peter Jonathan Sandford, 'Responding Well: Growing Individual and Congregational Confidence to Reach out to People with Mental Health Issues' (unpublished master's dissertation, University of Sheffield, 2018), pp. 39-40.

[287] Ibid., p. 40.

[288] Owen, p. 32.

economic downturn may favour innovators, not least those who understand the needs of those they aim to serve.

Conclusions

I have shown how the core concept Critical Friends, like All Hands on Deck, emerged from the participant interviews. I have argued that MHSs and FCs have complementary strengths (and resulting vulnerabilities) based on their underpinning philosophies. I suggested the divergence between MHSs and FCs began at the Enlightenment and that excessive focus on expertise or compassion may render care unsafe.

Acknowledging respective strengths or 'vital' contributions encourages partnership.[289] It invites MHSs and FCs to see the other as gift and inspires innovation. In the next chapter, I explore how these principles might lead to a co-produced approach to well-being, supported by a Stepped Care model.

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[289] Slay and Stephens, p. 3.

5   Partners in Health Promotion: Core Concept Three

In the last chapter, I outlined the development of Core Concept Two 'Critical Friends'. I reported that all but one participant welcomed MHS–FC greater cooperation. In considering safe and effective protocols, participants found that MHSs and FCs had complementary strengths and resulting vulnerabilities. They suggested safeguarding as a fruitful context to develop collaboration.

In this chapter, I address my third RQ: *What do [stakeholders] believe contributes to well-being and recovery?* Here both GT and co-production form natural allies in yielding insights beyond my original frame. Again, I have structured the chapter to prioritize service user and carer 'voices'.

Core Concept Three, 'Partners in Health Promotion', is the result of three GT categories. In Section 5.1, I examine 'Developing Fact–Value Partnerships' between MHSs and FCs. I explore how their complementary strengths might influence service transformation. Section 5.2 'Co-Producing the Future' brings co-production into the mix. Section 5.3, 'A Vision for Stepped Care', develops a model for collaboration. Again, I use Leach's action–reflection method (see Section 1.3).[1] The present chapter's final shorter section defends a crucial part of my conceptual framework, integrating the fieldwork with the literature.

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[1] Leach, p. 31; Costa and Kallick.

5.1 Developing Fact–Value Partnerships: Core Category Seven

The core category Developing Fact–Value Partnerships originated in Ophelia's observation that 'FCs and MHSs [are] respectively stronger on love and skill'.[2] Her suggestion implied each might offer the other something beyond safe and effective protocols for supporting service users. This mutuality is institutionalized in the hospital chaplain and parish nurse.[3]

Further consideration of Oscar's analytical reflection, 'seeing the West as fixated on 400-year-old [Enlightenment] thinking', invites more radical examination of both MHSs and FCs.[4] Despite the potential for considering FC involvement in care pathways — assuming appropriate safe and effective protocols — my findings suggest reconfiguring the 'broken and demoralised system' and marginalized FCs would be preferable.[5]

Attention to Participants' 'Voices'

Participants showed significant awareness of MHSs' and FCs' intended purpose. Service users and carers desired acceptance and inclusion beyond anything else. Unsurprisingly, FBO leaders took a more societal approach than MHS staff, with FC leaders mostly in between. Attending to participants' voices, as previously, I begin with service users.

Service users identified the church 'as having things to teach the hospital'.[6] Pippa saw churches 'as offering far more than firefighting'.[7] She considered 'churches' understanding of the human condition as their gift to the NHS'.[8] Perry argued that 'anti-stigma is central to social inclusion'.[9] Peter found exclusion far more distressing than his voices. He valued churches' wider perspective, believing 'community could help with greater opportunities, activities, and

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[2] C129.

[3] Craig M96; Pam C221.

[4] C155.

[5] Schizophrenia Commission, p. 4.

[6] Pam C221.

[7] C351.

[8] C1236.

[9] C303.

job prospects'.[10] Peter saw the value of participation 'as reducing violence and temptation'.[11] He identified social opportunity 'as potentially helping him more than tablets.[12] Pippa suggested FCs may be 'an untapped resource in mitigating suicide'.[13] She proposed that their social context may be 'a really good resource in detecting early deterioration'.[14]

Carers felt threatened by austerity.[15] Charlie expected 'the state to continue shrinking and the church's role becoming [*sic*] more vital'.[16] He suggested 'we may be returning to the Nineteenth Century', ominously echoing MacIntyre's anticipation of revisiting the Dark Ages.[17] Charlie, recognizing 'structures don't bring life', identified 'excellence as essential in inviting partnership'.[18] He suggested delaying 'involving other agencies [in new projects until] after initial development'.[19] In building such partnerships, Craig thought 'chaplaincy has a huge part to play'.[20]

Staff participants spoke openly about the potential of partnerships. Susan proposed that 'concern for human beings can bring us together'.[21] Sharon identified 'a seamless service as vital'.[22] On fact, Susan and Sharon saw 'the church desperately wanting to [support people with mental health problems] but getting held back by lack of knowledge and lacking the resources to address chronic needs'.[23]

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[10] C77.

[11] C106.

[12] C133.

[13] Pippa C612.

[14] Pippa C162.

[15] Christine C714; C751.

[16] C573.

[17] C555; MacIntyre, p. 263.

[18] C526; C542.

[19] C530.

[20] C33.

[21] C701.

[22] C9.

[23] Susan C557; Sharon C434.

Sally, favouring value, affirmed FCs' broader canvas. She described "FC leaders [as] walking with their people at the heart of the issues that mattered the most and shouting out very loudly and clearly in society".[24] She considered their values-driven approach beyond the sights of classic EBM, with significant work going unrecognized. Sharon proposed 'relationships with mental health staff as the solution to stereotyping […] church leadership'.[25] Serena anticipated 'the possibility of a greater and stronger force for health'.[26] In particular, she saw 'Parish Nursing as practical local healthcare'.[27] Sharon suggested that Parish Nursing could complement hospital chaplaincies.[28]

Faith community leader participants unanimously identified 'opportunities for cross-pollination'.[29] Those interviewed wanted 'closer partnership with MHSs'.[30] They welcomed 'backup, support, and information'.[31] Fraser found 'NHS models "quite appealing"'.[32] Faith community leaders saw fact–value partnerships as an opportunity to improve quality. [33] Florence described MHSs and FCs as 'two parts of a necessary multifaceted approach to support'.[34] She saw 'overlap between mental health and clergy training'.[35]

Though Faye had never 'contacted a mental health practitioner in [the] course of [her] duties', FC leaders identified pointers towards fact–value partnerships.[36] They cited the 'hospice movement', the Alzheimer's Society's 'raised profile', and 'Jewish communities'.[37] A specific

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[24] C32.

[25] C706.

[26] C132.

[27] C24.

[28] C651.

[29] Florence C33.

[30] Faye C295.

[31] Faye C299.

[32] C870.

[33] Faye C51; Fergus C44.

[34] C159.

[35] C29.

[36] C330.

[37] Florence C17; Faye C57; Fergus C237.

suggestion was 'giving NHS accreditation to clergy'.[38] Faith community leaders' focus on broader community well-being resembled that of the FBO leaders.

Organizational leaders found inadequate 'recognition that we're all sinking and need to collaborate'.[39] They saw FCs as playing a vital role, 'often [being] the first port of call'.[40] Oscar suggested the pastor was often the effective "care coordinator".[41] Odette envisaged three-way partnerships, recognizing 'the voluntary sector as having provided a bridge between the faith and statutory sectors'.[42] Ophelia challenged assumptions behind narrow definitions of treatment, stating that people did not need to have 'medical expertise to do something useful for people with mental health issues'.[43]

Odette saw the church 'as having greater understanding and commitment to communities' and underlined 'the stability of FCs as important to people with mental health problems'.[44] One FC-led collaboration sought to address 'a chain of incest and poverty and mental health problems with no one to break the chain'.[45] Another identified 'sanctuary as particularly relevant due to the marginalization of people with mental health problems'.[46] Orla saw 'trust as central' and anticipated 'a common goal […] reconciling the two worlds'.[47] Oscar recognized 'a need to believe each other'.[48] Odette recommended 'drop-in nurses as a means to strengthen relationships'.[49]

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[38] Florence C576.

[39] Ophelia C429.

[40] Odette C11; Ophelia C8.

[41] C18.

[42] C148.

[43] C850.

[44] C203; C102.

[45] Olivia C41.

[46] Ophelia C22.

[47] C65; C72.

[48] C40.

[49] C406; C99.

Overall, participants were realistic about the challenges of achieving collaboration. Most felt it necessary to support individuals and communities. Some suggested that shared training for FC leaders and MHS staff offered a practical way to advance greater mutual awareness. With suitable recognition, chaplains and parish nurses could offer essential waymarks. With these thoughts in mind, I turn to consider my own 'Voice'.

Attention to my Own 'Voice'

I may have polarized fact and value. However, the fact–value debate finds expression within as well as between MHSs and FCs (and additionally within individuals).[50] The 'perfect storm' is not confined to MHSs.[51] Though a simplification, I see MHSs chiefly working from an emergency medicine perspective, aspiring to repair individuals in crisis. In contrast, FCs tend to take a longer-term perspective, looking to build communities of hope. Either approach, though valid, becomes potentially harmful when overreaching or exclusive. I noted: 'The mention of possible full recovery connects with the promise of healing. Both medics [*sic*] and church leaders need to manage hope/healing'.[52]

In considering partnerships, 'reflection is required around the relative merits of clergy and NHS models of relationship'.[53] All parties implied that 'a way of relating that is appropriate when someone is well ceases to be so when they become [mentally] unwell'.[54] While the converse may be equally true, openness to debate is essential. I reflected that 'NHS services offer anonymity but are by the same token impersonal'.[55] If staff are 'less relationally able' than previously, 'the contribution that FCs stand to make is all the greater'.[56] Perhaps churches can

[50] M. Parker, 'Overstating Values: Medical Facts, Diverse Values, Bioethics and Values-Based Medicine', *Bioethics,* 27 (2013), pp. 97-104; Mila Petrova, Jeremy Dale, and Bill (KWM) Fulford, 'Values-Based Practice in Primary Care: Easing the Tensions between Individual Values, Ethical Principles and Best Evidence', *British Journal of General Practice,* 56 (2006), pp. 703-09.

[51] Raffay, The Francis Report, p. 31.

[52] Connie M894; Roy McCloughry, *The Enabled Life: Christianity in a Disabling World* (London: SPCK, 2013), pp. 86-93.

[53] Odette M126.

[54] Odette M 126.

[55] Susan M50.

[56] Frank M550.

'teach the NHS about interpersonal skills'?[57] Indeed, 'clergy may have the answers for mental health workers seeking to respond to changes to relationships entailed in [and beyond] recovery approaches'.[58] The Baby Peter Inquiry reminds us that lack of communication risks lives.[59] It is 'important not to think in terms of sharing or not sharing but what to share'.[60]

I inferred that FC leaders 'are specifically rooted in their communities and prospectively have a huge advantage over MHS professionals'.[61] Undoubtedly, 'there are things that the church understands that the health service may not' (and vice versa).[62] Indeed, 'nurses' lack of knowledge of FCs may be a lack of knowledge of their communities, especially if they live somewhere else'.[63] Ignorance about communities may be especially problematic in mental health, creating 'a vicious spiral towards self-imposed isolation'.[64]

Combatting the 'vicious spiral' of low self-esteem remains a daily challenge for many, especially when 'community services […] have retreated into technical mode' and offer little emotional support.[65] Where loneliness overwhelms, 'there is a greater need for ways to enable people to belong and have a meaningful, supportive conversation'.[66] Such ways, I reflected, rarely need expensive ongoing professional expertise (though FCs may lack [the] expertise to reach beyond lunch clubs or coffee mornings). However, 'coffee mornings plus seems an excellent idea and some way towards a one-stop shop' or a Renew Space (see Section 4.4).[67] They could offer a pathway through volunteering to recovery and potential employment. Indeed, 'churches [and other FCs] have qualities that enable them to do things the NHS cannot, e.g. in

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[57] Otis M539.

[58] Odette M115.

[59] Faye M330.

[60] Sally M194.

[61] Frank M520.

[62] Odette M102.

[63] Sharon M872.

[64] Peter M331.

[65] Peter M306.

[66] Peter M306.

[67] Otis M530.

[the] locality [*sic*], available twenty-four-seven'.[68] Many FCs want 'to achieve their potential' but need 'partnerships to be able to do so'.[69]

I envisage four matters that fact–value partnerships would improve. The simplest are those at the boundary between MHSs and FCs, sharing expertise in running drop-ins and similar. An example might be 'mental health nurses helping design pastoral care training'.[70] A second, more challenging, area might be where MHS staff members work in an FC, offering consultancy on pastoral care or theology. Such consultancy already happens informally where a nurse, doctor, or similar undertakes this responsibility as part of their religious affiliation. However, these arrangements are inevitably piecemeal.

A third domain where FCs influence MHSs routinely is through hospital chaplaincy and occasionally at higher-level as in the Gosport Inquiry.[71] In exploring MHS–FC relationships, chaplains could have a leading role, though that may entail rewriting job descriptions.[72] The fourth sphere may have the most potential. It would involve bringing service users, carers, MHSs, FCs, and other partners together to co-produce well-being.[73] For instance, FC-based 'youth workers could potentially exercise a valuable role precisely through teenage years'.[74] More boldly, 'a range of prototype posts could be considered' either regionally or nationally.[75] Parish nurses, community development workers, and public health advisers might work alongside volunteers and FCs to 'help broker care and act as advocates'.[76]

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[68] Otis M566.

[69] Olivia M199.

[70] Odette M406.

[71] James Jones, 'Gosport War Memorial Hospital: The Report of the Gosport Independent Panel' ([London]: Gosport Independent Panel, 2018).

[72] Odette M516.

[73] Otis M564; Simon Parker and Niamh Gallagher, 'The Collaborative State: How Working Together Can Transform Public Services' (London: Demos, 2007).

[74] Connie M178.

[75] Odette M541.

[76] Connie M21.

Attention to the Theological Tradition

Gazing on Rublev's *Trinity*, we may identify hope, agency, and opportunity: hope that

alternatives may be envisaged, agency in deciding our response, and opportunity to respond to

The Divine Dance.[77] Reflecting the Trinity, co-production brings many opportunities to

recognize an abundance of 'vital' contributions and possible synergies. If we could, for instance,

implement Odette's suggestion that 'the NHS need[s] to see how clergy develop relationships'

and 'the NHS can teach faith leaders the boundaries of relationships', MHSs and FCs could

become effective partners in safeguarding and more widely.[78]

Where MHSs bring outcome-orientated provision to the table, FCs offer values-led

sustenance. Balancing the two approaches promises greater resilience. Both MHSs and FCs

stand to make vital contributions to one another and, more importantly, to those they serve. The

collaboration between Street Pastors and the Police shows what is achievable.[79] Parish Nursing

and similar models can support service users returning to the community.[80]

The typical failure to co-produce in the manner I have been developing may explain

why participants considered Flair so remarkable and found Alcoholics Anonymous's recovering

alcoholic so inspiring.[81] Flair may also clarify why the conscientious jobsworth is often

ineffective by comparison and why Sally saw 'innovation as largely absent from NHS and

church'.[82] The reason — known to the recovering alcoholic — is 'skin in the game' and a

degree of innovation beyond the jobsworth's grasp.[83]

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[77] Richard Rohr and Mike Morrell, *The Divine Dance: The Trinity and Your Transformation* (London: SPCK, 2016), pp. 28-30.

[78] C130; C132.

[79] Olivia C282.

[80] Perry M270.

[81] Florence C214; Olivia C325;

[82] C128.

[83] Nassim Nicholas Taleb, *Skin in the Game: Hidden Asymmetries in Daily Life* (London: Allen Lane, 2018), pp. 1-12.

Co-production, enriched by Trinitarian theology, could potentially address weaknesses arising from excessive focus on atomistic outcome measures. An insight emerges from self-harm:

> Definitively effective psycho-social interventions for self-harm remain elusive. This however may be an artifact (*sic*) of the consistent failure to actively involve service users in efficacy research. The use of repetition of self-harm as an outcome measure is considered an invalid measurement of success by those who self-harm.[84]

Inspired by the Trinity, we might consider bringing together people who self-harm, carers, and staff, to co-produce a service where each holds the other in their compassionate gaze. Indeed, that compassionate gaze includes 'the body of the ascended Christ [that] is not a perfect body, but a body of scars (Heb. 7:25)'.[85] Such a service might entail mutual learning and joint evaluation, possibly guided by Alcoholics Anonymous and similar. As in the Trinity, there would be differentiation of roles, each making their 'vital' contribution.[86]

In Peplau's terms, the 'art' of nursing may need to trump the 'science'.[87] Love's supremacy (I Corinthians 13.1-3) points to a possible explanation of Forrest and associates' observation that 'the most important thing nurses can do is abandon their training'.[88] Their 'findings strongly suggested that being able to function as a friendly human being was seen by service users as key', challenging fact's unethical precedence over value.[89] When fact excludes value, wards become 'emotional deserts', unsafe places.[90] In contrast, hope, resonant with 'the Easter story' was striking in many of the interviews and 'implicit in hope-filled conversations'.[91] A carer hoped her son in high secure services 'would make it to university

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[84] James Ward, Claire de Motte, and Di Bailey, 'Service User Involvement in the Evaluation of Psycho-Social Intervention for Self-Harm: A Systematic Literature Review', *Journal of Research in Nursing,* 18 (2012), pp. 114-31 (p. 127). Citation from the edition published at https://scholar.google.co.uk/scholar.

[85] Hull, *A Spirituality of Disability*, pp. 31-32.

[86] Slay and Stephens, p. 3.

[87] Peplau, p. 8.

[88] Forrest and others, p. 53.

[89] Ibid.

[90] Craig M582.

[91] Charlie C34.

after "this monster" [schizophrenia] entered him'.[92] I reflected: 'Hope is not a commodity; indeed, it is more a phrase than a construct. Two people may understand it very differently', yet its absence can be fatal.[93] As mentioned, The Royal College of Psychiatrists asserts: 'recovery is probably impossible without hope'.[94] However, a superficial read of their document risks overlooking its more profound riches. They argue that recovery entails 'three core concepts': hope, agency, and opportunity.[95]

In this section, I have shown that participants considered partnerships desirable and practicable with chaplains and parish nurses well-placed to encourage 'cross-pollination'.[96] I have suggested practical steps, proposing that partnerships might have their fullest potential in exploring co-produced well-being. This brings us directly to our next core category: Co-Producing the Future.

5.2   Co-Producing the Future: Core Category Eight

Alongside the core category Developing Fact–Value Partnerships emerged another, Co-Producing the Future. This latter is logically complicated as co-production disallows predetermined formulations. The need for some outline vision risks abusing power and preconceiving the vision.

One instance of co-production risks becoming everyone else's delivered service. A solution might be for separate groups to tackle different issues. For example, Chambers and associates' paper on co-producing emergency detention might be accepted, leaving

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[92] Anonymized C86.

[93] Frank M69;Viktor Frankl, *Man's Search for Meaning: An Introduction to Logotherapy*, Rev. and enlarged edn (London: Hodder and Stoughton, (1987 printing), 1962).

[94] South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 'Recovery Is for All: Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists' (London: SLAM/SWLSTG, 2010), pp. 5, 12.

[95] Ibid., pp. 4-5.

[96] Florence C33; Kelly and Swinton.

co-production teams to focus their efforts elsewhere.[97] I address these challenges in Section 6.3 but, after Leach, I first present the participants' 'voices', as previously.[98]

Attention to Participants' 'Voices'

Participants suggested that one aspect of organizational culture that may need breaking is utilitarianism. They recognized its every offering as barely acceptable, a meagre gruel, leaving people hungry yet fearful of asking for more.[99] Participants appreciated the impact of current austerity but did not observe 'ordering more speed' addressing the 'broken and demoralised system' or helping its dependants.[100] They believed that their views could benefit service design and drive improvements. We consider the groups in turn.

Service users found 'MHSs insufficient for well-being'.[101] Perry suggested 'care pathways could be much better managed [by] taking people's faith more seriously' and remarked that 'information about services can be less than ideal in real life'.[102] Pippa saw faith groups as 'welcoming people and providing additional help' while also granting 'a sense of belonging'.[103] She found 'almost everybody in a faith group ending up delivering help to others'.[104] Pippa favoured an asset–based approach, 'seeing responsibility as belonging to the community rather than just its leaders'.[105] She recognized that co-production unleashes resources and invites people with mental health problems to become part of the solution, with 'partnership […] providing a pathway out of services'.[106]

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[97] Chambers and others.

[98] Leach.

[99] Cf. Charles Dickens, *Oliver Twist* (London: Penguin, 2012), p. 15.

[100] Cameron, 'Titanic'; Schizophrenia Commission, p. 4.

[101] Perry C21.

[102] C79.

[103] C956; C882.

[104] C644.

[105] C1073.

[106] C1105.

Carers described 'having ultimate responsibility'.[107] One likened 'schizophrenia to a death', imagining 'things would have been different if [they] had been listened to'.[108] Another described 'having thirteen support workers in two years'.[109] In these circumstances, the carers were effectively the care coordinators, regardless of who claimed that title.[110] These carers felt unheard. Craig described 'MHSs as in a downward spiral' and suggested the brakes 'need slamming on'.[111]

Staff participants appreciated the limitations of delivered services. Sharon saw 'professionalism as having widened the gap' and undermining supportive relationships.[112] She considered that MHSs 'disempowered ordinary people and excluded them from [exercising] care'.[113] Serena identified 'deep-rooted issues in our understanding of care'.[114] She saw 'relationship as lost in the pursuit of evidence-based practice'.[115] Simon considered utilitarianism unable to grasp the richness in his account of a churchgoer with learning difficulties who 'finds value, purpose, and work in making tea [after worship] every week'.[116]

Staff affirmed the advances brought about by EBM, but several felt 'called to a countercultural response'.[117] Sharon and Serena saw 'love as the fundamental thing of Christianity', and hoped the church might stop 'keeping its light under a shade'.[118] Serena suggested 'Catholic Social Teaching could help the NHS formulate frameworks' or identify 'a challenge and opportunity to frame a positive path' for MHSs and FCs.[119] She was keen to

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[107] Anonymized C13.

[108] Anonymized C1095; C1132.

[109] Connie C1150.

[110] Anonymized C1150.

[111] C1157; C1165.

[112] C670; C651.

[113] C666.

[114] C539.

[115] C453.

[116] C223.

[117] Sally C55.

[118] Sharon C661; Serena C96; cf. Forrest and others.

[119] C99.

work alongside service users to create 'way stations or destinations' to ensure 'safe pathways away from MHSs'.[120]

Faith leaders were equally realistic. Florence considered service user agency central. She described 'the service user's voice as the most important voice'.[121] She proposed that 'if [service] users are not listened to, we may be working to our personal objectives'.[122] For her, autonomy involves "really helping to support that person find themselves again".[123] She offered 'I Corinthians 12 as an image for valuing different participants' and identified 'partnerships as having the potential to increase resources exponentially'.[124]

Fred identified the need to be "sufficiently spiritually attuned to face hate or anger because we have dared criticize the wonderful NHS at a strategic policy level".[125] He suggested 'FCs have to tell the NHS it's off-message'.[126] Fergus saw FCs as 'having an ethical role in campaigning against failing healthcare provision'.[127] Fred considered the status quo ethically compromised. He saw Christianity offering 'something working for the NHS cannot'.[128] Fred, echoing Williams' lament in *Lost Icons*, saw a 'lack of ethics in secular practice' and recognized the 'need to come back to the true form of our FCs'.[129]

An FBO leader considered 'emotional support very important in chronic conditions'.[130] Otis saw 'the only solution to diabetes as talking to people about healthy eating'.[131] His perspective places service user agency at the heart of recovery and well-being. Similarly,

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[120] C20; C12.

[121] C431.

[122] C435.

[123] C441.

[124] C294.

[125] C416.

[126] C388.

[127] C317.

[128] C371.

[129] C358; Williams, *Lost Icons,* passim.

[130] Otis C419.

[131] C338.

Ophelia asserted that people did not need to have 'medical expertise to do something useful for people with mental health issues'.[132] Oscar suggested a need 'to respect [organizational] culture but break it where it is wrong'.[133]

Participants' creativity was unlikely to be captured by utilitarianism's metrics. Their thoughts suggested a co-produced future would result in more effective and more efficient services. I considered that 'ordering more speed' is only helpful when heading in the right direction.[134] Excess activity may paradoxically be a sign of despondency and exhaustion.[135]

Attention to my Own 'Voice'

As co-production looks to organize systems around people rather than the converse, it may at first feel demanding. However, my experience with LEAPs suggests it is readily workable. Co-production, in offering fresh solutions to intractable problems, can be intensely fulfilling for all concerned. By tying organizational objectives to service user ambitions, co-production potentially mitigates utilitarian claims' covert 'ideological uses'.[136]

One day, I had an extraordinary asset–based experience when attending a reading group.[137] Having forgotten my reading glasses, I was struggling. A service user with learning disabilities helped me, pointing to the text word by word. I will never forget that moment and inferred that 'compassion [cannot] fit into evidence-based care'.[138] When we see people as assets, we discover contributions we could never have imagined and find we have 'enough'.[139] Co-production welcomes a boy's 'five barley loaves and two fish' (John 6.9). It accepts that

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[132] C850.

[133] C776.

[134] Cameron, 'Titanic'.

[135] Julian Raffay, 'Follow the Leader? A Viewpoint on the Exercise of Leadership', *The International Journal of Leadership in Public Services,* 7 (2011), pp. 166-78 (pp. 169-70).

[136] MacIntyre, p. 64.

[137] I do not consider myself to have learning disabilities.

[138] Oscar M225; cf. Wells, pp. 174-75.

[139] Cahn, pp. 87-90.

'ward cleaners can make the difference' as can 'church members and leaders'.[140] It accepts help when struggling to read. In Cahn's terminology, 'an asset perspective means finding a way to convert latent capacity into kinetic energy'.[141]

I did not expect when composing my Participant Invitation Letter that I would later write: 'the desire for humanity is a recurrent theme throughout'.[142] I felt disturbed by 'care when it doesn't have a human face'.[143] I wondered whether compassion might be Procyclidine's equivalent for EBM's toxic side effects.[144]

From an asset–based perspective, the 'broken and demoralised system' needs reconfiguring. When reconfigured, service users, carers, FCs and — yes, MHS staff — should be able to contribute their 'five barley loaves and two fish' (John 6.9).[145] It is crucial that FCs 'recognize [their] unique selling point and not become subservient'.[146] The 'church […] should work to ensure that other players are able to come to the table rather than simply promoting its own opportunities'.[147]

Co-production (and MHS–FC collaboration) holds out the prospect of 'demonstrable economic advantage […in] detecting early deterioration'.[148] Community psychiatric nurses could share 'what they find the hardest'.[149] If it is 'lack of knowledge of their communities', FCs could engage 'the poor and weak, the sick and lonely and those who are oppressed and powerless'.[150] Since churches are 'often seen as a one-stop-shop by the needy', linking them to

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[140] Frank M263.

[141] Cahn, p. 97.

[142] See Appendix A; Pippa M661.

[143] Charlie M323.

[144] Procyclidine is used to counteract the side effects of antipsychotics medication.

[145] Schizophrenia Commission, p. 4.

[146] Otis M395.

[147] Florence M296.

[148] Serena M20.

[149] Serena M24.

[150] Sharon M872; Church of England, *Common Worship: Ordination Services*, Study edn (London: Church House, 2007), p. 15.

the crisis team or training them in *Mental Health First Aid* appears self-evident.[151] Service users could contribute, either using Chambers and associates' logic or through advance statements and Wellness Recovery Action Plans.[152]

My research supports Orla's suggestion of a Venn diagram enabling 'organizations to consider their niches without focusing on competing for [the same] shrinking pot'.[153] I suggest that care includes several dimensions, each with their relative skill.[154] The sociologist England laments that health is:

> increasingly seen as a commodity, from which we as 'customers' expect to have certain outcomes of which we are relatively passive recipients rather than active participants. […] With significant exceptions, health is seen as a private transaction between an individual and a service rather than the activity of people in relationship together, as families and communities with responsibility both for their own health and the well-being of their neighbours.[155]

A genuinely integrated approach would acknowledge everyone's vital contribution, not least those of service users and carers.

Prophetic vision reaches beyond Charlie's assertion that 'the institutional shell' is 'empty'.[156] It asserts that 'mosques and churches [and synagogues] can make a major contribution to well-being and health education'.[157] Prophetic vision affirms 'the importance of human relationship in a fragmented society', building communities of hope.[158] In seeking to be prophetic, I asked three questions:

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[151] Pippa M8; MHFA England, 'Training for Your Organisation' (2018).

[152] Chambers and others, p. 2; Mary Ellen Copeland, *Wellness Recovery Action Plan*, Rev. edn (West Dummerston, VT: Peach Press, 2000).

[153] Orla C9; Ophelia C425.

[154] Raffay, Wood, and Todd, pp. 5-6; Slay and Stephens, p. 3.

[155] England, pp. 141-42).

[156] C312.

[157] Fraser M811.

[158] Pippa C1191.

a) 'How can I ensure I manage a risky assertiveness and prophetic' edge 'without over-talking the research?'[159]

b) 'What difference would it make if the church leaders (or indeed I) showed extraordinary courage?'[160]

c) 'What is the difference between the scourge of mental ill health and the scourge of slavery that led Wilberforce and social reformers in the past?'[161]

These questions have shaped my purposes in the thesis and surface periodically, not least as I now attend to the theological tradition.

Attention to the Theological Tradition

In seeking to be prophetic, I feel obliged to decry Orla's "very deep chasm between churches and statutory provision".[162] In its most extreme form, I observe not only that MHSs and FCs — prioritizing fact and value respectively — speak different languages and have lost the phrase book but commonly pride themselves in their positions. One the one side, we have atomistic positivism, on the other redescription in its various guises. Orla's chasm is not of service users' and carers' making. Whether we contrast quantitative–qualitative, fact–value, art–science, or MHSs–FCs, my findings showed most participants considering that recovery benefits from a balance between polarities in every case. Undoubtedly, chaplains can help bridge this particular chasm.[163]

There is another "very deep chasm" between *The Hospitality of Abraham* and the impoverished offerings typical of MHSs and FCs.[164] Raising one's gaze from 'ordering more

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[159] Simon C378.

[160] Simon M576; Cf. Esther 4.14.

[161] Orla M622.

[162] Ophelia C986.

[163] Peter Kevern and Lisa Hill, 'Chaplains for Well-Being in Primary Care: Analysis of the Results of a Retrospective Study', *Primary Health Care Research and Development,* 16 (2015), pp. 87-99; Ben Ryan, 'A Very Modern Ministry: Chaplaincy in the UK' (London: Theos with Cardiff Centre for Chaplaincy Studies, 2015), p. 6.

[164] Rublev.

speed' to beholding the Trinity inspires 'a risky assertiveness and prophetic edge'.[165] However, cooperation demands both MHSs and FCs consider the log in their eye (Luke 6.42). As I have suggested, transformation could progress through pilot projects like shared safeguarding training, developing alongside growing trust and mutual affection.

Even were MHSs and FCs to achieve full collaboration, we could not be guaranteed that would benefit service users and carers without embedded co-production. Here I want to speak out with the 'extraordinary courage' I identified as necessary in the previous subsection.[166] I suggest that even were MHSs and FCs responding 100 per cent to service users and carer needs, they would remain ethically deficient without co-production. The reason is that they would at best be 'doing to'.[167] We see this deficiency in *Setting God's People Free* (see page 29).[168] As previously mentioned (page 56), the more readily apparent problem with such approaches is that:

> their creation, interpretation, and practice have not been generated from the perspective of those seeking relief from what malady is theirs. This limits the sources of knowledge we draw from for practicing [*sic*] our vocation and neglects the authority of those who may experience different social and historical realities.[169]

From Thornton's perspective, it is debatable whether 'doing to' can ever be effective. However, remaining courageous, I suggest that delivered services suffer a glaring ethical weakness.

From a Trinitarian perspective, it is impossible to sanction the violation of another's agency. Such action is at best a breach of hospitality and in its more extreme forms nothing less than abusive coercion. I propose this to be true not just of Mid Staffordshire and Winterbourne View but of routine MHS delivery, even where 'Excellent' Care Quality Commission ratings

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[165] Simon C378; Cameron, 'Titanic'.

[166] Simon M576; Cf. Esther 4.14.

[167] Slay and Stephens, pp. 3-4.

[168] Archbishops' Council.

[169] Thornton, p. 42.

are achieved.[170] In Moltmann's words, 'we have become used to it'.[171] We have come to accept delivered services as the benchmark. The problem is not the NHS's mostly excellent front-line staff but the myopic 'broken and demoralised system'.

We need Wilberforce-like reform to ensure people with mental health problems and their carers have the opportunity to co-produce services and outlaw current practice, however well-intentioned.[172] Even momentary study of Rublev's *Trinity* (let alone of the Trinity) shows an absolute co-equality of the three figures that will brook no Orwellian erosion of the other's dignity and agency.[173] From this perspective, I propose that traditionally–delivered services be proscribed as ethically inadequate as slavery is.

My findings suggest that it is only when MHSs regard users and carers as equals that we will approach anything ethically acceptable. In the upcoming section attending to the theological tradition, I break off from ethics to offer a biblical perspective on stepped care. However, the remaining chapters of my thesis are primarily concerned with the ethics of co-production. Theological reflection on the Trinity lifts our horizons, calling for a Wilberforce-like individual to give FCs the necessary 'kick up the backside', get their own house in order, and 'tell the NHS it's off-message'.[174]

5.3   A Vision for Stepped Care: Core Category Nine

Partnerships co-produced with service users, carers, and staff may be well-placed to foster the best of fact and value. Participants suggested that people with moderate mental health problems and those with severe problems in remission might gain most from collaboration.

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[170] Francis; P. Oakes, 'Crash: What Went Wrong at Winterbourne View?', *Journal of Intellectual Disability,* 16 (2012), pp. 155-62.

[171] Moltmann, *The Open Church*, p. 19.

[172] Orla M622; Hague, p. 264.

[173] George Orwell, *Animal Farm. A Fairy Story* (London: Secker & Warburg, 1945).

[174] Ophelia C898; Fred C388.

My reflections considered how collaborations might reduce admissions and support people on discharge. Expertise from chaplains, parish nurses, and community development workers could support co-produced Stepped Care. They might focus on prevention and health promotion rather than gaps in provision. Theologically, I draw on Jethro's advice to Moses (Exodus 18.13-26), the appointment of deacons (Acts 6.1-7), and the Feeding of the Five Thousand (John 6.1-14) to inspire a more imaginative use of limited resources. As previously, I first attend to the participants.

Attention to Participants' 'Voices'

Participants overwhelmingly considered FCs an essential resource in helping people recover and in promoting well-being. This may be because they saw social inclusion as inversely related to mental health problems. They recognized different niches in a support ecosystem that shaped the 'Stepped Care' core category.

Service users considered 'a lot of the issues being addressed as not strictly health issues' and arguably better resolved within the community.[175] They considered that 'medication is [often] insufficient'.[176] Given the stigma attached to MHSs, they preferred returning to mainstream society wherever possible. Not only did service users see 'partnership as providing a pathway out of services', but they also considered 'FCs very definitely […] able to address loneliness and feeling unloved'.[177] Peter identified 'participation as reducing violence and temptation'.[178]

Pippa saw 'faith groups as having dual goals', focused around a social activity but with the secondary (or primary) purpose of offering social support.[179] While service user participants were aware of secular social groups, they saw many 'as potentially having high thresholds',

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[175] Pippa C944; cf. Pope Pius XI.

[176] Perry C21; Perry C22.

[177] Pippa C1105; C954.

[178] C106.

[179] C812.

excluding anyone who did not fit.[180] Service users not only valued FCs' 'ability to identify and prevent relapse' but they also considered that FCs could support less-well people with guidance from MHSs.[181] Pippa identified the 'Salvation Army as providing [a] very high level of support to very poorly people'.[182] She was 'amazed' by their 'ability to support people through the whole gamut of mental health problems'.[183] The Salvation Army's ability suggested that MHS expertise could significantly increase the range of care offered by other FCs. Pippa affirmed 'the need for a balance between expertise and compassion'.[184]

Carers, with one exception, suggested 'the church should be involved throughout the care pathway' as they welcomed its more compassionate approach.[185] Their greatest concern with mental health provision was 'problems on discharge', supporting someone far from well.[186] Craig proposed that 'chaplaincy has a huge part to play'.[187]

Staff members saw 'long waits with statutory services as problematic' and admitted they could not meet the scale of need.[188] Sharon quipped: "You've either got over your problem or you've [laughter] topped yourself by the time you actually get the people that you need".[189] Serena wanted 'safe pathways away from MHSs', thus opening the door for Stepped Care.[190] Overall, the staff saw FCs wishing to engage but often compromised by the complexity and scale of the task. However, in considering Stepped Care, staff participants acknowledged FC

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[180] Pippa C869.

[181] Pippa C251.

[182] C531.

[183] C521.

[184] C895.

[185] Charlie C83.

[186] Charlie C93.

[187] C33.

[188] Sharon C694.

[189] C695.

[190] C12.

skill. Serena agreed that 'Catholic social teaching could help the NHS formulate frameworks'.[191]

Faith community leaders' responses were mostly practical and based on experience. Faye, for example, considered 'pastoral care […] the best approach to many problems'.[192] FC leaders considered MHSs' frame of reference too narrow. Fraser described 'a spectrum beyond clinical issues' and scope for FCs to contribute towards recovery and well-being.[193] Faye found professional services limited in their ability to wraparound because of their restrictive governance and funding. She described 'people needing support after using other professional services'.[194] Florence saw 'the church as [better] able to welcome people and incorporate them into community life'.[195] Fraser envisaged a more seamless and potentially informal approach than stepped care, 'suggesting a trust might ask a mosque to keep an eye on a service user'.[196]

Organizational leaders thought FCs could alert 'hospital or residential establishment[s] to care shortfalls' lessening gaps in provision.[197] They suggested FCs could 'keep an eye on people', encouraging those 'becoming unwell' to seek help.[198] Otis identified 'a level of need between congregation and GP' and suggested this zone might be fruitful for collaboration.[199]

Orla saw 'churches as able to offer opportunities for integration'.[200] She saw 'people in mental health groups as feeding [negatively] off one another' and found their 'mood lifting when they move to mainstream groups'.[201] Orla's observation suggested the ideal for many

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[191] C99.

[192] C120.

[193] C187.

[194] C157.

[195] C24.

[196] C457.

[197] Otis C24.

[198] Olivia C171; Orla C693.

[199] C160.

[200] C129.

[201] C290; C286.

would be taking part in FC (or secular) groups with 'MHSs […] providing backup'.[202] She

proposed that 'if groups need to meet around mental health, MHSs should provide them' and

that 'churches should concentrate on supporting people where there is no threat'.[203]

Olivia, as previously mentioned, identified 'a chain of incest and poverty and mental

health problems with no one to break the chain'.[204] Otis suggested 'churches could do a lot more

on health promotion', from individual care through shaping thinking to organizing 'health fairs

with […] stalls from voluntary organizations'.[205] He envisaged events being 'open to the

community' and based on its specific health needs.[206]

Overall, participants felt that FCs offered people with mild mental health problems

excellent opportunities for social interaction. They implied that people with moderate mental

health problems (and potentially severe mental health problems in remission) would gain from

the increased partnership. They thought FCs should remain involved in more acute illness but

hand over primary responsibility to MHSs.

Attention to my Own 'Voice'

I attend to my own 'voice' by discussing co-produced Stepped Care. I consider health

promotion before attending to the theological tradition.

Any vision for stepped care, Ophelia reminded me, needs to be realistic. I reflected that

'we face a picture of increasingly failing services where we can no longer pretend to

safeguard'.[207] Participants described the dilemma as: "clergy or nothing, what should we

do?".[208] In such contexts, best practice offers at least a starting point. The best of MHSs and

FCs would need to avoid creating larger and more bureaucratic organizations. Exclusion would

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[202] C141.

[203] C311; C213.

[204] C41.

[205] C258; C262.

[206] C287.

[207] M749.

[208] Oscar M122.

be unacceptable.[209] Pippa expressed another valid concern: 'If churches and MHSs are complementary, that begs the question of the atheists'.[210] Ideally, FC action would be inclusive of other people of goodwill, inspiring them to launch their own projects, or indeed do both.

We should not 'consider patients as pawns in FCs and [mental health] services but as people who will navigate what both offer'.[211] Co-produced partnerships should focus on genuine need. Since many dioceses have chaplains, parish nurses, community development workers, and pastoral workers — not to mention people with lived experience and carers — there is no shortage of relevant knowledge. Indeed 'mental health chaplains could have a central role', and 'prototype posts could be considered'.[212]

As mentioned, several participants cited The Salvation Army. They saw it organizing itself into a unit for a city (as in Strawberry Field in Section 4.4), potentially offering 'a better model than every church seeking to provide' locally.[213] In the Anglican Church, Sheffield Cathedral, St Bride's in Liverpool, and St George's in Leeds run similarly.[214] I reflected that 'a diocese could develop a strategy for mental health care, deciding what local churches can do and discovering what approaches to take at deanery or diocesan level'.[215] Such a shift in emphasis would support a Stepped Care model that recognizes 'different thresholds for different groups: (a) support, (b) partnership, and (c) referral'.[216] It could help churches 'wanting to achieve their potential but requiring partnerships to be able to do so'.[217]

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[209] Goffman, *Asylums*, p. 128.

[210] M1198.

[211] Sharon M65.

[212] Odette M516; M541.

[213] Sharon M91.

[214] Sharon M91.

[215] A deanery is an administrative cluster of some fifteen churches. Sharon M92.

[216] Sharon M82.

[217] Olivia M199.

Stepped care, at its most basic, could be planned at three levels:

a) people FCs (and relevant secular organizations) currently support effectively within their own resources

b) people they could assist in partnership with MHSs

c) people whose acute condition calls for MHSs having primary responsibility.

New Zealand's Te Pou o Te Whakaaro Nui (see Section 6.5) offers a readily adaptable model for stepped care.[218] Alternatively, mental health clustering, though steeped in utilitarianism, provides a more technical framework.[219] Clustering 'could potentially be considered when planning buddying'.[220] I reflected that 'if community care is something that churches can offer with lower [or, more accurately, easier] clusters, they may have a real contribution to make in preventing long-stay hospitalizations'.[221]

Regarding people with moderate mental health problems, 'if there is a gap between what churches offer and criteria for admission, [we might ask] how could churches and FCs bridge that gap' in collaboration with MHSs?[222] One possibility might be to co-produce such provision with 'people who need extra help but don't meet referral threshold[s]'.[223] MHSs and FCs could begin by co-producing alongside people with mild mental health problems, progressing to include people whose behaviour they find more challenging. Indeed, 'additional support at the "messy" stage might prevent admissions'.[224] Parish nurses would be one group 'well-placed to help people with mental health problems that churches cannot cope with but

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[218] 'Assessment: How to Match Talking Therapies to Peoples' Needs' (Auckland: Te Pou, 2015), pp. 6-10.

[219] NHS England, 'Mental Health Clustering Booklet' ([Leeds]: NHS England, 2017); Trevithick, Painter, and Keown.

[220] Orla M226.

[221] Claire M46.

[222] We might include here severe problems in remission; Ophelia M627.

[223] Craig M388.

[224] Pippa M38.

who do not meet admission criteria'.[225] Alternatively, their role might be advisory, acting as consultants to a LEAP serving as a diocesan or deanery operational management group.

Co-produced partnerships might not only reduce admissions but could assist people around discharge. They could allay anxieties and ensure the best of what MHSs and FCs have to offer. I reflected that 'helping people settle into a church [whether for social activities or worship] can be supported by chaplains. It requires information and contact around the time of discharge (ideally as part of the discharge plan)'.[226] We 'could consider something along the lines of Street Pastors serving service users returning to or in the community'.[227] Though from a different jurisdiction, The Wales Accord on the Sharing of Personal Information offers a model framework for quality assurance.[228] I reflected that 'staff who do not provide the opportunity for service users to participate in FCs may [*sic*] be unaware of the [potential] benefits'.[229]

More ambitiously, co-produced partnerships could devise models of care. A values-based approach might, however, prefer a multiplicity of pathways to an overengineered pipeline. Responding to Orla, I noted that 'stepped care, integrated care, and diversity of care [are all] seen as desirable'.[230] With greater encouragement from MHSs, 'clergy could have a major role in health promotion'.[231] With this in mind, we now consider the theological tradition.

Attention to the Theological Tradition

As mentioned, in this final subsection attending to the theological tradition, I anchor the emerging vision for stepped care within biblical material. I do this not to 'baptize' my ideas but

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[225] Otis M160.

[226] Sally M32.

[227] Perry M270.

[228] John Sweeney, 'Wales Accord on the Sharing of Personal Information (WASPI): The Accord' ([Cardiff]: WASPI Service Integration and Development Team, 2013). This includes at least one church.

[229] Sharon M13.

[230] Orla M102; Sara Shaw, Rebecca Rosen, and Benedict Rumbold, 'What Is Integrated Care? An Overview of Integrated Care in the NHS' (London: Nuffield Trust, 2011), pp. 7-13.

[231] Olivia M319.

rather to illustrate how accepting stakeholders' vital contributions can release resources beyond the cadre of professionals. It can further empower professionals to be more effective.

Stepped care is far from new. Exodus 18.13-26 relates Jethro's advice to Moses to triage excessive demand. In the passage, we see insatiable demand, challenge, role clarification, and a form of partnership. Risking eisegesis, we may draw parallels with MHSs and indeed with FCs. In Cahn's terminology, Moses showed a classic deficit-based perspective.[232] He sat 'alone' while the people 'stand around from morning until evening' (18.14). It takes an outsider, his father-in-law Jethro, to recognize that what he is doing is 'not good' (18.17).

Jethro advises: "You will surely wear yourself out, both you and these people with you. For the task is too heavy for you; you cannot do it alone" (18.18). Jethro finds that Moses has overreached and gone off-mission. His task is to 'represent people before God' (18.20), only addressing 'every important case' and no more (18.22).

We find a similar phenomenon in Acts 6.1-7, though with a more asset–based solution. Again, we see insatiable demand, challenge, role clarification, but this time a form of co-production. Insatiable demand, arising from the disciples' increase in number (6.1), results in passive discrimination, evident only to those affected.[233] The Hellenists' complaint causes the Twelve to focus on "the word of God" rather than "wait on tables" (6.2). They delegate rather than relegating for they suggest appointing "seven men of good standing, full of the Spirit and of wisdom" (6.3).

We see something resembling co-production when the Hellenistic Jews are invited to make a choice (6.3). The Twelve did not consider the Hellenists a problem but rather a resource within the church. The Twelve's approach resembles Jesus's asset-affirming behaviour at the Feeding of the Five Thousand (John 6.1-14) that contrasts with the deficit-based models extensively used by professionals. Cahn writes:

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[232] Cahn, pp. 87-96.

[233] Freire, p. 38.

> A needs analysis overlooks the important roles of groups, associations and organizations. As a result, real developmental activity and authentic capacity-building are omitted, defined out of the plan. With the entire focus on individuals or families, success in meeting a need translates into Exodus—moving to a better place—rather than building that community and transforming it into a place to live and contribute.[234]

Had Moses not taken Jethro's advice, the Hebrews would not have become a great nation. Had the Twelve not seen that the community held the solution, we might not have a worldwide church. The church's calling may be to — become like Balaam's donkey (Numbers 22.22-34) and — divert MHSs from their self-destructive path? Perhaps FCs need to be more open to God's voice and more prophetically assertive?[235]

I suggest that MHSs' self-destructive path lies not in failing to address 'every important case' (Exodus 18.22). They rightly assess those who most need their attention but rarely see that the community might yield the solution. They neglect the contemporary equivalent of Jethro's second piece of advice to Moses: 'You should also look for able men [and women] among all the people […]; set such men [and women] over them as officers over thousands, hundreds, fifties, and tens' (18.21). In citing this verse, I am suggesting that partnerships, co-production, and Stepped Care more closely resemble theological tradition than deficit-based approaches.[236]

The Stepped Care approach I propose affirms medical science's expertise in the 'important case' (18.22) but also recognizes FCs' vital contributions elsewhere. It further admits that problems occur when either asserts — using St Paul's image of the body — "I have no need of you" (18.21). When MHSs create emotional deserts or FCs insensitively promise healing, everyone's gift becomes lessened. Neither MHSs nor FCs will be for everyone — indeed, I avoided MHSs when I probably needed them — but collaboration could give their respective strengths far greater reach.

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[234] Cahn, p. 95.

[235] Fred C398.

[236] I am not seeking to proof-text or support literalism. Neither am I suggesting we should expect (or even necessarily want) direct equivalents for present-day care approaches.

In this section, I have shown how the core category 'A Vision for Stepped Care' arose from participants' reflections. Were such a vision co-produced, the detail might be different. Co-produced partnerships might begin developing Stepped Care and progress to reconfiguring services around health promotion. Critically, co-produced partnerships would place service user (and carer) agency at the heart of service evaluation and address 'a culture focused on doing the system's business — not that of the patients'.[237]

5.4   Grounded Theory: Evidencing and Integrating the Material

In the last three chapters, I have shown how my core concepts emerged from the fieldwork data. After Leach, I considered participants' 'voices', my own 'voice', and the theological tradition.

I begin this shorter section by reviewing my core categories and concepts, defending their coherence. I next elaborate the material that introduced Chapter 3, explaining the logic of my argument.[238] I then show how this material relates to its chiastic outer 'sandwich': my literature review and upcoming more theological chapter. By this means, I approach Chapter 6, untrammelled by my study's methodological complexity.

Forming Inductive Theory

A map of my core categories and concepts (see Table 5 below), reveals an incremental schema at both levels. In the face of core category (1) The Perfect Storm, participants perceived (2) greater FC Resilience that they attributed to (3) Flair. Since Flair is about (4) compassion as distinct from expertise, my findings suggest that the absence of either leads to (5) Vulnerabilities, necessitating (6) Critical Friends. (7) Fact–value partnerships (8) create opportunities for Co-Producing the Future, (9) possibly entailing Stepped Care.

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[237] Francis, p. 4.

[238] Lawrence A. Machi and Brenda T. McEvoy, *The Literature Review: Six Steps to Success*, 2nd edn (London: Corwin Press, 2012); Ravitch and Riggan.

On my core concepts, participants welcomed (a) All Hands on Deck, saw the need for MHSs and FCs to become (b) Critical Friends, and supremely (c) Partners in Health Promotion. I discovered that each core concept fortuitously addressed one of my RQs. The participants:

1) suggested All Hands on Deck would benefit them

2) saw critical friendship as likely to achieve safe protocols

3) envisaged partnership in health promotion contributing to well-being and recovery.

Thus, my core categories, core concepts, and RQs create a coherent whole that emerged naturally without forcing the data.

Chapter	Core Categories	Core Concept
3	1. Surviving the Storm 2. Faith Community Resilience 3. Flair	1. All Hands on Deck
4	4. Expertise versus Compassion 5. Vulnerabilities 6. Critical Friends for Safeguarding	2. Critical Friends
5	7. Developing Fact–Value Partnerships 8. Co-Producing the Future 9. A Vision for Stepped Care	3. Partners in Health Promotion

Table 5 Map of Core Categories and Concepts

As stated on page 8, my RQs sought a better solution to MHS–FC relationships for stakeholders. In constructing my RQs, I focused on achieving equipoise (see page 33). However, the fact I was recruiting as a chaplain may have had greater impact than their precise phrasing. That RQ1 is potentially a closed question did not present a problem as participants readily responded when invited to elaborate. Each RQ was logically independent but RQ1 was placed ahead of RQ3 for ease of interviewing. Hindsight reveals that this order facilitated the incremental nature of my core concepts. The RQs were framed with caution arising from the MHS–FC stand-off. The findings, in contrast, hold 'surprise wide open', revealing originally

unimagined possibilities quite beyond the prejudice I had anticipated.[239] The ethics of

co-production emerged through reflection on the finding that participants wanted something

altogether different from what MHSs routinely provide.

Central to evidencing my argument in my fieldwork is transparency. I detail my

purposive sampling and demographics in Appendices B and C.[240] Since Faith Community

Resilience is central to my case, I have shown the SWOT analysis findings in Appendix F.

I outlined my audit trail in Section 3.1, enabling examination of my work.[241]

In line with informed GT, I drafted my literature review after analysing my fieldwork

data and writing Chapter 3 (but in advance of writing chapters 4 and 5).[242] I would not

otherwise have found the terms 'patient' and 'agent' for my computerized search. The literature

review, evidencing inductive shuttling, is informed by the fieldwork. I conducted both with

rigour and transparency, ensuring the highest possible internal consistency and linkage between

them. Having reviewed the integrity of my fieldwork, I now defend my argument.

The Logic of my Argument

Toulmin states that claims need to be based on evidence supported by a valid warrant with

enough backing.[243] I consider each in turn. In Hart's terminology, I make a 'claim of policy',

namely that my findings suggest MHSs should be co-produced.[244] Hart helpfully defines such

claims as 'normative statements about what ought to be done rather than what is done'.[245] My

core concepts are, similarly, 'claims of policy'. (I make a similar argument for FCs in the next

chapter).

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[239] Heaney, p. 350.

[240] I have made some minimal anonymization for confidentiality.

[241] My processes may be readily inspected in my Data Map (Appendix H) and my Analysis Framework (Appendix D).

[242] Thornberg, pp. 247-48.

[243] Stephen Toulmin, *The Uses of Argument*, Updated edn (Cambridge: Cambridge University Press, 2003), p. 55.

[244] Chris Hart, *Doing a Literature Review: Releasing the Social Science Research Imagination* (London: Sage, 1998), p. 90.

[245] Ibid.

Supporting these claims is my evidence including my carefully documented fieldwork and literature review. Both corroborate the Schizophrenia Commission's epithet of MHSs as 'a broken and demoralised system that does not deliver the quality of treatment that is needed for people to recover'.[246] Participants saw this failure as systemic rather than the fault of individual staff.

My findings substantiate earlier research reporting FCs as willing to engage yet marginalized.[247] Banks' observation supports my attention to ethics:

> alongside the growth of managerialism and market-driven social welfare programmes, there has also been a growth of interest in the topic of ethics. Some of the growing concern with ethics has been in response to the erosion of the […] value base.[248]

Though I present my literature review and fieldwork findings as text, they reflect a process underpinned by the logic of my claim.

To prove that my claim is a valid interpretation of my evidence, I need to show that the data warrant it. Hart defines a warrant as 'an expectation that provides the link between evidence and claim'.[249] However faithfully I have reported the participants' 'voices', my sample size was commensurate with qualitative design and therefore may be less generalizable. I have therefore moderated my claim, arguing that my findings 'suggest' MHSs (and FCs) should be co-produced. This is a proper inference from my fieldwork data, well-supported by GT practice in the literature.

Since my use of GT conforms to good practice, questions about my sample are effectively questions about GT's validity and that of my warrant. Verheij argues that 'backings provide support for warrants. They become relevant when a warrant is challenged. This occurs

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[246] Schizophrenia Commission, p. 4.

[247] Wood, Watson, and Hayter, p. 778; Wonders, pp. 85-88.

[248] 'Reclaiming Social Work Ethics: Challenging the New Public Management', *Ethics,* 20 (2014), pp. 1-23 (p. 2).

[249] Hart, p. 88.

when the legitimacy of the range of arguments as licensed by a warrant is challenged'.[250] To

address this matter, I need first show that my GT theorization is credible or at least consistent

with good practice in GT. Charmaz admits that 'interpretive theories aim to understand meaning

and actions and how people construct them. Thus, these theories bring in the subjectivity of the

actor and may recognize the subjectivity of the researcher'.[251] Here, I have had the opportunity

to test my subjectivity formally with a LEAP and informally with service users, carers, and

staff. In the light of their feedback, my theorization appears valid as does my sample. Leach's

action–reflection framework supported my core concepts and encouraged me to consider

participants' 'voices' ahead of mine.[252]

Summing up, I have shown how my core concepts emerged from the fieldwork data in

characteristic GT fashion (influenced by Thornberg). I have further defended the coherence of

my findings and showed the rigour of my work. I have argued, after Toulmin, that my claims

are connected to my evidence using a valid warrant with substantial backing. My claims derive

from my research findings, though more extensive co-production would shape the exact nature

of any developments.

Conclusions

Despite my project's epistemological complexity, the findings suggest that, in making services

responsive to service user agency, co-production offers distinct advantages. I have argued that

co-produced, and co-evaluated services are intrinsically more ethical.[253] With one exception,

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[250] 'Evaluating Arguments Based on Toulmin's Scheme', in *Arguing on the Toulmin Model: New Essays in Argument Analysis and Evaluation,* ed. by David Hitchcock and Bart Verheij (Dordrecht: Springer, 2006), pp. 181-202 (p. 192).

[251] Charmaz, p. 231.

[252] Leach, pp. 21, 24.

[253] This assumes co-producers do not make unethical choices.

participants in my study welcomed MHS–FC cooperation in care provision and service design. For most, hostility to religion appeared to be an unwanted external influence.[254]

In the next chapter, I attend to the second half of my chiastic outer 'sandwich' which balances my literature review's primary focus on MHSs. Chapter 6, with its deliberately ambiguous title 'Responding to the 'Voices'', is at first theological and gives much attention to FCs. I begin by reviewing PT before similarly discussing co-production. The remaining sections contain recommendations for MHSs and FCs in turn.

For both MHSs and FCs, a key topic is how we frame reality, set criteria for evaluation, and who decides. Indeed, 'mad studies' might bring sense to theology as much as to mental health.[255] A service user expressed her thoughts succinctly: "I don't feel I need bits of paper to care".[256]

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[254] Wonders, pp. 85-87.

[255] Peter Beresford, 'Mad Studies Brings a Voice of Sanity to Psychiatry', in *The Guardian* (2014).

[256] Iris Benson, 'Annual General Meeting' (Aintree: Mersey Care NHS Foundation Trust, 2018).

6   Responding to the 'Voices': Discussion

In the last chapter, I suggested that MHS–FC partnerships might have their greatest potential in co-producing well-being. I argued that their complementary strengths could benefit both individuals and communities. I asserted (in Section 5.2) that there appears to be another "very deep chasm" between *The Hospitality of Abraham* and the impoverished offerings typical of MHSs and FCs.[1] However, this overlooks God's love at the heart of the Trinity (reflected in typically lavish Middle Eastern hospitality).[2]

I therefore begin the current chapter, by further exploring the Doctrine of the Trinity to provide the theological underpinning for my thesis. In doing so, I address Leach's Step Five *'attention to the mission of the church'*, developing ideas explored in my literature review and emerging from my fieldwork.[3] In Section 2, I consider PT's aims before critiquing Leach's Action–Reflection Method and addressing epistemological questions.

In the third section, I clarify the ethics of co-production, proposing that a thoroughgoing emphasis on patient agency might redefine our understanding of MHSs. I anchor the ethics of co-production in the principal ethical theories and consider CPE. Section 4 complexifies co-production, offering insights from four areas of experience: training, progression, meetings, and organizational ethos. The last section explores potential endgames with four hypothetical worked examples of co-production.

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[1] Orla M622; Rublev.

[2] Castle, pp. 17-18; Kenneth E. Bailey, *Jesus through Middle Eastern Eyes* (Downers Grove, IL: InterVarsity Press, 2008), pp. 34-36; Charities Aid Foundation, 'CAF World Giving Index 2016' (London: Charities Aid Foundation, 2016), p. 16.

[3] Leach, pp. 29-30.

6.1   The Hospitality of Abraham

In the first subsection, I offer a brief overview of the Trinity to contextualize my work. In the next, I synthesize the findings of the nine 'Attending to the Theological Tradition' sections, each of which emerged from reflection on a core category.[4] I deliberately regroup the material thematically to develop my Trinitarian motif as I work towards providing my thesis with its theological underpinning. Subsection Three integrates the content thus presented; the closing subsection supplying the theological basis for my conclusions.

Overview of the Trinity

The *Oxford Dictionary of the Christian Church* defines the Doctrine of the Trinity as: 'The central dogma of Christian theology, viz. that the One God exists in Three Persons and One Substance'.[5] The doctrine is an inference from Scripture, experience, and is understood as revealed.[6] It is principally an outworking of the 325 AD Nicene Council's determination, in the face of the Arian heresy, that Christ was fully divine, ὁμοούσιος (of the same substance) with the Father.[7] Crucial for our purposes is the Trinity's *Schutzlehre* or 'protective doctrine' character that resists 'attempts to reduce or simplify it.'[8] Thus orthodox Christianity considers the Trinity to be the pinnacle of human ability to articulate God's glory. Any departure from this pinnacle is considered to diminish our understanding of divine love.[9]

The conceptual key linking the Trinity with MacIntyre's fact–value divide is the AD 451 Chalcedonian Definition that Christ is fully divine and fully human. The Definition is, similarly, a *Schutzlehre.* Again, departure from the Definition may deliver 'something we can

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[4] See Chapters Three to Five.

[5] F. L. Cross and E. A. Livingstone (Oxford: Oxford University Press, 1983), p. 1394.

[6] Emil Brunner, *Dogmatik I: Die Christliche Lehre Von Gott* (Zurich: Zwingli-Verlag, 1959), p. 241.

[7] McGrath, p. 17.

[8] Ibid.

[9] In wrestling with the 'Three Persons and One Substance', the Western church has traditionally emphasized God's numerical identity and the East, the three hypostases; Vigen Gurioan, 'Love in Orthodox Ethics: Trinitarian and Christological Reflections', *CrossCurrents,* 33 (1983), pp. 181-97 (pp. 181-86).

cope with' but at an unacceptable cost.[10] Similarly, the church understands a person as a body–soul being, a fact–value entity, and any retreat from this understanding causes ontological degradation. On the fact side, EBM risks commodifying isolated individuals.[11] On the value side, we may encounter false promises of faith healing.[12] Neither reflects the Social Trinity.[13]Both may be deemed inhospitable, regrettable outworkings of degraded conceptualizations, ἁμαρτια.

Synthesizing my Earlier Theological Reflections

In regrouping my theological reflections from chapters three to five, I found myself saddened by the ἁμαρτια causing MHSs to become empty shells and FCs to offer dull religion instead of an inclusive invitation to the heavenly table.[14] However, I choose to reject Moltmann's 'death of the soul' rather than become '"used to it"'.[15] Thankfully, I find in the Trinity infinite resources to inspire the desired Wilberforce-type reforms my results demand.[16]

The first Trinitarian theme my findings suggest is that co-production reflects the divine perichoresis.[17] Unsurprisingly, relationships within (and emanating from) the Trinity offer a pattern and *telos* for healing.[18] Coequal relationships disallow objectification, atomization, ontological degradation, and loss of agency.[19] Disregarding this understanding that 'persons are by their very nature interactive, interdependent, in communion with one another', EBM risks

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[10] McGrath, p. 300.

[11] England, pp. 141-42.

[12] I welcome healing ministry when conducted sensitively as an expression of compassionate love.

[13] Social trinitarianism is a loosely defined concept emphasizing tightly-related 'distinct centers of consciousness' Thomas H. McCall and Michael C. Rea, *Philosophical and Theological Essays on the Trinity* (Oxford: Oxford University Press, 2009), pp. 2-7.

[14] Charlie C312; Bayes, pp. 1-5.

[15] Moltmann, p. 19.

[16] Hague, p. 195.

[17] McFadyen, pp. 151-61.

[18] Kilby, p. 434.

[19] Charles Taylor, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Cambridge University Press, 1992), pp. 175-76.

causing harm.[20] A Trinitarian perspective suggests that many mental health problems result from this communion having been ruptured or abused and may be better addressed through 'pleasant process[es]'.[21]

We need to rediscover these 'pleasant process[es]' in compassion's deep roots in both medical and FC traditions. Inspired by the Trinity, we might look to co-produce a service where each holds the other in their compassionate gaze, recalling my earlier quotation that 'the body of the ascended Christ is not a perfect body, but a body of scars (Hebrews 7.25)'[22] Significantly, this gaze embraces the stigmatized person, includes them at the table, and invites them to participate in *The Divine Dance*.[23]

Secondly, and perhaps more importantly, beholding the Trinity inspires 'a risky assertiveness and prophetic edge' that rejects 'doing to' as unethical.[24] The Trinity holds together the tension between God being three persons, yet in perfect unity.[25] Reflecting the Trinity, co-production brings many asset–based opportunities to recognize abundant synergistic 'vital' contributions.[26] Co-produced MHSs, properly designed and implemented, could incorporate self-regulation to prevent abuse, stigma, disadvantage, and rejection. The biblical accounts of Jethro (Exodus 18.13-26) and the appointment of deacons (Acts 6.1-7) illustrate how 'vital' contributions can serve the wider community.[27]

Reintegrating Fact and Value

In looking to integrate my fieldwork reflections and overview of the Trinity, I find that EBM is at variance with the Church Fathers' approach. Whereas EBM is reductionist, the Fathers put

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[20] Kilby, p. 434; cf. John Zizioulas, *Being as Communion: Studies in Personhood and the Church* (London: Darton, Longman and Todd, 1985), p. 27.

[21] Halliburton, p. 62.

[22] Hull, *A Spirituality of Disability*, pp. 31-32.

[23] Rohr and Morrell, pp. 28-30.

[24] Simon C378; Thornton, p. 42.

[25] Kilby, pp. 433-35.

[26] Cahn, pp. 100-12.

[27] Slay and Stephens, p. 3.

words and images 'to new uses in an attempt to capture and preserve precious insights into the nature of God.'[28] We might liken the former to surgical cloths occluding all but the operating site and the latter to someone gazing wide-eyed upon *The Trinity*.[29]

However, if mental health problems result from abuse, neglect, membership of the precariat, or being "in the community but not in the community" then the priority may be perichoretic love.[30] Anyone desperate for, *eudaimonia*, community, for opportunities to 'interact, laugh, and join in activities', may experience 'thin, and cold, and [often] very dead' EBM interventions as confirming internalized stigma.[31] This suggests an explanation for my earlier findings that people reacted adversely to the ontological degradation they encountered in the biopsychosocial model, preferring more 'pleasant process[es]'.[32]

I propose that 'thin, and cold, and [often] very dead' positivist interventions exert double jeopardy on those already harmed by an atomizing 'liberal construction that makes the world ready for the advance of capitalism and a kind of liberal democracy that serves the desires of certain groups at the expense of a proper human self-understanding'.[33] When capitalism enlists utilitarianism as a 'pseudo-concept available for a variety of ideological uses', it whips up the 'perfect storm', turning psychiatric wards into 'emotional deserts', places unsafe for staff, let alone service users and carers.[34]

Diametrically, 'in Christianity, the one thing we *must* hold on to is the insight that God, whom no one could possibly see, rightly bears the name of love (I John 4.7-16). No doctrine must ever be allowed to obscure this.'[35] Neither must the church's praxis fall short. Undeniably

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[28] McGrath, p. 299.

[29] Rublev.

[30] Guy Standing, *The Precariat: The New Dangerous Class* (London: Bloomsbury Academic, 2011), pp. 1, 7-13; Patrick C44.

[31] Peter C352; Owen, p. 32.

[32] Halliburton, p. 62; Raffay, Wood, and Todd, pp. 9-10.

[33] Owen, p. 32; Smith, pp. 48-49.

[34] MacIntyre, p. 64; Raffay, Are our Practices?, p. 39; Craig M582.

[35] Jeff Astley, *SCM Studyguide to Christian Doctrine* (London: SCM, 2010), p. 202.

there are times when we need EBM alongside Christ-like compassion. However, Forrest and associates' recommendation that nurses 'slide up and down the 'human' 'professional' continuum' suggests the pinnacle of clinical practice. Hardwiring service user and carer preferences into service evaluation may prove the best means to prevent falling down either precipitous slope.[36]

Theological Underpinnings

Marsh offers criteria that challenge MHS and FC ἁμαρτια. He proposes that the hand of Christ may be seen 'when solidarity is shown with those who are mistreated', 'wherever forgiveness occurs', 'when people experience a transformation in life', 'whenever creativity blossoms', 'wherever the abuse of power is challenged', 'whenever people renounce reliance on wealth'.[37] Set against such 'outcome measures', those typical of MHSs' 'broken and demoralised system' are myopic and, in Moltmann's phrase, "used to it".[38]

The Chalcedonian Definition, the Doctrine of the Trinity, Rublev's *Trinity*, and the Social Trinity all aspire to make pinnacle statements that supply a *Schutzlehre.* This way of thinking is valid as much in its *telos* as in its detail. It gives us grounds to challenge the sufficiency of either fact or value, let alone the ontological degradation from which I have argued that co-production affords protection.

Though implying that only Christian Trinitarian thinking can produce this framework, I welcome the contributions of highly creative MHS staff, not least occupational and arts therapists. However, Christians can gift (or give in grace) the Social Trinity, notwithstanding Kilby's critique, to other disciplines.[39] Such giving may be precisely how Christians attend to the mission of the church (and indeed one that postmodernity may increasingly welcome).[40]

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[36] Forrest and others, p. 53; Raffay, Are our Practices?, p. 74.

[37] Marsh, pp. 23-43.

[38] Schizophrenia Commission, p. 4; , *The Open Church*, p. 19.

[39] Kilby, pp. 443-44. Note: The Social Trinity is but one of many possible images, another might be Jesus calming the storm (Mark 5.35-41).

[40] Richard R. Osmer, 'Practical Theology: A Current International Perspective', *HTS Teologiese Studies/Theological Studies,* 67 (2011), p. 5.

I invite anyone uncomfortable with the Trinity's credal nature to consider the doctrine a valuable thought experiment or invitation to reframe.

Despite my finite epistemological self-awareness as a practitioner, I have sought throughout the project to treat others — borrowing a phrase —as perichoretic equals. Doing so does not require me to be a pluralist or even a modernist[41] In Leach's words:

> Being attentive […] involves attention not just to the voices we are hearing but to those we are not hearing. We need to learn to weigh what we hear and see it in perspective. We need to broaden our understanding in the light of the wider issues and try to achieve a deeper theological perspective before we respond.[42]

In offering the Trinity as the basis for reintegrating fact and value, words from Hebrews seem apposite: 'Let mutual love continue. Do not neglect to show hospitality to strangers, for by doing that some have entertained angels without knowing it' (13.1-2).

If the Trinity provides a sound basis for reintegrating fact and value, and if Kelly is right in considering MHSs to be 'double-f***ed', then this implies that (in this context at least), MacIntyre's critique of utilitarianism is apt.[43] My findings suggest 'solutions [that] are the same in essence and have never worked' cannot repair the 'broken and demoralised system'.[44] Further targets, not least cost improvements tantamount to 'ordering more speed', risk greater demoralization and failure.[45] Similarly, where FCs embrace managerialism, they should not presume their immunity.[46]

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[41] Gavin D'Costa, *The Meeting of Religions and the Trinity* (Edinburgh: T&T Clark), pp. 1-2.

[42] Leach, Pastoral Theology.

Ewan Kelly, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool, 2018); MacIntyre, p. 64.

[44] Fred C175; Schizophrenia Commission, p. 4.

[45] Cameron, 'Titanic'.

[46] John Milbank, 'Stale Expressions: The Management-Shaped Church', *Studies in Christian Ethics,* 21 (2008), pp. 117-28 (p. 128).

6.2   Reviewing Practical Theology

Building on the theological underpinning I developed in the previous section, I now show how my work relates to current debates within PT. I explain how PT is evolving as practitioners engage changing culture and gain confidence in exercising leadership beyond ecclesiastical domains. In subsection two, I critique Leach's action–reflection method, suggesting it is a valuable but insufficient tool, albeit one that complements co-production. In subsection three, I reflect on the relationship between Leach's 'voices'.[47] Lastly, I give further attention to epistemological questions within PT. I first consider current debates.

Debates within Practical Theology

In 2008, Osmer identified four core tasks or aims within PT: descriptive-empirical, interpretive, normative, and pragmatic.[48] Unsurprisingly, it is the interpretive task 'drawing on theories of the arts and sciences to better understand and explain why these [observed] patterns and dynamics are occurring' that is most obviously contentious from a co-production perspective.[49] However, by 2010 already, Cameron and associates asserted that PT's 'central task is to propose anew the *deep connectedness* of the Christian theological tradition and human experience. Practical theology is theology in active mode, grappling with the contemporary culture'.[50]

Engaging postmodern culture's distrust of institutions enabled Osmer (in 2011) to reflect on PT's metatheoretical context in a manner reminiscent of MacIntyre (though drawing on Kuhn and Toulmin).[51] Osmer argues that:

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[47] I am not suggesting any direct correspondence between Leach's 'voices' to the 'personae' of the Trinity.

[48] Richard R. Osmer, *Practical Theology: An Introduction* (Grand Rapids, Michigan: William B. Eerdmans), pp. 4-11.

[49] Ibid., pp. 4, 6-9. Note: I appreciate the normative task may also raise concerns.

[50] Cameron and others, p. 13. Italics original.

[51] Osmer, PT: An International Perspective, p. 4; Schön, pp. 3-20.

the end of modernity has removed a formidable obstacle in our path. The modernist portrait of science offering public, objective and verifiable knowledge, whilst theology offers private, subjective and dogmatic knowledge is largely discredited. It has given way to an understanding that various spheres, fields, or domains of life have their own distinctive traditions and patterns of rationality and that natural science does not serve as the paradigm of rationality for every area of life. As a rational enterprise of the Christian community, theology has both the right and obligation to discern its own unique forms of critical reflection.

I welcome his approach that encourages both PT and ordinary Christians to contribute to the 'common good'.[52]

Osmer, referring to a South African context, invites PT to consider a broader role in addressing the: 'massive damage and danger modern science and technology have unleashed upon the world.'[53] He asserts:

Both nature and human communities have been wounded and it is quite conceivable that the worst is yet to come. With this image, I also want to communicate that reason itself has been wounded by its complicity in this evil'.[54]

In response, I return briefly to Rublev's icon, desiring that PT should undertake the demanding task of offering an open and hospitable table to all who are willing to attend in their "dirty shirt".[55]

Osmer's assertion sets my 'perfect storm' theory in a broader ecological context, substantially enlarging the potential for MHSs and FCs to collaborate as Partners in Health Promotion towards *eudaimonia* and the restoration of creation (Romans 8.18-29).

Critiquing Leach's Action–Reflection Method

In 2007, Leach went some way to 'to engage theological perspectives with the broad issues of cultural and political life and not just with the pre-occupations of the religious'.[56] Though she

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[52] Osmer, p. 5.

[53] Ibid.

[54] Ibid., pp. 5-6.

[55] Rublev; Castle, p. 18; Bayes, pp. 1-5; Serena C385.

[56] Leach, p. 23, Pastoral Theology.

takes listening — to the participants and God — seriously, I consider that she places excess confidence in researchers' ability to 'listen through the silence […] to the stillness that is Christ, whose resurrection, life and power is [*sic*] deeper than any pain'.[57] Omitting the question of who decides the transformation leaves her research framework predetermined by those with the most power, in a manner reminiscent of *The Truman Show* or *The Matrix*.[58] Hidden positivist assumptions, overlooking more recent insights from theological action research and co-production, lead me to deem Leach's action–reflection method insufficient.[59] Similarly, Astley challenges the utility of 'second-hand' theology.[60]

I not only question anyone's right — however well-meaning — to define another's reality, but I am also revisiting the matter of agency. In Heaney's language, theological action research and co-production hold 'surprise wide open'.[61] Whereas Leach's method develops students' reflexivity, these more recent methods prospectively enable, for instance, trans people to undertake theological enquiry independent of a researcher's lens.[62]

Ideally, research provides 'a hospitable environment to understand life experience and discern God's call — to do theology', believing 'we can work together to build institutions like the church to enhance life'.[63] Hull's perspective (see Section 1.3) allows diverse vital contributions — blind, sighted, trans, cis — without collapsing into emotivism.[64]

If agency is indeed central to well-being, we need to step beyond merely listening to Leach's 'voices'. Our primary task may entail supporting stakeholders to achieve whatever reasonable ends they might wish (without discounting *eudaimonia*). Research may supply the

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[57] Ibid., p. 24.

[58] Laurence Wachowski and Andrew Wachowski, 'The Matrix' (Warner Brothers, 1999); Peter Weir, 'The Truman Show' (Paramount Pictures, 1998).

[59] Banicki, p. 23; Cameron and others, p. 16.

[60] Astley, *Ordinary Theology*, p. 37.

[61] Heaney, p. 350; Cameron and others, pp. 16, 23.

[62] Barnsley, p. 110. See Footnote in text.

[63] Margaret Ann Crain and Jack L. Seymour, 'The Ethnographer as Minister: Ethnographic Research in Ministry', *Religious Education,* 91 (1996), pp. 299-315 (pp. 312, 13).

[64] John M. Hull, *Touching the Rock: An Experience of Blindness* (London: SPCK, 1990), pp. 48-49, 80-81.

proper means, but current practice might have to change.[65] Both co-production and action

research offer tools to hold 'surprise wide open' yet lack GT's formal theorization.[66]

Bringing the 'Voices' into Conversation

In Leach's and similar models, we find little clarity as to how a conversation between the

'voices' is intended to occur, let alone which 'voice' (or 'voices') should have greater

authority.[67] Leach observes: 'At the personal level we wait, we pay attention to all the many

connections, the disordered patterns of relation, hearkening, listening, discerning, pulling back

from rhythms we've moved to thoughtlessly'.[68] While this is valid, her method overlooks the

political or power conflicts between the 'voices' themselves (though she recognizes the issue in

a later publication).[69]

In giving service users and carers precedence in the interviews (page 75), in using GT

order, and through co-production with the LEAP, I have evidenced reflexivity regarding the

conversation between the 'voices'.[70] I accept that only Leach's Step One involved the

participants, leaving me with the disproportionately privileged 'voice'. Like Leach's student

ministers with:

> their own stories to tell: their prejudices against NGOs [non-governmental
> organizations] who seemed to them in many places to be perpetuating tasks in
> order to fund their own jobs; their own unwillingness to uncover how members
> of their own families had become infected with HiV [*sic*]; their own encultured
> attitudes to women…[71]

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[65] INVOLVE, 'Payment for Involvement: A Guide to Making Payments to Members of the Public'*,* (2010) <http://www.invo.org.uk/wp-content/uploads/2012/11/INVOLVEPayment-Guiderev2012.pdf> [accessed 5 December 2014].

[66] Cameron and others, pp. 49-60; Heaney, p. 350.

[67] Leach, Pastoral Theology; Belenky, p. 124; Barnsley, p. 116; Bruce Stevens, 'Grounded Theology? A Call for a Community of Practice', *Practical Theology,* 10 (2017), 201-06, (p. 202).

[68] Leach, Pastoral Theology, p. 27.

[69] Ibid., p. 26; Jane Leach, 'Power and Vulnerability', in *Creative Supervision across Modalities: Theory and Applications for Therapists, Counsellors and Other Helping Professionals,* ed. by Anna Chesner and Lia Zografou (London: Jessica Kingsley, 2014), pp. 145-60.

[70] This precedence left others with the final say (as I realized in my analysis of Flair).

[71] Leach, Pastoral Theology, p. 27.

I, and indeed most other researchers, using widely accepted methodologies, have stories to tell.

My practice as a researcher (in part necessitated by protocols) parallels that of the front-line staff as sole ethical agents (page 22). Fuller conversation between the 'voices' could be enhanced by several non-exclusive approaches, each with its relative merits. One would require all participants to have full (and properly remunerated) opportunity to participate in and evaluate each of Leach's five steps. Another would be to add 'Step Six: *Participants' analysis and evaluation*'. Alternatively, Cameron and associates advance theological action research, 'rejecting the superiority of professional research knowledge over the practical knowledge of local stakeholders'.[72] None of these, however, ensures all voices are both represented and heard (as in my commissioners or indeed *Setting Gods People Free*).[73]

Determining which 'voices' carry authority remains unresolved and, acknowledging the particularity of Leach's terminology, the co-production literature offers scant guidance. We would ideally need to resolve who are the legitimate gatekeepers for each of her steps.[74] My experience with LEAPs suggests that virtue-inspired praxis, seeking almost perichoretic personal relationships of genuine trust, begins to address consensus. Lencioni offers management insight into the complexity of the matter.[75] Perhaps, neither Leach nor co-production can achieve more than seek to ensure all participants claim to be fairly heard. Action research may provide valuable guidance though Cameron and associates say little on the issue.[76]

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[72] Cameron and others, pp. 36-39; Davydd Greenwood, J. and Morten Levin, *Introduction to Action Research* (London: Sage, 2007), p. 53.

[73] Leach, Pastoral Theology, p. 25; Eric Stoddart, '(In)Visibility and the Process of Public Theology', *International Journal of Public Theology,* 7 (2013), pp. 45-64; Archbishops' Council.

[74] Leach, Power and Vulnerability.

[75] Patrick Lencioni, *The Five Dysfunctions of a Team: A Leadership Fable* (Chichester: Wiley, 2002), pp. 187-90.

[76] Cameron and others, *Talking about God*, p. 43.

Further Epistemological Questions

It would be inequitable to charge EBM's epistemology in MHS provision with creating artefacts without further attending to PT's epistemological assumptions.[77] Graham acknowledges that practical theologians wrestle with tensions between their received tradition and evidence gathered from research participants and other disciplines:

> This aspect of practical theological method is, however, controversial. It locates us on one of the chief fault-lines of Christian tradition and theological study, which is the question of the relative status and authority of tradition versus experience, or of the balance between theological and non-theological sources and norms. As I will indicate later, this tension between the inductive and the deductive within practical theology has re-emerged as a key controversy in recent years.[78]

Notwithstanding the differences between positivist EBM and biblical authority, in reality both front-line staff and ministers routinely use abductive processes with varying degrees of self-awareness.[79] In GT terminology, their ensuing insecurities may expose the basic social psychological process contributing to Ophelia's "very narrow but very deep chasm between churches and statutory provision that neither wants to cross".[80]

When theologians' desire to redescribe meets NHS 'hidebound religion', both may project their epistemological insecurities, perceiving weaknesses in the other.[81] The equivalent of what Beaudoin observes of theologians may apply to front-line staff: 'It is threatening for many practical theologians to imagine releasing a Christian center [of authority] for practical theology, but that is exactly what confronts us, with no guarantee of what comes next.'[82] Flatt suggests an embodied solution:

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[77] Salvador-Carulla, Lukersmith, and Sullivan, p. 106; de Sousa Santos, p. 19.

[78] Elaine Graham, 'The State of the Art: Practical Theology Yesterday, Today and Tomorrow', *Theology,* 120 (2017), pp. 172-80 (p. 174).

[79] Banicki, p. 23.

[80] Charmaz, pp. 34-35; Ophelia C986.

[81] Brueggemann, p. 4; Sally C16.

[82] Tony Beaudoin, 'Why Does Practice Matter Theologically?', in *Conundrums in Practical Theology: Theology in Practice,* ed. by Bonnie J. Miller-McLemore and Joyce Mercer (Boston, MA: Brill, 2016), pp. 8-32 (pp. 12-13).

The chaplain, fully part of their faith community, enables the hospital that has become technological and scientific to regain an understanding of illness and health as part of what it means to be human. The chaplain achieves this is by being himself [or herself], modelling truth and integrity in all his [or her] relationships and holding together the sacred and the secular, sickness and health.[83]

Leach, similarly implies that we should emphasize praxis, observing that 'no probationer minister will be ordained in the MCSA who has not established a successful project which engages with HiV/AIDS issues [*sic*] and a project which promotes black empowerment.'[84] Cameron and associates argue that 'practical theology is theology in active mode' and necessarily 'interactive'.[85] Whereas we can reasonably bring epistemology to critique EBM's excessive focus on targets, it too needs balancing with orthopraxy.[86]

Co-production questions who selects projects for research, what conclusions are reached, and how projects are executed and evaluated. The ethics of co-production disallows these choices from being usurped by the academy, whether medical or ecclesiastical. Combining insights from Astley and Salvador-Carulla, I suggest we need ordinary people's vital contributions to drive ordinary epistemology and ordinary orthopraxy.[87]

In arguing that provided services should be deemed ethically deficient, I am not slighting front-line staff but rather arguing that 'ordering more speed' is harming MHS stakeholders.[88] The Griffiths legacy has sanctioned over "26 years of experience" at prioritizing external goods.[89] It has helped turn 'nurses into technicians and patients into data', against the

[83] Stephen Flatt, 'Making Use of Models of Healthcare Chaplaincy', in *Critical Care: Delivering Spiritual Care in Healthcare Contexts,* ed. by Peter Sedgwick, Andrew Todd, and Jonathan Pye (London: Jessica Kingsley, 2015), pp. 37-50 (p. 46).

[84] MCSA: Methodist Church of South Africa; Leach, Practical Theology, p. 23.

[85] Cameron and others, *Talking about God*, p. 13.

[86] Francis, p. 4.

[87] Astley, *Ordinary Theology*, pp. 54-56; Salvador-Carulla, Lukersmith, and Sullivan, pp. 108-10.

[88] Cameron, 'Titanic'.

[89] Martin Gorsky, "Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry', *Medical History,* 57 (2013), pp. 87-107; Cameron, 'Titanic'.

wishes of either.[90] Captain Smith offers a profoundly unsettling metaphor for MHS

utilitarianism.

6.3   Reviewing Co-Production

I begin this section by recapping the limitations of clinician-focused ethics and suggest we need

a broader, arguably theologically-informed, perspective. I next clarify the ethics of

co-production, highlighting the importance of involving all stakeholders as agents in recovery.

I then anchor the ethics of co-production within the major ethical systems, namely

consequentialist, deontological, and virtue ethics. The final subsection considers the more

prospective CPE.

Beyond Clinician-Focused Ethics

My findings suggest that excessive emphasis on external goods has a ready ally in EBM.

A quote from Taylor recaps positivism's epistemological feet of clay:[91]

> We see the origin of one of the greatest paradoxes of modern philosophy. The
> philosophy of disengagement and objectification has helped to create a picture
> of the human being, at its most extreme in certain forms of materialism, from
> which the last vestiges of subjectivity seem to have been expelled. It is a picture
> of the human being from a completely third person perspective. The paradox is
> that this severe outlook is connected with, indeed, based on, according a central
> place to the first-person stance. Radical objectivity is only intelligible and
> accessible through radical subjectivity.[92]

My results, though based on a small dataset corroborate Taylor's verdict, suggesting the need for

a reframe.

We may take this reframe from patristic debates. Just as the Church Fathers eschewed

monism and tritheism, we need to avoid the polarities of seeing front-line staff as indistinct

from service users or as professionally detached.[93] Even disregarding the risks of detachment

highlighted by social science, EBM replaces Bonhoeffer's 'divine reality' with a 'thin, and cold,

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[90] Raffay, What are the Factors?, p. 74.

[91] Daniel 2.

[92] Taylor, pp. 175-76.

[93] Kilby, pp. 434-35; Forrest and others, p. 53.

and very dead' contractual relationship quite incapable of restoring the individual to genuine community.[94] Thus construed, EBM in MHSs could be conceived of as ontological degradation. As Bonhoeffer writes: 'Christian community is not an ideal which we must realize; it is rather a [collective] reality created by God in Christ in which we may participate'.[95]

From within the *habitus* of privilege, the 'patronising disposition of unaccountable power' is undoubtedly seductive yet almost indiscernible.[96] In deliberately prioritizing service user and carer 'voices', my work calls for a more 'pleasant process'.[97] A suitably 'pleasant process', my earlier research reveals, is likely to be more holistic, addressing service users' and carers' adverse experience of EBM.[98] Co-production and specifically co-evaluation would empower service users and carers, as ethical agents, to protect those attributes they most value.

Clarifying the Ethics of Co-Production

Addressing ontological degradation is not PT's classical focus as PT's origins are primarily pedagogical.[99] Nevertheless, my enquiry is legitimately PT as the discipline 'asks contextual and experiential questions and challenges historical formulations in a quest for more inclusive and relevant forms'.[100] Freirean insights into pedagogy drew me in turn to liberative and virtue ethics.[101] Exploring these fields led me to discover that ethics provides a powerful, albeit hitherto undiscovered, argument for co-production.

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[94] Muzafer Sherif and others, *Intergroup Conflict and Cooperation: The Robbers Cave Experiment* (Oklahoma, OK: Institute of Group Relations, 1961); Stanley Milgram, 'Some Conditions of Obedience and Disobedience to Authority', *Human relations,* 18 (1965), pp. 57-76; Philip Zimbardo, *The Lucifer Effect: Understanding How Good People Turn Evil* (New York: Random House, 2007); Owen.

[95] Dietrich Bonhoeffer, *Life Together* (London: SCM Press, 1954), p. 18.

[96] James Jones, 'The Patronising Disposition of Unaccountable Power' (London: HMSO, 2017); Freire, pp. 41, 137.

[97] Francis, p. 25; Halliburton, p. 62.

[98] Raffay, Wood, and Todd, pp. 9-10; Baxter, Mugglestone, and Maher, p. 12.

[99] Emmanuel Lartey, 'Practical Theology as a Theological Form', in *The Blackwell Reader in Pastoral and Practical Theology,* ed. by James Woodward and Stephen Pattison (Oxford: Blackwell, 2000), pp. 128-34 (p. 129).

[100] Ibid.; Freire, p. 40.

[101] Walsh, McSherry, and Kevern, p. 162.

My work may be understood to be Christian ethics in emerging from an unapologetically Christian context.[102] I have deliberately framed it in like manner to De La Torre's liberative ethics and offer it as a gift to broader ethical debate.[103] I recognize that it may be deemed Eurocentric and conceived from within my *habitus*, but hope that others enrich my contribution with their insights.[104]

My claim to ethics sits comfortably within the OED definition of 'moral principles that govern a person's behaviour or the conducting of an activity'.[105] Within ethics, it rightly belongs to applied ethics in morally examining MHS (and FC provision).[106] I have argued that the ethics of co-production begins with the premise that MHSs should be researched, designed, commissioned, delivered, and evaluated jointly between service users, carers, and staff.[107] The tenets detailed on page 67 suggest that a service might be considered reasonably co-produced when service users and carers evaluate it as making satisfactory progress towards extensive co-production.[108] Attention would be needed to avoid co-production creating a further battery of metrics.

We can further clarify the ethics of co-production by declaring that it does not look to be a philosophical system. Neither is it:

a) an all-time solution applicable across all contexts and cultures

b) CPE

c) necessarily relevant to all branches of medicine

d) a collaboration between professionals within or across organizations

e) fulfilled through service user and carer representation alone

f) accomplished unless diversity is valued, and discrimination mitigated.

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[102] Neil Messer, *SCM Studyguide to Christian Ethics* (London: SCM, 2006), pp. 10-14.

[103] De La Torre, *Doing Christian Ethics*, pp. 5-6.

[104] De La Torre, *Doing Christian Ethics*, p. 6.

[105] Oxford University Press.

[106] I subjected this definition and its parameters to review with the LEAP and in seminars; Raffay, Co-Productive Ethics.

[107] This is not to deny the legitimate place of service user, survivor, and mad research.

[108] Tritter and McCallum, pp. 163-64.

The ethics of co-production requires all stakeholders, capacity allowing, to act as agents in seeking recovery and well-being.

Anchoring the Ethics of Co-Production

I have argued that the ethics of co-production is a legitimate branch of practical ethics but have yet to locate it in the main ethical theories. Broadly, we may identify consequentialist, deontological, and virtue ethics as concerning outcomes, duties, and values, respectively. Thus construed, the ethics of co-production concerns shared outcomes, shared duties, and shared values.

I first address consequentialist ethics. Metrics and outcome measures have their proper place but become problematic when a privileged group are both agents and evaluators of their actions over a disadvantaged group. The matter is further complicated when the utilitarian form of consequentialist ethics is deployed to create a pseudo-rationale.[109] However, if the disadvantaged group — in our case service users, carers, and sometimes, front-line staff — co-produce and co-evaluate the outcomes and metrics, we curtail the 'patronising disposition of unaccountable power'.[110]

On deontology, in affirming everyone's 'vital' contribution, the ethics of co-production highlights shared duty.[111] Shared duty expects service users and carers (and everyone else) to make a reasonable effort to play a eudaemonic role — capacity and ability permitting —in the community, the broad nature of which should be decided through co-production. Unsurprisingly, I suggest the ethics of co-production entails a duty to co-produce. I accept that this may be unpalatable, even offensive, to those identifying themselves as survivors of the mental health system. Individuals should not experience double jeopardy for the impact of stigma and social exclusion.

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[109] MacIntyre, p. 64.

[110] Jones, The Patronising Disposition, pp. 2, 94.

[111] Seedhouse, p. 151.

On virtue ethics, shared values challenge biomedical ethics' predication on front-line staff's sole agency. As I have argued, by drawing extensively on MacIntyre and Moore, co-producing values is likely to rebalance fact and potentially create a more 'pleasant' experience.[112] It may prove the most effective way of mitigating organizational failure.[113]

Having anchored my work within the main ethical theories, asserting that it is applied ethics emphasizes praxis. From henceforth, GT's technical theoretical apparatus is unnecessary. Action research, and indeed theological action research, offer a more collaborative means to identify issues and implement change.[114] Cameron and associates' action–reflection cycle is deliberately rooted in 'social science methods of gathering data' where 'both practitioners and researchers identify significant learnings from their particular perspectives, and make suggestions for renewed action and theology'.[115] In short, Cameron and associates provide a suitable approach for enabling a co-production team to make their distinctive 'vital' contributions.[116] Their specifically theological content could be embraced, modified, or discarded as suitable.

Finally, the ethics of co-production, like De La Torre's liberative ethics, is not exclusively or necessarily Christian (and, here, I wish to distance myself from much of the 'dominant culture's' baggage).[117] However, should my work prove disadvantageous to those 'who struggle within oppressive structures', I will reckon it as ἁμαρτια.[118]

Co-Productive Ethics

We need to distinguish the ethics of co-production from CPE, the latter definable as 'the moral principles arising from reflection on the exercise of co-production'. Primarily a thought

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[112] Halliburton, p. 162.

[113] Moore, pp. 125, 30; Francis, p. 32.

[114] Cameron and others, pp. 70-110.

[115] Ibid., pp. 49-51.

[116] Slay and Stephens, p. 4.

[117] De La Torre, *Doing Christian Ethics,* pp. 5-6.

[118] Ibid., p. 6.

experiment, CPE originates in the academy. In its purest form, it may be absurd.[119] From a pure CPE perspective, my work would have arisen from a LEAP, having received its members' consent before accreting content.[120]

Self-determination and the Principle of Subsidiarity conflict with any universal conceptualization of CPE.[121] Nevertheless, CPE might ensure co-production rather than the imposition of values by an MHS. Similarly, CPE would sit uncomfortably with some FCs, most notably those drawing their ethics from revealed scriptures through didactic hermeneutical processes.[122] As a concept, CPE could have international scope, yet its first ethical principle, recursive circularity aside, might be the need to co-produce any assertions. Its second might involve creating a framework for testing existing claims or prioritizing them for review.

We can envisage debate around whether to focus on principles or instead engage more in situation ethics. A key question might be whether co-production should concentrate on outputs (co-production in its strictest form), outcomes (co-evaluation), or processes (involvement). Ultimately, CPE is more a thought experiment than a 'way of being and doing' or of 'prayerful discernment'.[123]

Neither CPE nor the ethics of co-production should be considered mutually exclusive. Early liberation theology was reflexive.[124] Though identification with Marxism is likely to be unhelpful today, I would hope that anyone exploring CPE would identify with liberation theology's emphasis on praxis. Similarly, action–reflection models — whether Leach's or Cameron and associates' — are intended to be reflexive and action research has its own similar

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[119] Taken to its logical conclusion, CPE risks endless recursions.

[120] As soon as content is added, the logical possibility of Orwellian hegemony of one group over another becomes obvious; Orwell; Voronka, The Politics, pp. 191-93.

[121] Pope Pius XI, p. 16; in practice, this may be primarily a logistical problem

[122] Here the Quakers might supply an interesting case study; Britain Yearly Meeting, *Quaker Faith & Practice: The Book of Christian Discipline of the Yearly Meeting of the Religious Society of Friends (Quakers) in Britain*, 5th edn (London: Religious Society of Friends (Quakers), 2018).

[123] Lartey, (p. 131); Leach, p. 19.

[124] Gustavo Gutiérrez, *We Drink from Our Own Wells: The Spiritual Journey of a People* (Maryknoll, NY Orbis, 2003), pp. xvii-xix.

commitment. For Christians or those sympathetic to Christian tradition, perichoretic insights can help ensure the proper agency of all participants in any enquiry.

The ethics of co-production, in common with liberative ethics, feminism, grounded theology and similar approaches, declares that delivered services are *ipso facto* to be superseded.[125] Thankfully, co-production can be approached incrementally, at first through LEAPs, and afterwards through a more radical transformation.[126] I now show how focusing on co-evaluation, prioritizing value to rebalance fact works in practice, outlining projects I have co-produced.

6.4   Complexifying Co-Production

Anyone proposing a novel approach faces a dilemma. Make it sound too hard, and even the most risk-embracing pioneer will baulk. Make it appear simple, and many will assume insufficient depth of analysis. To address this challenge, I now detail four projects, drawing heavily on my experience to show the progress I have made and the challenges I faced.

I first consider co-produced meetings. I then address training, beginning with co-designing training and then attending to the training service users and carers may need to deliver co-production. I move on to progression, using a model I introduced to my workplace. Finally, I reflect on balancing fact and value in an organization's ethos. First, however, we consider co-produced meetings.

Co-Producing Meetings

On becoming a chaplain, I imported my thoroughgoing, theologically-driven commitment to every member ministry into the less amenable MHS setting.[127] I did so by setting up a Spirituality Strategy Group. This naturally, and seamlessly developed into an informal

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[125] Pamela Fisher and Victoria Byrne, 'Identity, Emotion and the Internal Goods of Practice: A Study of Learning Disability Professionals', *Sociology of Health and Illness,* 34 (2012), pp. 79-94.

[126] Handy, p. 123.

[127] Cf. Ephesians 4; I Corinthians 12.

governance board (LEAP) that oversaw and evaluated the chaplaincy's work. It culminated in the successful appointment of Chaplaincy Support Workers, with lived experience a desired criterion in the person specification.

I faced considerable personal ethical challenge on the inequitable payment of LEAPs.[128] I consider it unjust that service users and carers should attend the same meeting as I and be expected to be grateful for their bus fare. However, we discussed this openly. The LEAP members entirely appreciated that I was powerless to change national policy and welcomed my acknowledgement of health inequalities propagated within the NHS.[129]

More recently, I have been privileged to collaborate with VoiceBox Inc., an organization using co-production principles and multimedia communication alongside people with mental health problems.[130] VoiceBox put creative arts at the disposal of another LEAP, successfully enabling them to express their opinions on Mersey Care's Life Rooms.[131] Though co-producing in this way is resource intensive, in putting patient agency centre stage, it had an enormous impact on the participating individuals. It provided rich narrative accounts to justify the Life Rooms programme.

I acknowledge that co-production could prove a more laborious journey for anyone new to it or lacking the group work skills equivalent of many years in parish ministry. However, committing at a personal level to LEAP members – emphasizing value over fact –will foster authentic relationships and avoid counterfeit co-production. Erring on the concern for people (value) side of Blake's conceptual managerial grid is appropriate when working with

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[128] INVOLVE, pp. 1-4.

[129] Beresford.

[130] Nigel Cox, Amanda Clayson, and Lucy Webb, 'A Safe Place to Reflect on the Meaning of Recovery: A Recovery Community Co-Productive Approach Using Multimedia Interviewing Technology', *Drugs and Alcohol Today,* 16 (2016), pp. 4-15; Amanda Clayson and others, 'When Two Worlds Collide: Critical Reflection on Co-Production', *Drugs and Alcohol Today,* (2018).

[131] Rotheram and Raffay.

volunteers.[132] Openness about one's own 'mutable identity' is likely to engender Flair (see Section 3.4).[133]

Co-Producing Training

I have found co-producing training straightforward. This may be because the LEAPs have worked as teams over several years and mutual trust has undoubtedly increased confidence. I have co-produced three main training programmes. The first, 'Mental Health: Challenge or Opportunity?', is a study day that continues to be delivered across Sheffield and Liverpool dioceses and has been academically evaluated.[134] It has been extensively revised in response to participant feedback. In contrast with *Mental Health First Aid*, it deliberately speaks from lived experience, with rather than about people.[135]

The second programme, albeit more a project, was a symposium entitled 'Researching Spiritual and Pastoral Care'.[136] Though both have been extensively co-designed and co-evaluated, their co-delivery has been more limited. Cost pressures on the study day and the challenges of public speaking have created obstacles.

More extensive co-delivery has been possible with the third part of the training programme, a seminar series on spirituality, 'The Whole of Me', that we delivered through Mersey Care's recovery college. The small group size of up to twelve, supported by a philosophy of co-production, enabled peer tutors and participants to interact fully. Not only did everyone gain from contributing but they also improved later iterations. A flexible approach supported people with autism and those with diverse mental health conditions. Arguably, our

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[132] Robert R. Blake, Jane S. Mouton, and Alvin C. Bidwell, 'Managerial Grid', *Advanced Management - Office Executive,* 1 (1962), pp. 12-15.

[133] Kara, p. 131.

[134] Sunoiki Olatunji Abolaji, 'Evaluating a Novel Mental Health Training Programme with a Spirituality Dimension: How Is the Training Used in Practice?' (unpublished master's dissertation, University of Sheffield, 2013).

[135] MHFA England.

[136] Julian Raffay, 'Symposium Report: Researching Spiritual and Pastoral Care: Measuring the Value of Chaplaincy', *Health and Social Care Chaplaincy,* 5 (2017), pp. 306-11.

understanding of co-production differed little from best practice in inclusion or from applying I Corinthians 12.14-26.

In considering the training service users and carers (not to mention staff) may need to deliver co-production, I start from Crepaz-Keay's perspective. Crepaz-Keay usefully states that 'expertise and experience are NOT [*sic*] the same thing. But with support, and a methodical approach, experience can be transformed into expertise'.[137] His excellent chapter, though considering involvement, is equally applicable to co-production. I merely reproduce his grid (see Table 6) as a sample.[138] The specifics of 'who, how, and why' could easily be co-produced.

	Who	**How**	**Why**
Personal	More people and greater diversity is better	Ensure a good range of mechanisms	Ensure clarity of purpose
Operational	Check for bias to or against particular groups (for example: age, gender, race, diagnosis)	Be aware of things that block particular groups or individuals	Ensure everyone involved understands purpose and limits
Strategic	Ensure this is not the preserve of an elite	Diversity in approaches leads to diversity in involvement	Link involvement initiatives to observable outcomes

Table 6 Service User Involvement Indicators

Co-Producing Progression

In the same way that organizations recognize the value of offering career progression to their staff, any ethical approach to co-production should offer similar pathways to service users and carers. Such pathways would ideally give opportunities for integration into the wider community. Where desired, employment and volunteering should be available both within and beyond the organization.

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[137] 'Evaluating Service-User Involvement in Mental Health Services', in *Empowerment, Lifelong Learning and Recovery in Mental Health: Towards a New Paradigm,* ed. by Peter Ryan, Shulamit Ramon, and Tim Graecen (Basingstoke: Palgrave MacMillan, 2012), pp. 146-53 (p. 153).

[138] Ibid., p. 151.

Mersey Care employs vocational Pathways Advisers, some of whom were recruited on account of their lived experience.[139] The lack of comparable clarity for LEAP members led me to devise a research career pathway (see Figure 2 below). I used co-production and systems theory to reduce the isolation of LEAP members in their projects. I suggested three competency levels through which those interested could graduate. The scheme offered wide-ranging project experience to the LEAP member. For chief (and local) investigators, it supplied a pool of talent, not least during their projects' intensive fieldwork phases.

At entry-level were service user and carer volunteers, approved by human resources, who had attended the Trust's induction and basic training. Most service users and carers without research experience gained elsewhere found themselves trapped at this level, unable to progress. A few had received training previously offered by a research librarian but no longer available. After discussion with this librarian, I co-produced a six-session 'Introduction to Research' course that we delivered in the trust's recovery college. This course offered 'medium competency' (see Figure 2), suitable for the role of Survey Volunteer.

Accredited Survey Volunteers learnt the elements of research design and safe practice. They were competent to review participant handouts, undertake straightforward research surveys, and help analyse findings. After an initial refusal, and with later support from my Director of Research, I received a favourable ethical opinion for them to work in a research project.

I drafted the 'advanced competency', to be supported by guest tutors, that would have enabled LEAP members to contribute to ethics applications and recruit participants. Regrettably, and to the annoyance of LEAP members, my scheme was not taken up.[140] Instead, Mersey Care reduced its commitment to research.

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[139] Rotheram and Raffay, p. 37.

[140] Cf. Voronka, Peer Work.

The pathway design was co-produced. I field-tested the idea with the LEAP and, as mentioned, co-produced the introductory course. We ran the class as a seminar and told students at the outset that they would be helping us develop it further. The competencies were explored at other LEAPs (see acronyms in Figure 2) and in research meetings.
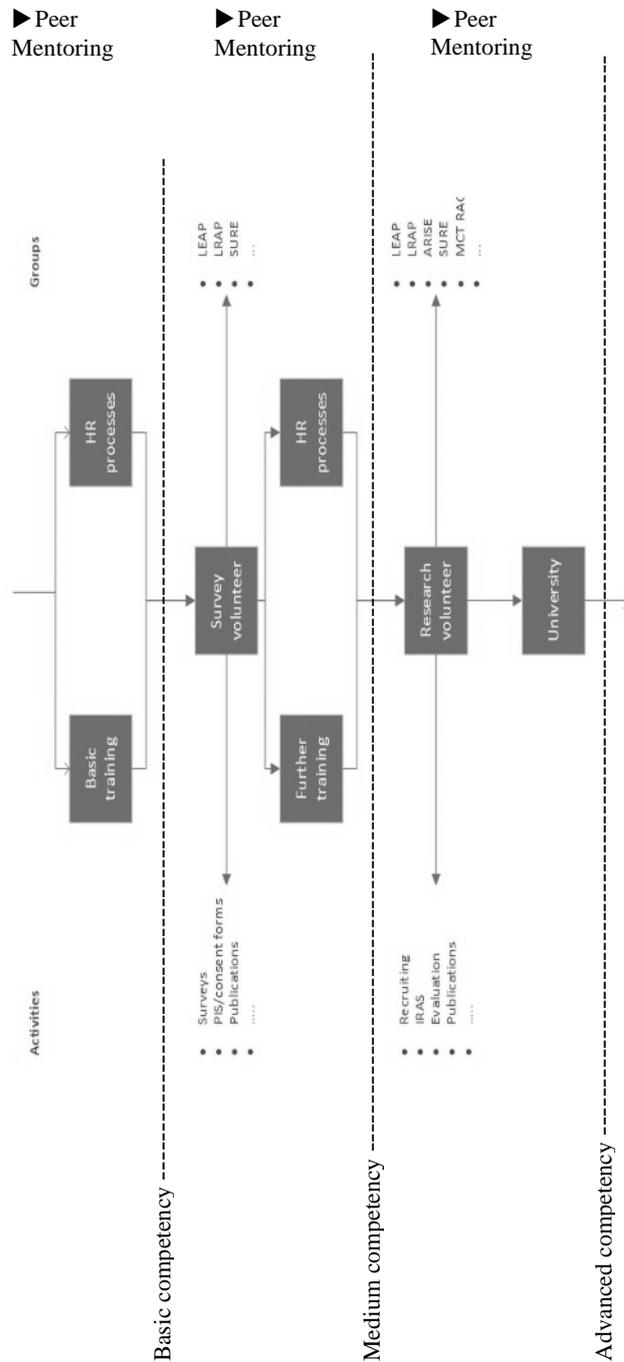

Figure 2 A Co-Produced Research Career Pathway

Co-Producing Ethos

For me, the greatest challenge in implementing co-production has been organizational resistance. My experience echoes Voronka's who, as mentioned, found that 'any goal to influence conceptual knowledge was blocked'.[141] Some of the resistance may be attributable to the 'dysfunctional relationship', but I suggest that genuine misunderstanding arises from co-production's origins as a largely empirical term rather than a theoretical construct. [142] My employing trust's Chief Executive was able to declare: "The most important thing is that we put the patient first and co-produce everything with the patient." However, this was unsubstantiated in the subsequent Annual Report.[143] Despite attempts by the Board to promote co-production, senior managers either deliberately blocked its progress or where genuinely too busy to engage with the topic.

In suggesting how Mersey Care might have further incorporated co-production, I drew on the fact–value distinction. From this perspective, Trust Values would need to be co-produced (with service users, carers, and front-line staff), themselves appointed through Values Based Recruitment.[144] In its 'Strategic Wheel', Mersey Care refers to 'Empowered Teams' alongside 'Empowered Service Users and Carers'. This envisages power being handed out in fulfilment of a predetermined vision that service users and carers have had little obvious opportunity to influence.[145]

In implementing co-production, we need to return to Handy's observation that we cannot understand organizations unless we recognize the way individuals within them use

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[141] Ibid.

[142] Boyle and others, p. 7.

[143] Rafferty; Mersey Care NHS Foundation Trust, 'Annual Report 2017/2018' (Liverpool: Mersey Care NHS Foundation Trust, 2018).

[144] Kath Ferguson, *Time to Act: Choosing to Work in Mental Health: The Recruitment of Health and Social Care Professionals* (Mansfield: University of Lincoln, 2005); Keith Pearson and Nicki Latham, 'Values Based Recruitment' (Leeds: Health Education England, 2016).

[145] Staniszewska and others, (p. 138).

power to gain influence (as do I towards extending co-production).[146] More positively, NHS

England is giving increasing attention to co-production that it defines as:

> 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.
> Co-production acknowledges that people with 'lived experience' of a particular
> condition are often best placed to advise on what support and services will
> make a positive difference to their lives.[147]

NHS England could potentially ensure at least counterfeit implementation in even the most

reluctant Trust but implanting co-production in staff values may rightly prove a much harder

task. Significantly, NHS England's definition helpfully includes communities 'in equal

partnership', potentially opening the door for FC engagement.[148]

Anyone seeking to implement co-production might appreciate Porteous' flowchart (see

Figure 3). Her model proposes co-worked discussion throughout the research cycle.[149] Though

considering involvement in research rather than co-production, her most helpful approach could

be adapted for development trust-wide.

These four accounts show that co-production is entirely workable. Scaling up should

not be an inordinate problem, provided Crepaz-Keay's insights are considered.[150] This may take

time, especially if we need to devise (and preferably co-produce) curricula for staff (and

potentially service users and carers) incorporating 'self awareness [*sic*], interpersonal skills

development and a focus on people rather than diagnosis'.[151] Service users and carers may,

however, be content to see a greater emphasis on value and be suspicious of any fact-driven race

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[146] p. 123.

[147] Coalition for Collaborative Care, 'A Co-Production Model: Five Values and Seven Steps to Make This Happen in Reality' (Leeds: NHS England).

[148] Ibid.

[149] Carol Porteous, 'Patient and Public Involvement in Health and Social Care Research'*,* (2016) <https://www.lshtm.ac.uk/aboutus/introducing/publicengagement/rds_ppi_handbook.pdf> [accessed 24 February 2019].

[150] Crepaz-Keay, pp. 151-52).

[151] Forrest and others, p. 53.

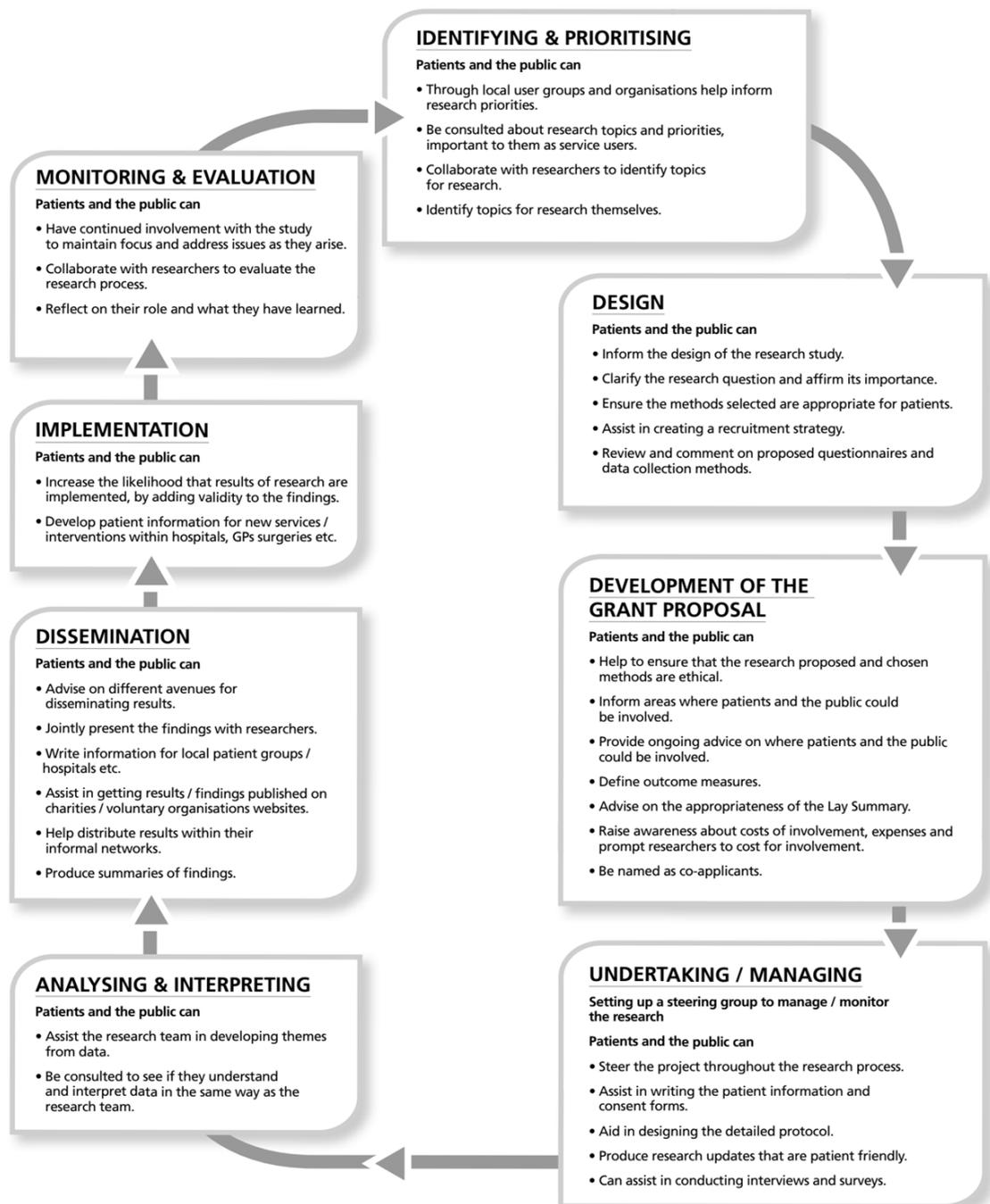into full-blown co-production. The greatest challenge may be addressing resistance by senior

managers.[152]

Figure 3 Incorporating Involvement in Research

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[152] Voronka, Troubling Inclusion, pp. 136-40.

6.5   Evaluating the Endgame

To further help envisage co-production in MHS–FC partnerships, I now offer four hypothetical examples. Not being co-designed, they would not satisfy my tenets (Section 2.4) but might be likened to sample answers in a textbook. Though preformulated solutions would be inappropriate, notional examples — built from elements I have seen in successful initiatives — show what is possible.

The first fictitious establishment is 'St Mary's Collaboration for Compassionate Mental Health Services'. At St Mary's, MHSs and FCs support co-production under the authority of a LEAP. My second notional example, St Thomas' Cathedral, exercises a critical friend relationship with the nearby MHS. My third hypothetical entity is an Anglican deanery, where St Barnabas' Church leads in co-producing Stepped Care in partnership with the local MHS, synagogue, and mosque. Finally, St John's is an informal partnership between a large socially active city centre church and a clinical commissioning group. St John's hosts the co-produced Skylight Drama Group that explores radical forms of mental health support.[153] I offer them in turn without intervening explanations.

Collaboration for Co-Produced Mental Health Services (St Mary's)

St Mary's Collaboration for Compassionate Mental Health Services got off to a difficult start. Both the FCs and MHSs imagined the other would support its aims and be well-resourced. After a three-month stand-off, they reconvened and founded a Charitable Incorporated Organization. In its constitution, they assigned two-thirds of the trustee board positions to people with lived experience (including carers). The four remaining seats were *ex officio*, split equally between the FC and MHS. The trustees committed to the Coalition for Collaborative Care's values (see

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[153] Heaney, p. 350.

Figure 4), adapting the plain English one to include sign language and Urdu in response to local

demographics.[154]

Figure 4 Collaboration for Compassionate Mental Health Services: Values

St Mary's is a LEAP-governed collaboration between MHSs and FCs with

co-production at its heart. To embed its unique selling point, the trustees adopted the Coalition

for Collaborative Care's Seven Steps as policy (see Figure 5), hoping to include them in the

constitution after their fourth annual general meeting.[155]

The board spent most of their first year developing standing operating procedures.

Though at first criticized for being bureaucratic, their diligence and commitment to sharing

power gained them European funding. They founded an art house that provides a supportive

environment where people with lived experience could learn skills alongside the public.[156] One

of the trustees with dual diagnosis gave the impetus for the café and dry bar.[157] Located opposite

an MHS counselling facility, referrals are made between the two agencies. The counselling staff

are familiar faces in the café.

The trustees are collaborating with the MHS in seeking funding to conduct health

economics research to evaluate the relative costs of counselling, art, and psychotherapy. They

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[154] Coalition for Collaborative Care.

[155] Ibid.

[156] Aspects of this example are based on The Art House, 'Our Aims' (Sheffield: The Art House, 2019).

[157] This statement is fictitious.

hope that such research might work to their project's advantage yet consider that statistics merely supply information on which to base complex decisions.
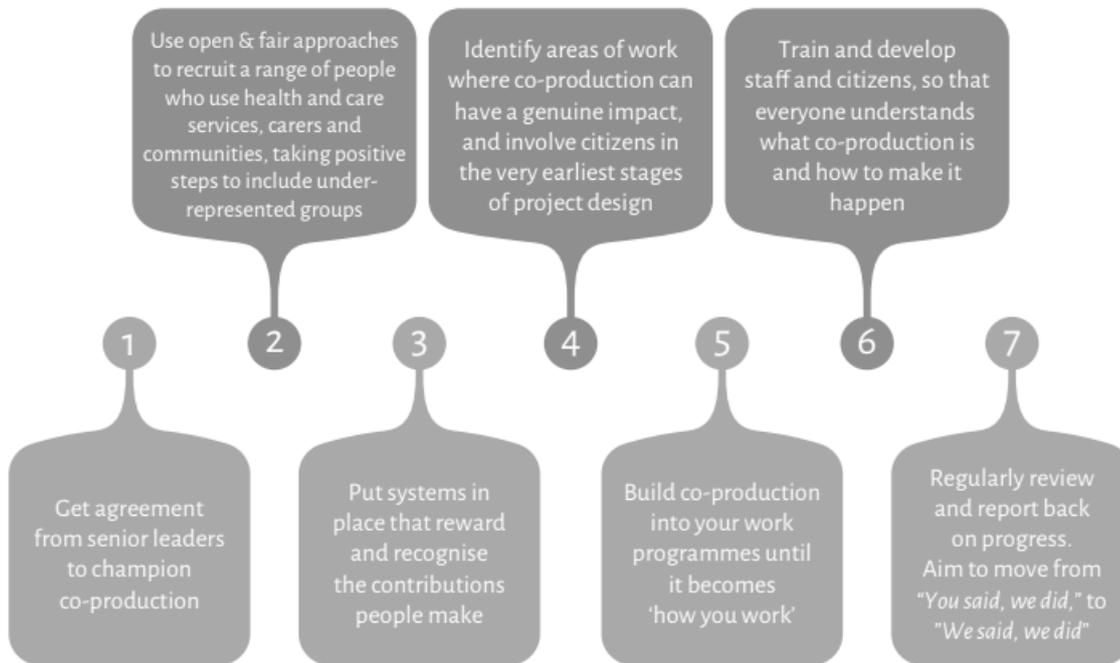
Figure 5 Collaboration for Compassionate Mental Health Services: Seven Steps

Though the trustees are aware of many excellent day services for people with mental health problems, St Mary's is unique locally in flanking co-production with an MHS–FC collaboration. Five years on, the project continues to grow. Its rootedness in three communities of interest (mental health, church, and arts) enables it to recruit trustees and other volunteers and offers resilience against austerity. Achieving co-production with all its stakeholders is the main item for the forthcoming annual meeting. Another consideration is whether to franchise the operation.

Critical Friends (St Thomas')

After an Adult at Risk expressed concern that legislation worsened their isolation, St Thomas' Cathedral decided to review its safeguarding policies and practice. Later discussion with the Diocesan Safeguarding Officer established a Steering Group of service users, all of whom had experienced abuse or neglect. Its members produced a Five-Year Plan. They pressed for representation, indeed co-production, leading to the appointment of a Canon for Mental Well-being, themselves a survivor.

After reading *How Survivors of Abuse Relate to God*, The Dean decided the Cathedral's anonymity and notable annual footfall granted unique opportunities.[158] She began by inviting MHSs to inspect St Thomas' policies and practice, responding quickly to the findings. The Dean made the Cathedral's infrastructure available to support agencies, creating a permanent poster display and online help access point deliberately near the public entrance to the tower (identified as a suicide risk). Through the Canon for Mental Well-being, she teamed up with the Railway Mission chaplaincy to equip the Cathedral staff and volunteers in supporting people facing mental health crises.[159]

The Canon backed the Steering Group in their request to collaborate with the National Association for People Abused in Childhood and Circles UK.[160] They provided separate groups for those who had been abused and for sex offenders. St Thomas' signed the mental health 'Friendly Places Pledge', ensuring their worshipping congregations and other groups were linked to mental health concerns.[161]

The Cathedral actively recruited chaplains and volunteers with lived experience of mental health problems to serve at all levels, becoming a Mindful Employer.[162] Co-producing with people with mental health problems and using asset–based approaches achieved the necessary extra capacity.[163] Despite recruiting a higher proportion of staff with mental health problems, relations improved, resulting in a more effective workforce.

St Thomas' good reputation became widespread, and the MHS invited the Canon for Mental Well-being to become a Foundation Governor. After the MHS received a poor Care Quality Commission rating, members of the Cathedral Chapter served as Critical Friends in a

[158] Shooter.

[159] Railway Mission, 'Chaplaincy Support' (Maud: Railway Mission, 2019).

[160] National Association for People Abused in Childhood, 'Supporting Recovery from Child Abuse' (London: NAPAC, 2019); Circles UK, 'Circles UK' (Reading: Circles UK, 2019).

[161] Faith Action, 'Friendly Places: Mental Health' (Dagenham: Faith Action, 2019).

[162] Mindful Employer, 'Be a Mindful Employer' (Exeter: Mindful Employer, 2019).

[163] Cahn, pp. 87-99.

safeguarding review. They co-produced this with the Steering Group, all the while ensuring robust governance and data management.

The Cathedral and the MHS gained from their critical friendship. Following approval by national bodies, they successfully combined their Level One and Two safeguarding training. Their joint learning brought not only fresh thinking to both groups but also began two-way referrals, and the Roman Catholic Cathedral later joined the scheme. This resulted in a wide range of parachurch organizations becoming more accessible to service users and carers. Though cooperation continued, the MHSs and FCs took care to remain distinct.

Stepped Care (St Barnabas's)

St Barnabas' Church is part of a dynamic deanery where each church contributes a distinctive mission/ministry specialism. 'Barny's' leads on co-produced Stepped Care in partnership with the local MHS, synagogue, and mosque. Their parochial church council deliberately includes posts for service users, carers, and NHS staff. It has responded to Ophelia's question 'If there is a gap between what churches offer and criteria for admission, how could churches and faith communities bridge that gap together?'[164]

Barny's *Closing the Gap* project has been running for three years. The idea arose from friendly discussions between the vicar, rabbi, and imam. They conducted a mission audit to learn what unmet needs the community identified. The minsters spent a year improving their pastoral support programmes, based on *The Emotionally Healthy Church* (adapted as fitting).[165] They set up a Renew Wellbeing space (see Section 4.4) in one of the deanery's churches located on the high street.[166] Growing in confidence, they entered a partnership with the MHS, adjusting a New Zealand stepped care model (see Figure 6 below).[167]

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[164] C627; Pippa M61.

[165] Peter L. Scazzero, *The Emotionally Healthy Church: A Strategy for Discipleship That Actually Changes Lives*, Updated and expanded edn (Grand Rapids, MI: Zondervan, 2010).

[166] Rice, What we Do.

[167] Te Pou o Te Whakaaro Nui, pp. 6-10.
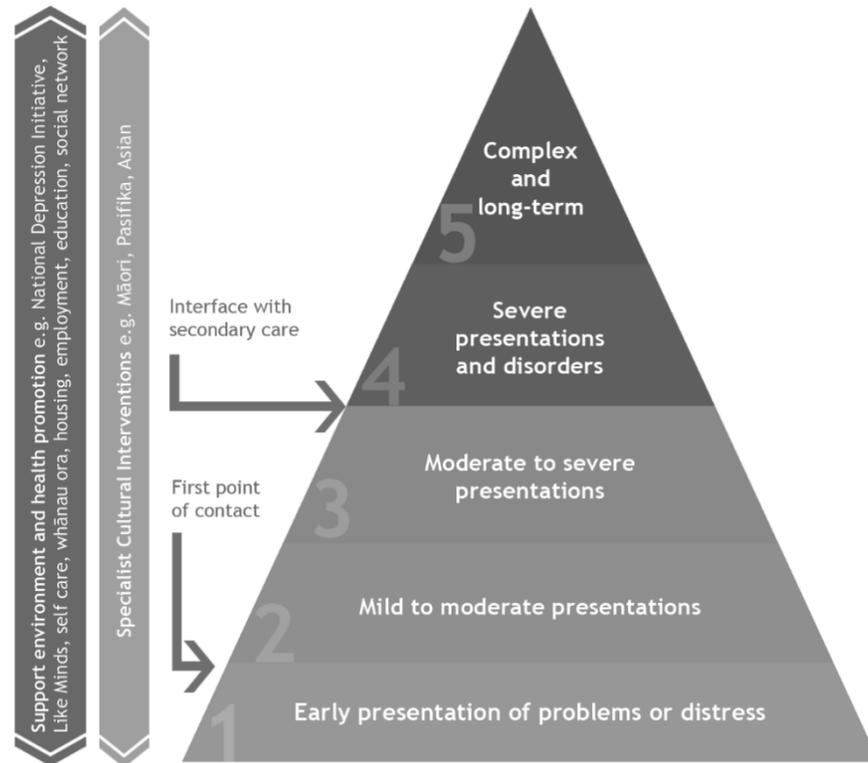
Figure 6 Te Pou Stepped Care Model

The partnership agreed that the FCs would continue working at Service Level One, with the pastoral workers receiving joint-funded *Mental Health First Aid* training.[168] The FCs contributed a parish nurse to support people at Level Two and develop capacity within the FCs. Addressing Levels Three to Four, the parish nurse sought service user consent to collaborate with general practitioners and mental health teams. Some of the FCs (after enhanced safeguarding training and NHS accreditation) supplied buddying through accredited volunteers and made their buildings available. In return, local MHS discharge pathways offered community integration through the FCs. The partnership adapted Te Pou's Level Five to comprise psychiatric inpatients and worked closely with the mental health chaplains, sharing information in line with NHS governance protocols.

Barny's beneficiaries co-evaluated the scheme every three months. The recipients negotiated what they felt would further aid their well-being and recovery. Despite early

[168] MHFA England.

reservations, the FCs and MHSs enjoyed the fact–value balance that resulted in greater compassion for the MHSs and greater professionalism for the FCs. Inevitably, there were difficulties. A few atheist staff were reluctant to collaborate, and a handful of FC members went elsewhere. Overall, the FCs found themselves becoming places of excitement, hope, and wholeness and their membership grew.

Partners in Health Promotion (St John's)

St John's, an informal partnership between a city centre church and a clinical commissioning group, agreed to conduct action research. They explored what support people with lived experience and their carers might choose were they co-designing services from scratch. At first, the project struggled but then hit on the idea of co-producing the Skylight Drama Group.[169] The drama and dance workshops, influenced by Nicholson's *Applied Drama*, quickly built trust. The project attracted the interest of the local institute of performing arts along with funding to pay instructors' salaries and expenses.

Underpinned by co-production and action research principles, with insights from GT, the instructors launched scenario-building workshops. These involved people with lived experience and front-line staff, using drama or dance to express their current situation alongside players enacting resources or barriers to their well-being. The Skylight Drama Group rapidly learnt to communicate that it was not explicitly offering therapy. In the briefing and debriefing, the instructors reiterated that their primary purpose was to redesign services in response to the workshop findings.

Of significance, and helped by grant-making stipulations, the workshops addressed health inequalities. Members collaborated with community development workers to engage service users and carers from backgrounds likely to experience multiple or intersectional discrimination.[170] Workshop participants from these groups gained enormously from

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[169] Heaney.

[170] Mel Bartley, *Health Inequality: An Introduction to Concepts, Theories and Methods*, Second edn (Cambridge: Polity Press, 2017).

co-production, finding it essential in addressing the majority culture's tendency to cause harm, albeit often through unwitting assumptions and widely held prejudices.

Skylight members compiled results across the drama groups. Their findings were remarkably consistent, concluding that most stigmatized individuals valued compassionate concern in settings they find both accessible and comfortable.[171] Having often faced rejection elsewhere, they hoped for acceptance, interest, and genuine human warmth (which many said they received from FC leaders).

Accessibility involved building design but also location, many finding existing MHS provision organized around staff convenience. Regarding comfort, the members preferred to meet staff in buildings resembling those they might frequent in their community. They considered large, expensive-looking buildings intimidating and better suited to corporate promotional literature.

Despite Skylight avoiding classical approaches to therapy, participants gained from its small-scale co-produced pragmatic approach. They baulked at symbols suggesting power differentials, preferring cottage hospitals to imposing institutions.[172] They considered that many FCs, like the house mosque, corner synagogue, or local church — provided they were not fundamentalist — more readily offered genuine acceptance and belonging.

In these four notional examples, I have shown that it is entirely possible for MHSs and FCs to deploy their relative strengths. Especially where inclusion is practised, effort spent in supporting people with mental health problems is likely to benefit a broader range of people at risk of isolation.[173] I would hope that actual groups (as opposed to these hypothetical examples) would engage in reflective practice, adapting or improving my tentative explorations.

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[171] Swinton, p. 10.

[172] E. F. Schumacher, *Small Is Beautiful: A Study of Economics as If People Mattered* (London: Abacus, 1978); Halliburton.

[173] Corey Keyes, 'The Mental Health Continuum: From Languishing to Flourishing in Life', *Journal of Health and Social Behaviour,* 43 (2002), pp. 207-22.

Conclusions

Reflection on *The Hospitality of Abraham* suggests that we no longer need accept delivered

services as the benchmark. I propose that with 'recovery approaches, the old [positivist] model

[of mental healthcare] is [largely] redundant'.[174] Fearless prophetic leadership could compel us

to abandon 'stale expressions', whether of MHSs or FCs.[175] Perhaps, drawing on insights from

chaplaincy, 'FCs and MHSs [can] identify a synthesis of the best of both?'?[176] I concur with

Parker Gallagher that:

> the big, complex social problems that governments want to address – from
> crime and security to poverty and health – simply cannot be tackled within the
> fragmented public sector delivery systems that have resulted from over a
> century of bureaucracy and decades of competitive reform.[177]

In De La Torre's words:

> The danger of doing ethical reflection from the center of power and privilege is
> that any moral truth may be distorted or perverted when the perspectives of the
> marginalized are ignored. Yet for these ignored voices to question the validity
> of how the dominant culture arrives at ethical precepts becomes an act of
> madness, or even sacrilege. […] The dominant culture operates within a
> framework constructed from the social location of privilege, and the resulting
> system of ethics functions to justify the norm.[178]

The ethics of co-production, I suggest, promises a legitimate sharing of power and agency,

addressing many of the criticisms levelled at MHSs and FCs. Ensuring service users and carers

co-evaluate services is not only desirable but morally necessary.[179] Implementing co-production

is at the centre of the recommendations in my next chapter to which we now turn.

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[174] Susan M804.

[175] Milbank, pp. 117-19; Peter Koestenbaum, *Leadership: The Inner Side of Greatness: A Philosophy for Leaders*, New rev. edn (San Francisco: Jossey-Bass, 2002), pp. 136-68.

[176] Ryan, p. 6; Susan M804.

[177] pp. 13-14.

[178] De La Torre, p. 27. Doing Christian Ethics; cf. Voronka, Peer Work.

[179] Department for Health and Social Care, pp. 2-3.

7   Beyond Care: Recommendations

A Trust Director optimistically suggested I could offer 'a hope-filled expression of what might be possible'.[1] Though good advice, I have instead prioritized participants 'voices', aiming to reflect their content and tone accurately. In doing so, I have advanced my novel approach, naming the fact–value divide between MHSs and FCs an artefact of clinician-focused ethics, rooted in the Enlightenment. I have proposed co-production and co-evaluation as potentially correcting excess emphasis on external goods.[2] I have built an ethical argument for co-production, suggesting that traditionally–delivered services are intrinsically flawed.

In this chapter, I review and consolidate my findings, suggesting topics for future research. In the first two sections, I present my recommendations, preparing for Section 3 'Recovering from Care' which shows how my three core concepts address my RQs. My closing section sets out by defending my work's validity and rigour. I outline its limitations before suggesting future research relevant to MHSs and FCs. I conclude my thesis with a brief Chapter 8, repeating the patently apt opening words of the NHS Constitution: 'The NHS belongs to the people.'[3]

I consider my specific recommendations less important than embedding stakeholders' vital contributions in service design, delivery, and most importantly evaluation. Were my recommendations accepted wholesale — which I neither expect nor advise — such action would entail a regrettable short-circuiting of co-production. I would sooner see these

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[1] Anonymized C254.

[2] Moore, pp. 60-8.

[3] Department for Health and Social Care, p. 2.

recommendations as 'starters for ten' for further discussion by LEAPs or similar groups. I am not dismissing them as insignificant — they arise from over six years' reflection on the topic — but I would rather emphasize co-production's relational nature and my wish to democratize mental health.[4] In practice, implementation might entail a project evaluation cycle similar to that in Figure 7.[5] Such cycles resemble Green's open-ended reflective spiral, whose outcome is unpredictable.[6]
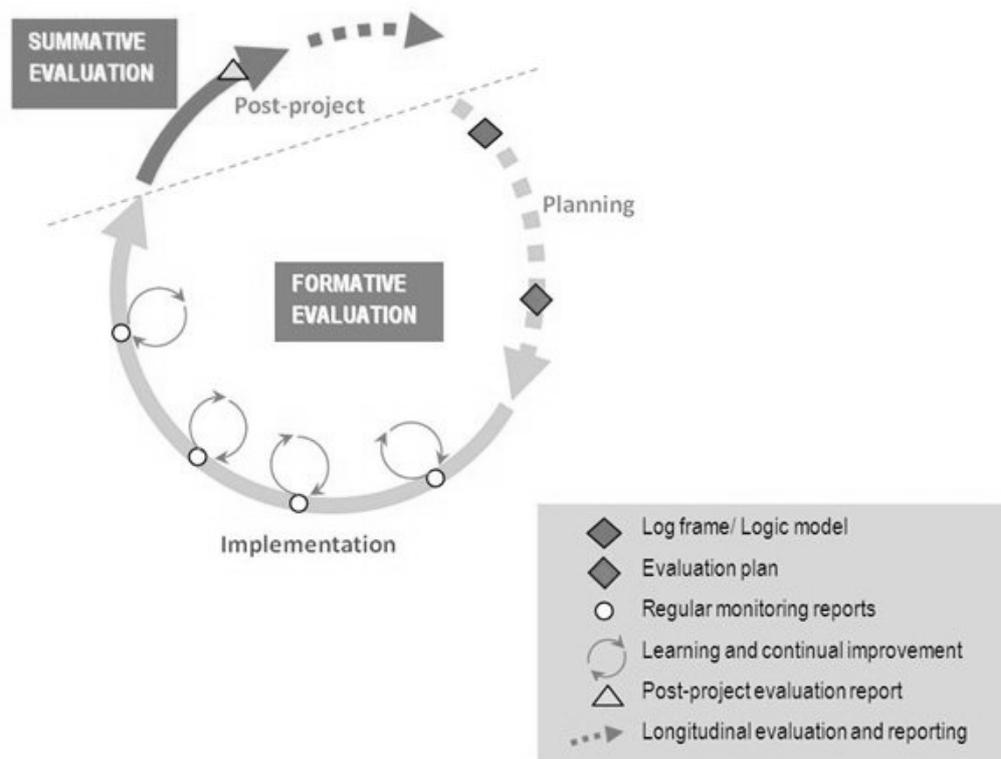
Figure 7 Project Evaluation Cycle

As mentioned, I do not expect anyone would reconfigure MHSs on the back of my single GT project with only 30 participants. I see my work as corroborating others' findings and suggesting a direction that needs testing through pilot projects and prototypes before any future scaling up. With these considerations in mind, we turn to consider my prospective

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[4] Mick McKeown and Linda Carey, 'Editorial: Democratic Leadership: A Charming Solution for Nursing's Legitimacy Crisis', *Journal of Clinical Nursing,* 24 (2015), pp. 315-7.

[5] Damien Sweeney and Martin Pritchard, 'Project Evaluation Cycle' (Mitcham: Pacific Research and Evaluation Associates, 2010).

[6] Laurie Green, *Let's Do Theology: Resources for Contextual Theology*, Completely revised and updated new edn (London: Mowbray, 2009), pp. 19-25.

recommendations, beginning with those for MHSs. Proposals for future research appear in the second half of Section 7.3. A fuller list of suggestions appears in Appendix G.

7.1   Recommendations for Mental Health Services

I make recommendations for MHSs, noting the *Five Year Forward View for Mental Health* call for 'a fresh mindset' to address mental health's £105 billion annual economic cost.[7] My findings suggest that partnerships co-produced with service users, carers, and staff could be that 'fresh mindset', well-placed to release the best of fact and value. In making recommendations, I do so, recognizing the:

> many challenges facing mental health services as we look to the future, including persistently high levels of psychiatric morbidity, increasing levels of comorbidity and multiple morbidity, an ageing population with high health and social care needs, barriers to providing good integrated care and severe constraints on public spending.[8]

I group my recommendations by four subsections: the three core concepts and the ethics of co-production. I have deliberately avoided SMART targets as these would back a positivist frame and risk prematurely anchoring the recommendations, potentially compromising their substitution or refinement through co-production.[9]

All Hands on Deck: Core Concept One

My findings suggest that MHSs, FCs (and potentially other organizations) should work collaboratively, organizing services to address the surge in mental health problems. Assuming it would be unrealistic at the outset to gather nationally representative service users, carers, MHS, FC, and FBO leaders, I propose refining my findings with existing groups. These might include Liverpool's Joint Mental Health Working Team and Sheffield's Mental Health Working

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[7] Mental Health Taskforce, p. 11.

[8] Dinesh Bhugra and Alex Carlile, 'Starting Today – the Future of Mental Health Services' (London: Mental Health Foundation, 2013), p. 2.

[9] SMART: Specific, Measurable, Attainable, Relevant, Timebound.

Group.[10] All Hands on Deck is a bold aim but The Salvation Army's Strawberry Field (see Section 4.4) offers an example of what is achievable.[11] Insights from implementation science could serve innovators. For instance, the model detailed in Figure 8 provides guidance on which stakeholders to engage.[12]
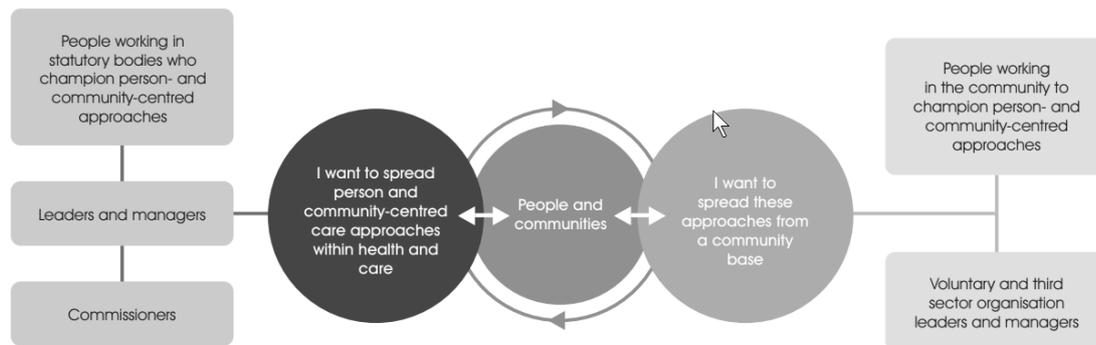
Figure 8 Spreading Change Model

I propose convening stakeholder groups to discover service user, carer, and front-line staff perspectives on how they might wish to use resources towards recovery, well-being, and participation in society. They would likely use a program logic model, underpinned by realistic expectations and potentially with dedicated project workers.[13]

What I am envisaging would extend beyond personal budgets to consider collective as well as individual choices.[14] It might explore issues including:

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[10] Sally Ross, 'Mental Health within a Church Context' (Sheffield: Diocese of Sheffield, 2019).

[11] Though Strawberry Field is a genuine case of All Hands on Deck, it has not evolved from service user and carer ambitions and did not fully engage issues of agency.

[12] Michael Hallsworth and Hannah Burd, 'Spreading Change: A Guide to Enabling the Spread of Person- and Community-Centred Approaches for Health and Wellbeing' (London: Nesta, 2016), p. 6.

[13] Damien Sweeney and Martin Pritchard, 'Program Logic' (Mitcham: Pacific Research and Evaluation Associates, 2010).

[14] Martin Webber and others, 'The Effectiveness of Personal Budgets for People with Mental Health Problems: A Systematic Review', *Journal of Mental Health,* 23 (2014), pp. 146-55.

- emphasis on health promotion and addressing health inequalities as alternatives to treatment[15]

- how FCs and other informal networks might support people struggling with mental health issues[16]

- the significance of Flair[17]

- the fact–value balance in existing MHSs and FCs[18]

- the proportion of spend allocated to combatting stigma[19]

- models of co-production[20]

- what training might support this novel approach[21]

- NHS-accredited training for clergy.[22]

Such a group or groups might evolve into a recognized think tank, potentially sponsored by a mental health charity or similar.

I propose addressing the myths explored in *Ensuring a Level Playing Field* with funding to acknowledge FCs as assets and support them in improving their offer.[23] Co-producing care planning and adopting the Tidal Commitments would ensure that service users are supported in addressing 'religious and spiritual concerns and practices in [*sic*] their

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[15] Olivia M158; Patrick C163; Pippa C43; Serena C142.

[16] Faye C120, C295; Fergus C237, C870; Odette C11, C102, C632; Ophelia C8; Oscar C398.

[17] Charlie C312; Connie M62; Florence C214; Simon C632.

[18] Craig C541; Faye M109; Ophelia M387; Pippa C895; Sharon M577; Stephen C71.

[19] Claire M62; Florence M264; Olivia C387; Ophelia C61; Otis C130; Perry C303; Sharon C187, M937; Simon M90; Susan M279.

[20] Craig C1215; Orla M622; Pippa M1283; Simon M576.

[21] Christine C526; Odette C573; Oscar C445; Pam C252; Serena C550; Sharon M87.

[22] Florence C576.

[23] Linking them to crisis teams or training them in *Mental Health First Aid* might be initial first steps; MHFA England; Department for Communities and Local Government, 'Ensuring a Level Playing Field' (London: Department for Communities and Local Government, 2010).

own terms'.[24] Both could be trialled locally and rolled out if considered useful. Program

management skills would be needed in scaling up.

Critical Friends: Core Concept Two

I propose that MHSs and FCs might share learning, including safeguarding training, as a readily

achievable first step towards closer collaboration.[25] Shared education could begin by inviting

observers to reflect on and potentially review current training. Reviewers — ideally, in the spirit

of co-production, people who have suffered from safeguarding failures — could ensure active

learning. They could help MHSs and FCs address the results of aligning themselves with fact

and value respectively.[26]

Shared learning, already happening in multi-agency working, could extend to involve a

broader range of stakeholders.[27] It would build relationships and reduce stereotyping between

MHS staff and FC leaders.[28] Awareness of each other's strengths, challenges, and perspectives,

would likely increase collaboration and referrals. It might have prevented the Victoria Climbié

tragedy.[29] Co-production could enable a LEAP or equivalent to draft protocols supporting

cooperation while maintaining independence.[30] Again, I would recommend an iterative project

evaluation cycle.

The church's involvement in the Gosport Inquiry offers an excellent example of how

MHSs and FCs can serve as Critical Friends and could potentially be extended.[31] The

approach's strengths lie both in the organizations' mutual independence and in their respective

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[24] Poppy Buchanan-Barker and Philip J. Barker, 'The Tidal Commitments: Extending the Value Base of Mental Health Recovery', *Journal of Psychiatric and Mental Health Nursing,* 15 (2008), pp. 93–100; Walsh, McSherry, and Kevern, p. 162.

[25] Susan C405; C360.

[26] Claire M425; Ophelia C129; Sally M75; Susan C36; Sharon M260.

[27] Susan M277.

[28] Christine C152; Fergus M159; Ophelia C156; Pippa C1040.

[29] Lord Laming, p. 26.

[30] Charlie C83, C93; Florence C24; Orla C311-312, C677, C693.

[31] Jones, Gosport Hospital.

emphasis on fact and value.[32] Jones' work provides a valid alternative to 'solutions [that] are the same in essence and have never worked'.[33] However, as Critical Friends, MHSs and FCs would need to avoid the problematic closeness recently found in the so-called 'Big Four' accountancy firms.[34] Faith-based organizations have found that too close alliances with Government agencies risks compromise as in asylum seeker repatriations.[35] Though the Gosport Inquiry was in response to specific failures, MHSs and FCs could work critically alongside each other to ensure both are intrinsically healthy.

I support Values Based Recruitment which recognizes that '"vocational people" need to "outbalance" those lacking vocation to avoid losing humanity'.[36] A more ambitious proposal would involve FCs in restoring Peplau's 'art and science' as a significant step towards addressing MHSs' target-driven culture and deficit-based opinion of service users.[37] This would clearly 'challenge entrenched positions' and only be possible with consent from, or after transformation of the 'broken and demoralised system'.[38] Recruitment and trust values could explicitly support staff with lived experience, harnessing insights from their 'mutable' identities to improve services.[39]

Partners in Health Promotion: Core Concept Three

As potential Partners in Health Promotion, I propose that MHSs need to accept that they are not the "only game in town".[40] My findings suggest they stand to learn from "FC leaders walking with their people at the heart of the issues that mattered the most and shouting out very loudly

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[32] Florence C33, C159; Orla C72, C147; Oscar C18, C40.

[33] Fred C175.

[34] Charlie M410; Frank C59; Odette C8, C9; Ophelia M266; Oscar C269; Madison Marriage, 'Probe Urged into Break-up of Big Four Accountants', in *Financial Times* (London: Nikkei Inc, 2018).

[35] Ophelia C8; Churches Together in the Merseyside Region, 'Refugees, Asylum Seekers & Migrants: Welcoming the Stranger' (Liverpool: CTMR, 2016), pp. 1-2.

[36] Charlie C346; cf. Pearson and Latham.

[37] Peplau, p.8; Francis, p. 3.

[38] Orla C54; Schizophrenia Commission, p. 4.

[39] Kara, p. 131.

[40] Carla M106; Pippa C552; Stephen C278, C515; Susan C392, C453.

and clearly in society".[41] In particular, they have much to learn from FCs' 'greater

understanding and commitment to communities'.[42] Knowledge held by FCs could support social

change and prevent MHSs from 'inflexibly responding to narrowly defined problems'.[43]

My findings favour transferring resources from treatment to prevention and recovery to

address the surge in mental health problems.[44] Such a transfer might be fruitful to co-produce as

users might prioritize more 'pleasant' processes than EBM.[45] Consultation with service users

could significantly mitigate the widespread fear they reported.[46] Similarly, were MHS staff to

allow FC leaders to 'teach them interpersonal skills', they might come to offer the compassion

so clearly valued by participants.[47] In return, MHSs could release nurses to help 'design pastoral

care training' but should also address the charge of creating 'emotional deserts'.[48]

After cybernetics, MHSs and FCs should consider three orders of co-production.[49] The

first order, I suggest concerns reflective practice around individual treatment episodes. Such

first-order co-production is illustrated by the hairdresser who asks what style their customer

would like and later checks it is satisfactory. Improvements may result, but the 'perfect, trunk-

lid fit of the old ceiling' remains.[50] Second-order co-production, as discussed in the previously

quoted King's Fund cancer study, invites transformation beyond the dyad. It redesigns care

pathways and potentially services. However, third-order co-production holds 'surprise wide

open', embracing cybernetics' third order of complexity.[51] It invites service users, carers, and

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[41] Sally C32.

[42] Charlie C427, M679; Christine C326; Connie C1160; Frank C520; Odette C203, M297; Olivia M528; Ophelia C627.

[43] Odette C223; Sally C16.

[44] Anonymized, Senior Manager.

[45] Halliburton, p. 162.

[46] Forrest and others, p. 53; Francis, p. 3.

[47] Otis M539.

[48] Fred C388; Odette M406.

[49] Norbert Wiener, *Cybernetics: Or Control and Communication in the Animal and the Machine* (Cambridge, MA: Massachusetts Institute of Technology, 1948). Note: My three orders here are for illustration purposes and not an exact match.

[50] Heaney.

[51] Raffay, Wood, and Todd, pp. 7-9; Heaney, p. 350.

staff to explore together what they consider most important in health promotion, without drawing a priori conclusions. Only this third order co-production affirms agency yet it is undoubtedly the most threatening to those with vested interests.

The Ethics of Co-Production

The primacy of service user and carer agency supplies the ethical rationale as to why co-production's worth does not lie chiefly in whether it makes MHSs more efficient.[52] I propose that we place service user agency rather than profitability centre stage.[53] Greater effort is required to ensure that 'the NHS belongs to the people' rather than to budget holders or those charged with securing external goods.[54]

One way of rebalancing fact with value would be to create Trust board posts for people with lived experience, ideally with roles, authority, training — and payment — on the same basis as non-executive directors. Such board members might ensure more radical commitment to service users' and carers' vital insights in seeking safer services, addressing many of Mid Staffordshire's failings.[55] They would offer an added bulwark against Fred's 'solutions [that…] have never worked'.[56]

I would hope that the ethics of co-production might contribute to making MHSs places where service users, carers, and staff learn to recognize each other's contributions as 'vital'.[57] My proposed solutions might serve as means but, if co-production is to depart from utilitarianism, it must emphasize relationship and process, even at the expense of outcome.

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[52] Baxter, Mugglestone, and Maher, p. 12.

[53] Sullivan, p. 13.

[54] Department for Health and Social Care, p. 2.

[55] Francis, pp. 3, 7.

[56] C175.

[57] Slay and Stephens, p. 3.

Embedding value through co-production invites a more 'pleasant', potentially safer, and certainly different service.[58]

7.2   Recommendations for Faith Communities and Others

As the sun sets on the welfare state, FCs like the moon, are becoming increasingly visible.[59] Though their total contribution is estimated at £3.3 billion, their diversity may prove their ultimate strength.[60] On present political trends, they could find themselves leading entire areas of provision. I envisage minster churches overseeing charity, as monasteries did in the Middle Ages.

Locally planned and ideally co-produced independent — voluntary or private sector — services might work alongside FCs and devolved statutory (or privatized) MHSs.[61] Ideally, MHSs and FCs would also work productively with other agencies. Such subsidiarity might offer complementary benefits to co-production.[62] Though risking regional or local inequality, any disadvantages may prove preferable to organizational megaliths.[63]

Overall, collaboration and co-production suggest an approach to addressing the problems that communities identify as important.[64] For instance, FC-based 'youth workers could exercise a valuable role [in mental well-being] through teenage years'.[65] More entrepreneurially, 'prototype posts could be considered' either regionally or nationally.[66] Parish

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[58] Halliburton, p. 162; Francis; Raffay, Wood, and Todd, p. 9.

[59] Jamie Merrill, 'Church of England to Open Credit Union in Its 'War on Wonga'', in *The Independent* (London: Independent Digital News and Media, 2014); Churches Together in the Merseyside Region.

[60] Welby, p. 37.

[61] Here, it is difficult to offer detailed recommendations.

[62] Based on the Principle of Subsidiarity that 'a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level' (OED), potentially inefficient bureaucracies could be removed; Pope Pius XI.

[63] We see the impact of systemic inequality where schools in wealthier localities typically have more able governors.

[64] Otis M564; Parker and Gallagher. Note: We need to accept the possibility this may increase duplication.

[65] Connie M178.

[66] Odette M541.

nurses, community development workers, and public health advisers might work alongside volunteers and FCs to 'help broker care and act as advocates'.[67] Service users and carers might consider opportunities for inclusion and social engagement more important than pursuing EBM's atomistic notions of well-being.[68]

In this section, I make recommendations for FCs, mental health chaplains and others, again grouped by my four subsections: the three core concepts and the ethics of co-production.

All Hands on Deck: Core Concept One

Regarding All Hands on Deck, my findings suggest FCs should be more confident in their social action projects.[69] My fieldwork implies that we should consider rejecting the narrative that FCs are bungling amateurs in favour of one declaring them complementary to MHSs and valued by people on the margins.[70] They have unrivalled reach into local communities and are often led by indigenous leaders.[71] Across a city, FCs offer a much wider range of activities than MHSs. Their more compassionate nature may be their unique selling point.

I suggest that FCs, particularly those that are '"very ill-informed" about mental health' collaborate with mental health chaplains, LEAPs, parish nurses, Street Pastors, and community development workers to include mental health problems within their conversation.[72] I commend Scazzero's *Emotionally Healthy Church*, based on lived experience, as an invaluable way of reconceiving churches as radically inclusive communities. I would encourage greater use of agencies like Renew Wellbeing (see Section 4.4) that can increase effectiveness and focus

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[67] Connie M21.

[68] World Health Organization.

[69] The C of E alone has more than 33,000 such projects according to The Church of England, 'Full Extent of Church of England Work to Support Local Communities Revealed' (London: The Church of England, 2018).

[70] Charlie C101, C435, C443; Ophelia C22; Sally C64; Serena C104, C426; Some form of accreditation could address low standards but may be no more of a guarantee than the Care Quality Commission, Francis, p. 3.

[71] Sharon C92; Simon C16; Stephen C101; Susan C147.

[72] Charlie C102; Sharon C167, C215, C651.

effort. Additionally, web pages signpost to further resources.[73] Pastoral support co-produced within the FC could free up its leadership.

I propose that FCs should follow the example of many charities, including Christian Aid and Citizens Advice and devote significant effort to campaigning for social change. Prophetic political support for MHSs around socioeconomic issues causing mental health problems is especially important in the face of austerity. In Faye's words, 'civil servants cannot easily be prophetic'.[74] Influencing social policy locally, regionally, and nationally could be hugely effective (as in the 'War on Wonga' and 'Safe Car Wash' initiatives).[75]

I would similarly encourage chaplains and parish nurses to think prophetically.[76] They are well-placed to help MHSs and FCs see that excess activity may be a sign of despondency and exhaustion.[77] Quoting Vanier and Swinton, 'the friendship that is given to us in Jesus calls us to move beyond mere inclusion towards belonging. To belong, you need to be missed'.[78] If chaplains can promote synthesis of Mary (belonging) and Martha (inclusion) — reflected in MHSs' and FCs' relative strengths — they may achieve far more than through conducting individual spiritual or pastoral care.[79] They can challenge MHSs and FCs to know when the pull of external goods is eroding quality and becoming counterproductive.[80]

I propose that FCs, where possible, work regionally to develop links with MHSs.[81] This both facilitates strategic planning and enables projects like The Salvation Army's Strawberry

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[73] Odette C190; Oscar C201; Serena C412; Sally M254; Simon C353; Sally Ross, 'National Organisations and Resources' (Sheffield: Diocese of Sheffield, 2019).

[74] C429.

[75] Ophelia C477, M325; Perry M399; Sally C41-60; Serena M242; Simon M378; Kelly and Swinton; Merrill; Church of England, 'More Than 900 Reports of Potential Modern Slavery Recorded through App' (London: Church of England, 2019).

[76] Craig C361, M96; Fred M153; Odette C652; Sally M37; Simon C8, C63, M90.

[77] Odette C537; Raffay, Follow the Leader, pp. 169-70.

[78] *Mental Health: The Inclusive Church Resource* (London: Darton Longman & Todd, 2014), pp. 100-01.

[79] Kelly and Swinton.

[80] Connie M819; Simon C148; Moore, pp. 64-67.

[81] Pippa C521, C529; Sharon M91, M661; Regional level broadly corresponds to an Anglican Diocese or the purview of an NHS Trust.

Field (see Section 4.4). Ecumenical and interfaith groups' pre-existing networks could readily be adapted to enhance FC responses to mental health problems.[82]

Critical Friends: Core Concept Two

As Critical Friends, FCs should respond to criticism about insensitive promises of healing.[83] Co-production could help FC leaders become more skilful in handling the pastoral complexities of healing ministries.[84] A LEAP comprising people from diverse denominations and faith traditions could usefully draw up best practice guidelines and a code of conduct.[85] These guidelines would ideally be subjected to MHS peer review.

Labelling people as 'at risk', though with the best of intent, can further isolate vulnerable individuals.[86] Safeguarding could be co-produced with people who have been abused or neglected to ensure policy and practice serves their genuine welfare.[87] Faith communities, with their more values-driven approach, would be well-placed to lead improvements.[88] Similarly, they should see critical friendship — as in the Gosport Inquiry — as a way of blessing MHSs.[89] Historic failures aside, my findings suggest that FCs should take the initiative in shared training, modelling humility and inspiring cooperation.[90] Joint learning could lead to collaborative co-produced joint planning for safeguarding becoming the norm.[91]

My findings suggest that, for many people, mental well-being may be elusive. As Critical Friends, FCs should challenge EBM's progress paradigm.[92] Afflictions may not be

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[82] Faye M230; Fergus C162; Olivia M294; Serena M7.

[83] Fred C388, C398; Susan C405.

[84] Connie M894; Fraser C218; Oscar C30; Odette M314; Pam C143; Simon C6, C56.

[85] Fred C78; Claire C106; Otis C498.

[86] Christine M8; Fergus C111; Sharon C590.

[87] I am not suggesting a facile approach to this complex and sensitive matter; Faye C175; Fergus C111; Oscar C555.

[88] Fred M55; Odette M368.

[89] Patrick C57; Penny C17; Pippa C97; Jones. Gosport Hospital

[90] Pippa M1273; Serena M412; They would need to avoid financial exploitation by cash-strapped statutory services.

[91] Fergus C499; Florence M33; Odette C45; Olivia M272.

[92] Ophelia C12-14, M429; Oscar M255; Pippa M628; Serena C453; Simon M256.

treatable illnesses but rather 'a normal reaction to an abnormal class-ridden very unequal and very offensive society where money speaks'.[93] We may need to denounce any promised or anticipated quick fixes, recognizing instead the need to repeatedly address inequalities arising from power imbalances (Leviticus 25.50-52).[94]

Mental health chaplains should embrace Kelly and Swinton's vision of 'chaplains working as agents of transformation collaboratively with other health and social care disciplines and agencies, including FCs, to help others to utilize their assets to promote individual and collective well-being'.[95] Mental health chaplains could promote Flair at the expense of 'The Combine' and its post-Constantinian FC equivalents.[96] Indeed, both Renew Wellbeing and Strawberry Field — not to mention L'Arche — are products of flair in its broadest sense.

Finally, I reiterate Hauerwas' and Willimon's warning that the church should not be 'so intent on running errands for the world' that it no longer makes 'any difference, in our life together, in what we do, that in Jesus Christ God is reconciling the world to himself.'[97] Against this faith-frame, we now consider FCs' and others' role as Partners in Health Promotion.

Partners in Health Promotion: Core Concept Three

Further evidence of collective failure to address societal mental health issues comes from Freedom of Information research by *The Guardian* that reports a doubling in rough sleeper numbers between 2013 and 2017.[98] This disturbing finding, corroborating my research, suggests that FCs should exercise leadership on the following questions while avoiding self-interest:[99]

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[93] Peter C161; Swinton, p. 10; Beresford, User Involvement, pp. 310-11.

[94] Florence C750; Olivia C188; Orla M533; Orwell.

[95] Kelly and Swinton.

[96] Kesey, p. 6.

[97] pp. 94-95.

[98] Patrick Greenfield and Sara Marsh, 'Deaths of UK Homeless People More Than Double in Five Years', in *The Guardian* (London: Guardian News and Media, 2018).

[99] Sentamu, (p. 242).

a) faced with a 'tsunami' of mental health problems, what sort of society do we wish to become?[100]

b) what might address the 'scourge of mental ill health'?[101]

c) what sort of church — or FCs — do we need to support such a society?[102]

d) at what point might we back Ophelia's call for a Wilberforce-like individual to give FCs the necessary 'kick up the backside', get their own house in order, and 'tell the NHS it's off-message'?[103]

I believe that time has come. My findings corroborate MacIntyre's pessimistic lament, not just for a William Wilberforce but for a St Benedict to rescue us from the 'prevailing cultural power'.[104]

Ominously, de Sousa Santos argues that 'a sense of exhaustion' haunts the Western project, rooted in its decayed colonialism.[105] Oblivious to their feet of clay, I see positivism and utilitarianism displaying characteristics of the very fundamentalism they hoped to wrest society from.[106] I suggest there is a good reason for subjecting their epistemological domination and colonialism to wider ethical scrutiny. [107] Though deeply compromised — and, in the eyes of many, discredited — by its own 'dirty shirt', the church faces a challenge equivalent to Queen Esther's (Esther 4.14).[108] That task may require it first to step aside from its collusion with

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[100] Christine C125; Fraser M811; Oscar C380; Otis C419; Patrick C240; Perry C303; Peter C106, C133, C352; Rice, Renew You.

[101] Orla M23; Susan M250; Ophelia M627; Orla M622; Swinton, p. 10.

[102] Christine C195; Sally C225.

[103] Faye C385, C408; Ophelia C898; Oscar C275; Fred C388; Stephen C397; Susan M147.

[104] Stephen C397, M97; MacIntyre, p. 256.

[105] de Sousa Santos, p. 19.

[106] MacIntyre, p. 64.

[107] Ibid., p. 263.

[108] Fred C80; Olivia C188.

power and choose life.[109] Then, and only then, will the church find itself in a confident position to 'tell the NHS it's off-message'.[110]

Less ambitiously, my findings suggest that FCs should play their 'ethical role in campaigning against failing healthcare provision'.[111] Such campaigning might include alerting 'hospital or residential establishment[s] to care shortfalls' thus lessening gaps in provision.[112] They could support service users and carers around the time of discharge (ideally as part of their discharge plan) or help them settle into a church (whether for social activities or worship).[113]

Help might include the Stepped Care proposed in Section 5.3. Many local FCs could 'do a lot more on health promotion', ranging from individual care to shaping thinking to organizing 'health fairs with […] stalls from voluntary organizations'.[114] They could collaborate more deliberately with parish nurses, community development workers, and pastoral workers — not to mention people with lived experience and carers — to broker 'prototype [voluntary and paid] posts'.[115] Chaplains should embody their institutionally-validated role as bridge-builders.[116] Finally, FCs could invite MHS staff members to offer consultancy on their pastoral care or on the mental health aspects of their theology.

The Ethics of Co-Production

My first recommendation for FCs on the ethics of co-production would be to field-test its generalizability. Here, I am proposing testing the concept's usefulness and acceptability rather than research per se. Though I have offered a definition and suggested tenets (see Section 2.4), these are open to refinement and development. They may need rewording for different contexts and diverse cultures. It may be that in FC settings more theological terms such as 'the body of

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[109] Catholic Institute for International Relations; Moltmann, *The Open Church*, pp. 19-23.

[110] Ophelia C898; Fred C388.

[111] Fergus C317; Orla C444; Pippa M552; Simon M90.

[112] Claire C183; Ophelia M627; Otis C24, C101-103; Perry C294; Sally C64; Sharon C670.

[113] Sally M32, M37.

[114] Otis C258, C262; Pippa C1128.

[115] Odette M516, M541; Pippa M1283; Simon M63-90.

[116] Craig C19, M96; Pam C221.

Christ' already encompass the ideas making the concept redundant. Alternatively, the idea may prove more valuable than I have appreciated.

Faith communities could scope the ethics of co-production's value as an audit or evaluation tool.[117] For instance, I used it to critique *Setting God's People Free*.[118] Despite emphasizing hearing 'the voices of marginalised groups such as young people, BAME [people] and those from the urban Church [*sic*], especially in poorer areas' the Report's authorship could hardly reflect a more elite demographic.[119] I decided it was unsatisfactory from an ethics of co-production perspective. Another similar use might be to use (and field-test) the tenets in planning LEAPs and similar within and beyond FCs. The tenets could serve in structuring membership of an editorial panel, a project, or a charitable trust board. They could help incorporate co-production within existing teams in many contexts.

The tenets could be explored in co-producing Stepped Care with 'people who need extra help but don't meet referral threshold[s]'.[120] They could similarly be used to co-produce pathways through volunteering to recovery and potential employment.[121] More ambitiously, FCs could co-design 'safe pathways away from MHSs'.[122] Furthermore, FCs could work alongside non-adherents, exploring co-production's potential to reduce loneliness. They could work similarly with carers, ensuring they are not 'being neglected' (Acts 6.1-6).

Finally, exploring the ethics of co-production could help address Woodward and Pattison's charge that 'PT will always be vulnerable to the criticism of impracticality or uselessness unless it can really demonstrate what it achieves and that it is not simply going around in ever-complexifying methodological circles'.[123]

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[117] Fred C70.

[118] Archbishops' Council.

[119] Ibid., p. 20; cf. Annexe 2.

[120] Craig M388.

[121] Or meaningful occupation, as suitable.

[122] Serena C12. This would ideally involve collaboration with MHSs. Chambers and associates' workaround (pp. 2-3) may be relevant here (Section 1.2).

[123] *The Blackwell Reader in Pastoral and Practical Theology* (Oxford: Blackwell, 2000), pp. 128-29.

My recommendations for FCs are deliberately less specific than possibly expected (though I offered hypothetical examples in Section 6.5). My recommendations are not intended as a Mid Staffordshire Inquiry-style checklist to guarantee excellence.[124] Whatever the detail, my findings suggest that full humanity reflects the divine perichoresis.[125] Perichoresis corroborates Kara's 'mutable' identities, disallowing professionals' deficit-based views and mitigating the 'patronising disposition of unaccountable power'.[126]

7.3   Recovering from Care

Before making recommendations for future research, I review my three core concepts, evidencing how they emerged from participants' 'voices' and highlighting their implications. I elaborate on the 'deep-rooted issues in our understanding of care' they uncovered, explaining how the interviews and the literature led me to the ethics of co-production. [127] I restate how the three core concepts not only emerged from and addressed my three RQs but built on each other. I explain how my findings culminated in an expectation that co-produced (and co-evaluated) services might place agency at the heart of service design.[128] The core concepts, each forming a subsection, lead into some final thoughts. I begin with All Hands on Deck.

Reintegrating Fact and Value (All Hands on Deck)

My first core concept emerged from participants' sense that MHSs are overwhelmed by the 'tsunami of mental ill health facing this nation'.[129] Moving towards my conclusions, I want to revise my earlier metaphor of the stricken MHS ship and the FC rescue crew.[130] A more fitting image might be several vessels alongside each other with 'all hands' comprising MHSs, FCs,

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[124] Moore, p. 115; Francis.

[125] McFadyen, p. 168.

[126] Kara, p. 131; Jones, The Patronising Disposition, p. 31.

[127] Serena C539.

[128] South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust.

[129] Rice, Renew Well-being.

[130] Rafferty; Christine C72, C667; Craig, C217; C483, C549; Faye C64, C68.

and secular organizations. This is more suitable because most participants answered my first RQ affirmatively, considering that 'greater cooperation between MHSs and FCs would benefit service users and carers'.[131]

The core concept All Hands on Deck comprised three core categories. The first, Surviving the Storm, expressed the intensity of participants' distress at MHSs' 'broken and demoralised system'.[132] They implied that MHSs were not merely 'ordering more speed' but heading for the iceberg, condemned by their positivist logic.[133]

The second core category, Faith Community Resilience, reinforced the first. Participants considered FCs more resilient to austerity and better able to recover from failure to their more 'virtuous form'.[134] The ethics of co-production suggests this 'virtuous form' must necessarily be co-produced with service users, carers, and front-line staff. However, FCs' imputed greater resilience is relative.[135] They may similarly gain from co-production, possibly using it alongside ordinary theology. Rublev's *Trinity* offers a helpful image of hospitality where, everyone blesses each other, with belonging and acceptance offered to all.[136]

My third core category, Flair, suggested an alternative to recovery approaches, more akin to Rogers' core conditions of counselling than positivist explanations.[137] Flair may empower service users to find hope, enabling them to exploit their inner resources (suggested by Duncan and associates to be the engine for recovery).[138] Not only does Flair offer an explanation for service users' and carers' general preference for FC leaders over MHS staff.[139]

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[131] Reassuringly for those uncomfortable with FCs, none suggested merging. Participants' responses were respectful of diversity.

[132] Schizophrenia Commission, p. 4.

[133] Cameron 'Titanic'.

[134] Charlie C101; Christine C21; Fergus C473; Claire C261; Fergus; Fred C398; Odette C253. I deliberately avoid pre-empting the precise nature of this 'more virtuous form'.

[135] Craig C1168; Ophelia C429, C774; Oscar C74.

[136] Rublev.

[137] Rogers, pp. 242-43; Connie M62; Florence C214; Simon C632.

[138] Duncan and others, pp. 423-24.

[139] Halliburton, p. 162.

It suggests the need to reinject value into MHS practice.[140] Without co-production, MHSs risk myopia, only seeing organizational drivers and the outcomes of EBM's randomized controlled trials.[141]

Overcoming Rationalization (Critical Friends)

The core concept Critical Friends matched my second RQ regarding 'safe and effective protocols'. It emerged from core categories (4) Expertise versus Compassion, (5) Vulnerabilities, and (6) Critical Friends for Safeguarding.

My fourth core category described service users and carers experiencing a broad trade-off between what they might find in MHSs and FCs. They reported drawing what they could from MHSs and FCs while tolerating any accompanying stigma and discrimination.[142] Service user and carer participants described MHSs and FCs as struggling to recognize each other's strengths, often becoming fixated on perceived or actual weaknesses.[143] They suggested MHS staff may have much to learn from FC leaders in developing relationships that service users and carers find meaningful for recovery.[144] Conversely, FC leaders would benefit from MHSs' training and acceptance into referral pathways.

My fifth core category 'Vulnerabilities' suggested that overemphasis on fact or value brings exposure to matching weaknesses. Under stress, MHSs risk becoming 'emotional deserts' and FCs totalitarian.[145] Participants, naming both fact and value as essential to recovery, hoped that mutual influence would make MHSs more compassionate and FCs more skilful. Shared training, not least in safeguarding, could overcome the "very deep chasm" between them.[146]

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[140] Stephen C23.

[141] Moore, pp. 60-68; Raffay, What are the Factors?, p. 39.

[142] Perry C303; Sharon C187; M937.

[143] Charlie C314; Claire C109; Craig C564; Fergus C475; Frank C180; Ophelia C996.

[144] Forrest and others, p. 53.

[145] Claire C121; Craig C596; Fred C398; C388.

[146] Ophelia C986.

On Core Category Six, Critical Friends for Safeguarding, my research suggests that both MHSs and FCs show remarkable ability to rationalize their practices despite everyone's 'dirty shirt'.[147] This rationalization may be due to a lack of 'tradition-awareness', yet it disadvantages people with mental health problems and carers.[148] MHSs, entrapped by utilitarianism risk turning to EBM's circular logic that evidences what it can measure.[149] Similarly, FCs 'redescribe' others' failures yet baulk at external scrutiny.[150] In both instances, we have agents (professionals) and the objects of their attention (patients or congregations). Critical friendship potentially addresses defensive rationalization.

My findings suggest that the notion of care needs superseding by more equitable understandings that both affirm compassion yet, wherever possible, consider recipients' agency.[151]

Building Shalom (Partners in Health Promotion)

Core Concept Three Partners in Health Promotion, like Heaney's poem *Skylight*, 'held surprise wide open' on my third RQ concerning what service users and carers believe 'contributes to recovery and well-being'.[152] The core concept highlighted belonging as opposed to well-being, disallowing atomistic conceptions of personal recovery.[153] More broadly, it considered how people with mental health problems and their carers might play a full role in the community, locating MHSs and FCs within that context. Co-produced partnerships could centre service evaluation around service user (and carer) agency, thereby addressing 'a culture focused on doing the system's business — not that of the patients'.[154]

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[147] Fred C80; Odette C26.

[148] Moore, pp. 128-29.

[149] MacIntyre, p. 64.

[150] Brueggemann, p. 4.

[151] Cf. I Thessalonians 2.7-8; Seedhouse, pp. 149-51.

[152] Heaney, p. 350.

[153] Paul Smith, 'Authorized Personal Conversation', ed. by Julian Raffay (Skelmersdale, 2018); Christian Smith, pp. 48-49.

[154] Francis, p. 4.

Core Concept Three arose from core categories seven to nine: (7) Developing Fact–Value Partnerships, (8) Co-Producing the Future, and (9) A Vision for Stepped Care. On Core Category Seven, participants considered chaplains and parish nurses well-placed to lead on 'cross-pollination'.[155] This suggests that partnerships could support shared training, culminating in more in-depth reflection on recovery. My eighth core category, Co-Producing the Future, favours moving from treatment to recovery and eventually to prevention.[156] Core Category Nine, A Vision for Stepped Care, envisages a co-produced safety net involving MHSs, FCs, and other agencies.[157] Under such a scheme, FCs and other agencies might promote belonging and well-being for those coping with minimal support. Thus, FCs could work in partnership with MHSs to help people experiencing moderate mental health problems. People suffering from severe mental health problems would then receive focused attention from MHSs (with FCs supplying added support where proper and wanted).

Five Loaves and Two Fish

The 'church could or should work to ensure that other players can come to the table rather than simply promoting its own opportunities'.[158] Orla's image of a Venn diagram might help organizations consider their niches instead of competing for [the same] shrinking pot'.[159] My findings support this perspective, suggesting that care comprises at least two dimensions — expertise and compassion — each uniquely valuable.[160] A genuinely holistic approach could provide space for everyone's vital contribution, not least those of service users and carers. Within the church, change is needed 'to ensure that the front-line perspectives and realities of lay people are heard, understood, and acted on at Parish, Deanery, Diocesan and National

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[155] Florence C33; Frank C520; Otis M564, 566; Sally M68.

[156] Faye C157; Fergus C8; Ophelia C850; South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, p. 4.

[157] Florence C24; Fraser C187; Odette C209; Olivia C41; Ophelia M749; Oscar C380, 398; Perry C22; Peter C106.

[158] Florence M296.

[159] C9; Ophelia C425.

[160] Raffay, Wood, and Todd, p. 6; Slay and Stephens, p. 3.

levels'.[161] Demos' adaptive state provides a framework supportive of co-production alongside other valuable approaches.[162]

Faith communities have reason to be confident about their 'incredible amount of social action work'.[163] Their projects contribute over £3 billion yearly and support over 47 million UK beneficiaries.[164] As I suggested earlier, 'People of faith may be best equipped to understand what is going on', seeing their 'understanding of the human condition as their gift to the NHS'.[165] For FCs to help build the future, they need 'to recognize [their] unique selling point and not become subservient'.[166]

My three core concepts and nine core categories consider mental well-being and its absence in a broad social context. 'Shalom' demands a radical approach to health inequalities.[167] It implies that labelling people as mentally ill risks unfairly blaming those trapped in poverty or stress, often resulting from 'a normal reaction to an abnormal class-ridden very unequal and very offensive society where money speaks'.[168] Recovery from care may need more co-produced and more collective interpretations, less dependent on clinician-focused ethics, rooted in the Enlightenment.

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[161] Archbishops' Council, p. 20.

[162] Tom Bentley and James Wilsdon, 'The Adaptive State: Strategies for Personalising the Public Realm' (London: Demos, 2003), (p. 106).

[163] Cinnamon Network, 'Cinnamon (2016) Faith Action Audit' (London: Cinnamon Network, 2016), p. 16; Naomi Maynard, 'A Bigger Difference: Social Action and Church Growth in the Diocese of Liverpool' (Sheffield: Church Army Research Unit, 2018).

[164] Cinnamon Network, p. 3.

[165] Orla C25; Pippa C1236; cf. Brueggemann, p. 4.

[166] Otis M395.

[167] Graham Watt, 'What Can the NHS Do to Prevent and Reduce Health Inequalities?', *British Journal of General Practice,* 63 (2013), pp. 494-5.

[168] Peter C161; Beresford, *User Involvement*, p. 311.

7.4   Reflexivity and Future Research

Before proposing future research, I devote two subsections to appraising the current project. The first defends my work's validity and rigour and the second highlights its limitations. The remaining two subsections suggest future research relevant to MHSs and FCs respectively. We first consider validity and rigour.

Validity and Rigour

Proposing a new branch of applied ethics without being transparent about my work's quality would be disingenuous. I, therefore, explore the matter using the twin concepts of validity and rigour.

In qualitative design, validity is the degree to which research measures what it claims to measure.[169] In claiming validity for my study, feedback from the LEAP proved invaluable. Inviting participants to see their transcripts ensured best practice in transcribing. Making relevant sections of the thesis available increased scrutiny. Glaser's original criteria of fit, work, relevance, and modifiability alongside Charmaz's more recent tests of credibility, originality, resonance, and usefulness offered invaluable waymarks.[170]

Another aspect of validity concerns data integrity. Charmaz's standards for GT studies address the widespread lack of audit trails in academic papers, without which it is impossible to allow a 'reader to form an independent assessment'.[171] I have tackled the issue by providing unique identifiers to codes and memos (see Section 3.1) to enable authorities to track core concepts back through *NVivo* to my transcripts and recordings.[172]

A third aspect of validity concerns hermeneutics. Hermeneutics considers GT codes and memos as texts. It alerts us that logical and transparent thought processes from raw data to

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[169] Cf. John W. Creswell and Dana L. Miller, 'Determining Validity in Qualitative Inquiry', *Theory Into Practice,* 39 (2000), pp. 124-30.

[170] Glaser and Strauss, *The Discovery*, p. 261; Charmaz, p. 337

[171] Charmaz, pp. 337-38.

[172] QSR International; Charmaz, pp. 337-38.

theorization may prove inadequate without the 'contextual and self-reflexive awareness that PT brings to the pursuit of Christian theological inquiry [*sic*]'.[173] As mentioned in my critique of Barnsley and Leach, I have sought to evidence greater awareness of the potential pitfalls. Nevertheless, my reading of the texts may have involved omissions and eisegesis. I have therefore validated my theory with 'participants or people who share their experiences'.[174] Grounded theory typically overlooks this part of the process, so central to action research. I addressed it through co-production with the LEAP.

On rigour, Ravitch and Riggan require that 'the data to be collected provide the researcher with the raw material needed to explore the research questions'.[175] This necessitates suitable participants for the methodology. My sample (see Appendix C 'Participant Demographics'), chosen using purposive sampling and achieving theoretical saturation across the five groups, was in keeping with good practice in GT research.[176]

Ravitch and Riggan's third requirement for a conceptual framework is that 'the analytic approach allows the researcher to respond effectively (if not always answer)' the RQs.[177] Here, as Thornberg notes, GT can be problematic.[178] In Section 3.1, I showed how I addressed these concerns by using informed GT. To date, my project has met four of my five success criteria:

1) addressed the RQs

2) fulfilled my aims

3) developed a rich theoretical understanding

4) contributed to potentially greater cooperation between MHSs and FCs that is safe for all parties involved.

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[173] Other, equally robust approaches exist, though rarely deployed; Richard S. Briggs, 'Biblical Hermeneutics and Practical Theology: Method and Truth in Context', *Anglican Theological Review,* 97 (2015), pp. 201-17 (p. 201).

[174] De La Torre, *Doing Christian Ethics*, pp. 28-29; Charmaz, p. 338.

[175] Ravitch and Riggan, p. 7.

[176] Charmaz, p. 108.

[177] Ravitch and Riggan, p. 7.

[178] Thornberg, pp. 244-45.

I have yet to satisfy my fifth criterion, namely, to disseminate my findings to research and wider

communities.

Limitations

I acknowledge six potential limitations to my project: (a) sampling problems, (b) GT's

vulnerability to researcher effects, (c) risk of participants misunderstanding what was asked of

them, (d) restricted generalizability, (e) limited insights from non-Christian perspectives, and

(f) absence of some stakeholders. I respond to these in turn.

First, I used purposive sampling, but experience has taught me that recruiting a full

cohort of MHS users and carers is hard enough without applying rigid sampling criteria.

A consequence of my decision to recruit from five stakeholder categories (see Table 7 in

Appendix B) was the risk of bias within each sample. Four of the carers had relatives in secure

services. The FBO leaders were all from Christian organizations.[179] Three of the service user

participants were recruited from adult acute wards. My staff participants did not include any

staff nurses or support workers though this group featured heavily in my master's sample (that

influenced my sensitizing concept).[180] However, given the relatively uniform nature of adult

MHSs, NICE guidelines, and consistency of my findings, I anticipate that they are nevertheless

broadly generalizable.[181]

Where I could not remove recruiting bias, I reflected on it instead. Significantly, half

the service user and staff participants and two-thirds of the carers identified themselves as

practising their faith (see Table 10 in Appendix C). Though this was higher than the local

population, I nevertheless managed a spread of opinion. My sample was more ethnically diverse

than the population (see Table 9 in Appendix C).

Second, my research has limitations common to GT, specifically its vulnerability to

researcher effects. Here I looked to reproduce the intensity of participants' expressed emotion

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[179] I attempted to recruit Jewish and Muslim FBO leaders.

[180] Raffay, What are the Factors?, pp. 29-32.

[181] Francis, p. 35.

faithfully. I also created codes and memos to support emerging theory while staying close to the data. I have tried, in reading the literature concurrently with the fieldwork, to mitigate seeking literature supporting my findings rather than reflecting challenges or discrepancies arising from the literature search. Though I involved a LEAP and suitable rigour, the core concepts are my interpretation.[182] Despite rigorous governance, I cannot exclude the possibility that I may have misunderstood or unintentionally misrepresented participants' views. Some protection is afforded by GT's constant comparative method, by allowing participants the possibility of verifying their transcriptions, and by inviting responses to the Summary of Findings handouts.[183] Greater protection, however, comes from co-production's inherent democratizing nature, though unintended harm to minorities cannot be excluded.

Third, participants may have misunderstood what was asked of them. Systematic errors could have resulted from the participant handouts, though these were reviewed with the LEAP and piloted. Biases may have arisen from my recruiting on inpatient wards. Here, I checked for capacity and sought evidence from thick descriptions to ensure comprehension.[184] Since both GT and co-production are iterative and moderated by others' 'vital contributions', learning and refining are likely to increase understanding as any projects are implemented.

Fourth, on generalizability, the geographical region's higher-than-average religiosity may have had a bearing on the GT concepts. However, the wish for co-production would likely have emerged from the thick descriptions of service user and carer responses elsewhere. Evidence of effective collaboration worldwide, not least in disaster relief, supports broader applicability of my findings.[185]

Fifth, non-Christian perspectives deserve consideration. I welcome secular opinion and open debate and cite as evidence the deliberately diverse LEAP membership. I reflected on

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[182] Charmaz, pp. 337-38.

[183] Ibid., pp. 132-33.

[184] One participant had mild learning disabilities but was reflective of the population.

[185] O. Lee McCabe and others, 'An Academic-Government-Faith Partnership to Build Disaster Mental Health Preparedness and Community Resilience', *Public Health Reports,* 129 (2014), (pp. 100-04).

Pippa's remark that 'if churches and MHSs are complementary, that begs the question of the atheists'.[186] Here, I affirm the invaluable work of officially secular organizations like the Alzheimer's Society, Mind, and Rethink. I hope the reader may identify in my calling for All Hands on Deck, an openness to unprejudiced partnerships. My findings may have a bearing on the felt value of alternative therapies, suggesting this may in part be attributable to their generally more 'pleasant' processes.[187]

Sixth, the ethics of co-production should ensure that, wherever possible, all 'voices' are considered in researching, designing, creating, and evaluating services. I accept that I omitted commissioners and that my work might have been more robust with a cohort of senior MHS managers.

In all these matters, my research's limitations 'evidenced for me the value of a co-produced approach in recognizing the temptation towards the voice of the academy rather than hearing the 'voice' of the 'ordinary' reader.'[188] I believe I have been more successful than many similar ventures. While acknowledging these limitations, I now offer suggestions for future research, first in MHSs then in FCs.

Researching the Ethics of Co-Production in Mental Health Services

Service users' and carers' attribution of their recovery to Flair is potentially an affront to 'the conceptual practices and logics' of MHSs.[189] Most randomized controlled studies are blind to staff variables, commonly including them in the placebo effect.[190] However, if service users and carers assign their recovery to Flair, MHSs should provide reasonable opportunity to explore the phenomenon's evidence base. Ideally, research into Flair would be co-produced within an action

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[186] M1198.

[187] Parker and Gallagher, p. 13; Halliburton, p. 162.

[188] Sandford, pp. 19-20, 30.

[189] Voronka, Critical Perspectives.

[190] C. A. Green and others, 'Understanding How Clinician-Patient Relationships and Relational Continuity of Care Affect Recovery from Serious Mental Illness: STARS Study Results', *Psychiatric Rehabilitation Journal,* 32 (2008), pp. 9-22.

research cycle to avoid pre-empting findings. Additionally, Flair's relational nature may call for narrative accounts instead of quantitative methodologies.

It is precisely co-production's relational and complex nature that led me to seek an argument beyond health economics.[191] Despite much value in, for instance, The King's Fund's work, an ethical argument is complementary, and potentially more generalizable and powerful.[192] I propose further action research co-produced with LEAPs to validate my findings across diverse settings and contexts both within the UK and possibly abroad.

Research is needed to further explore the applicability of the ethics of co-production to MHSs and beyond. Such work would, I venture, look to develop an ethical framework through co-production. In giving 'voice' to service users and carers, it may closely resemble survivor research. It would potentially explore what considerations might be important and how services might further service user and carer agency and support stakeholders' ambitions to take part in society. In Voronka's terms, its knowledge would be 'studied up'.[193] Voronka's concerns call for change in current practice, not least — as I have suggested — in the inequitable payment of LEAPs.[194]

Researching the Ethics of Co-Production in Faith Communities

Faith communities have a distinct prophetic role, calling for faithfulness to their purpose.[195] Further research into grounded theology, ordinary theology, and the ethics of co-production would be worthwhile. Each might develop the others. Indeed, GT potentially makes theological enquiry more rigorous and transparent. [196] Stevens' proposed method, though he does not suggest this, could enable people with specific insights to engage with formal theology.[197]

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[191] Buck and others, pp. 15-17; Tritter and McCallum, pp. 160-61, 166.

[192] King's Fund.

[193] Voronka, Critical Perspectives.

[194] INVOLVE, p. 8.

[195] American Friends Service Committee, *Speak Truth to Power: A Quaker Search for an Alternative to Violence* (Philadelphia, PA: American Friends Service Committee, 1955).

[196] Stevens, p. 204.

[197] Ibid.

With grounded theology in its infancy, my findings could help develop the field. I see Leach's work, like Barnsley's and conventional PT as laudable but lacking where Heaney's 'perfect, trunk-lid fit of the old ceiling' remains.[198] There is a need to reach beyond first-order pastoral cycles where the conceptual framework is non-negotiable, and predetermined by the powerful. We might consider the ethics of co-production as an opportunity to engage with liberation, liberative, feminist, and ordinary theologies.[199] My research on spirituality and the current research suggests we need to hold 'surprise wide open', embracing cybernetics' third order of complexity.[200]

We might ask who is made invisible by my research.[201] Further co-produced research might sample purposively to include people with disabilities, those identifying as LGBTQIA+, people from Majority World cultures, abuse victims, and non-neurotypical people, among others. Research co-produced with these groups would satisfy my tenet that the ethics of co-production is not fulfilled unless diversity is valued, and discrimination mitigated.

Churches (and other FCs) may wish to research whether post-Constantinian bureaucratic monoliths might be inevitably hostile to the human relationships central to co-production. [202] New Monasticism would be a good starting point for relevant research. Finally, as recognized by classic monasticism, agency needs balancing with the community's needs.[203]

In this section, I have defended my work's validity and rigour. I have argued that 'the data to be collected provide […] the raw material needed to explore the research questions'.[204]

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[198] Heaney, p. 350.

[199] Astley, *Ordinary Theology,* pp. 50-51.

[200] Raffay, Wood, and Todd, pp. 7-9; Heaney, p. 350.

[201] Eric Stoddart, 'The Bible and (in)Visibility', in *Doctor of Theology and Ministry Residential School* (Cranmer Hall, Durham, 2015).

[202] Schumacher, pp. 52-62.

[203] Sullivan, pp. 3-9.

[204] Ravitch and Riggan, p. 7.

I have additionally shown that my project is on target against my success criteria.[205] I have proposed future research on the ethics of co-production, specifically around its wider application to MHSs and FCs.

Conclusions

I began this chapter by highlighting my prioritization of participants' voices and commitment to articulate their concerns. I emphasized that I consider specific recommendations subordinate to embedding stakeholders' concerns in service design, delivery, and evaluation. I grouped my recommendations into those for MHSs and those for FCs and other community organizations. I presented them core concept by core concept which enabled me to restate how the three core concepts not only emerged from and addressed my three RQs but built on each other. The parallel subsections on the ethics of co-production developed my argument favouring more co-produced and collectively derived interpretations than those solely arising from clinician-focused ethics. In the last section, I defended my work's validity and rigour. In recognition of limitations intrinsic to GT methodology, I propose future research regarding how the ethics of co-production might apply to MHSs and FCs.

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[205] I have yet to disseminate the findings beyond the Summary presented to participants.

8   Conclusions

I set out to examine stakeholders' opinions on MHS–FC relationships, deliberately sampling for diverse views on religion or belief. My findings corroborate recent research suggesting that services give inadequate attention to service user agency. I have argued that the fact–value divide between MHSs and FCs is an artefact of clinician-focused ethics, rooted in the Enlightenment.

Three GT core concepts emerged. (1) All Hands on Deck identified MHSs as inadequate to the scale of mental health problems and as disempowering FCs and communities more broadly.[1] (2) Critical Friends for Safeguarding proposed that, being respectively rooted in fact and value, MHSs and FCs might protect each other from their vulnerabilities. (3) Partners in Health Promotion suggested that MHSs and FCs have complementary strengths and saw partnership as potentially favourable to individuals and communities.

My work is original in advancing the ethics of co-production as a potential new branch of applied ethics. It offers a prospectively compelling argument for reconfiguring MHSs to serve their users better. The ethics of co-production considers that services omitting the vital contribution of service users, carers, and front-line staff in their commissioning, research, design, delivery, and evaluation, are flawed. It provides a set of guiding tenets, helping quasi-autonomous self-help groups to flourish with significantly less central effort. The more complex CPE offers a thought experiment supportive of the ethics of co-production.

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[1] Odette C509.

My theorization corroborates Moore's application of MacIntyre's fact–value divide. It suggests that co-production and co-evaluation might help mitigate organizational failure in MHSs and FCs. In MHSs at least, we can potentially embed virtue through service user, carer, and staff experience.[2] However, nothing less than privileging service users and carers in evaluating services is likely to redress the ingrained kind of culture Goffman censured and that Liaschenko names as an ever-present threat.[3]

I propose that in MHSs, EBM as commonly understood, risks being a means by which one group of people perceive themselves to be defined, delimited, and dehumanized by another. Significant pressures cause people to become stigmatized with labels rather than be supported to belong in mainstream society.[4]

I have argued that PT can contribute to secular professional practice and promote the church's mission in addressing mental health problems and other stigma. The ethics of co-production, I suggest, supports a legitimate transfer of power and acknowledgement of broader agency, potentially addressing criticisms levelled at MHSs and FCs. Ensuring service users and carers co-produce and co-evaluate services is not just desirable but morally necessary. It is in line with the opening words of the NHS Constitution: 'The NHS belongs to the people.'[5]

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[2] MacIntyre, p. 263.

[3] Goffman, *Asylums*, pp. 9, 177; Joan Liaschenko, 'Faithful to the Good: Morality and Philosophy in Nursing Practice' (Doctor of Philosophy, University of California, 1993), p. vii.

[4] Swinton, p. 10.

[5] Department for Health and Social Care, p. 2.

Appendices

The previously submitted material reproduced in Appendix A is mostly unedited. However, I have integrated the references within the overall scheme of the thesis.

Appendix A: Participant Handouts

The participant handouts include:

- sample Invitation Letter

- sample Participant Information

- sample Consent Form.

Mersey Care NHS

NHS Trust

Research Ethics Committee	Spiritual and Pastoral Care
North East — Newcastle and North Tyneside 1	Department
	Mersey Care NHS Trust
Version 2	Indigo Building
	Ashworth Hospital
R&D reference number: 2015/17	Parkbourn
	Liverpool
Date	L31 1HW
	Tel: 0151 471 2608

Web: www.merseycare.nhs.uk

Dear

Invitation to take part in research

I invite you to take part in a research project which will explore the relationship between mental health services and faith communities. It has the support of the Trust. The North East — Newcastle and North Tyneside 1 Research Ethics Committee has reviewed it and given favourable opinion.

The research title is: 'Perspectives on the relationship between statutory mental health services and faith communities: a co-produced constructivist grounded theory study.'

It is entirely your choice whether to take part. What's involved is an interview lasting up to an hour. During the interview, I will ask about how you think mental health services and faith communities work together. I will be interested in hearing your thoughts rather than any supposedly correct answers. I will be happy to hear about your experience, whether encouraging or difficult. I am looking at how we can deliver safe and effective services that reflect the hopes and concerns of people with mental health problems and carers.

If you would like to take part, please read the Participants' Information Sheet carefully and make sure that you have understood it. If you have questions, I will be happy to discuss these informally. Please allow yourself 24 hours to reflect on what you have read.

If, having read the Information Sheet, you would like to take part, please fill in the Contact Form and return it to one of the nursing staff or to me at the above address.

If you would prefer not to take part, this will not affect your treatment in any way.

Thank you for your consideration

Yours sincerely

Julian Raffay

Julian Raffay

Specialist Chaplain (Research, Education and Development)

Mersey Care NHS
NHS Trust

Research Ethics Committee North East —
Newcastle and North Tyneside 1

Version   2

Date   19/11/2015

R&D reference number 2015/17

Participant Information Sheet (Service User)

Research title: 'Perspectives on the relationship between statutory mental health services and faith communities: a co-produced constructivist grounded theory study.'

To participant: Please keep this sheet. It is for your information.

_____ *(name) handed you this sheet.*

If you have any questions, please speak to the person named above to the nursing team.

Part 1 — Outline of the study

What the study is about

This project aims to explore the relationship between mental health services and faith communities. I am seeking safe and effective ways of improving services. If you choose to take part, you will be agreeing to one interview lasting up to an hour.

Participation is voluntary

You have a **completely free choice** either to take part or not. To avoid putting anyone under pressure, I have chosen to invite people to take part at ward community meetings where other staff are present. If you do take part, you can withdraw at any stage. You can ask me to stop the interview. You can ask me to destroy all the data. The choice is yours and I will respect it.

Potential risks and inconvenience

If you choose to take part, I expect that you will find the experience both interesting and enjoyable. I have run pilot trials at every stage to make sure taking part is safe and of benefit to both service user and myself. You may find some of the questions a bit sensitive. However, I have the experience needed to make sure I respect your wishes throughout. I will arrange interview times to suit participants so should cause a **minimum of inconvenience**.

As I am the Specialist Chaplain (Research, Education and Development), previous conversations may be in our minds during the interview. In the interview, I will ignore any such conversations.

Should we meet afterwards for chaplaincy support, we may remember some of what you have said in the interview. I will not mention anything discussed in the interview, unless you invite me to do so.

What happens next

You have been handed this information sheet to **help you decide** whether you wish to take part in this study.

If you choose to take part, please complete your consent form and return it to one of the nursing staff or to me (Julian Raffay). I will then meet with you briefly to make sure you have understood what is involved. I will arrange an interview lasting up to an hour. I will remind you of your right to withdraw consent at any stage.

The interview will begin with a reminder that **you may withdraw consent** or chose not to answer particular questions. I will check that you have understood the contents of this Information Sheet and will seek your consent to record the interview.

During the interview, I will ask about how you think mental health services and faith communities work together. I will be interested in hearing your thoughts rather than supposedly correct answers. I will be happy to hear about your experience, whether encouraging or difficult. I am looking to see how safe and effective services can be delivered that reflect the hopes and concerns of people with mental health problems and carers as well as of those of service providers.

If you find any of the questions invasive or unhelpful, then please tell me. **You may ask me to pause or stop the recorder** at any time. At the end of the interview, I will check if you have concerns or would like extra support.

If you do not want to take part, please write on the Consent Form something like "no thanks" and return it to the nursing staff and you will hear nothing more. No one will think less of you for not taking part and your treatment will not be in any way affected by your choice.

Part 2 — More information about the study

Confidentiality

Anything you say during the research will normally be confidential. However, should you imply you might harm yourself or someone else, I have a duty of care to share this particular piece of information with the staff. I **will outline limits to confidentiality** at the beginning of your interview. Please feel free to discuss the matter with me if you have any concerns.

I will encrypt all electronic data. I will store paper records and digital recordings in a locked filing cabinet to which only I have access.

Data Protection

I will keep all information I collect about you during the research strictly confidential. With the exception of the optional Request for Summary of Findings Form, I will remove your name and address from any information about you which leaves the hospital/unit so no one will be able to identify you. You may ask to see what information I have recorded and ask me to correct any errors. I will handle data in accordance with the Data Protection Act 1988. I will follow the Caldecott Principles at all times. NHS Research and Development offices and regulatory inspectors may need access to clinical notes to verify or cross check data.

I will not add your name to a mailing list other than for sending you a Summary of Findings if you chose to receive this. I will destroy your contact details immediately after I have sent the Summary and I will then have no means of contacting you.

Communication with your nursing team

As a matter of routine courtesy, I will let your nursing team know you are taking part in this study. I will need to gain your consent for this. I will tell your nursing team that you have offered to take part in a research project run by Mersey Care NHS Trust. You can ask to see a copy of this communication.

Withdrawal of consent

If at any stage you wish to withdraw your consent, please contact any of the following:

the staff member named at the top of page one.

Julian Raffay, Specialist Chaplain (Research, Education and Development)
on 0151 471 2608 julian.raffay@merseycare.nhs.uk.

any other staff member.

You may withdraw consent at any stage without offering any explanation. If you chose to withdraw consent, please let me know if you would like me to destroy all your data relating to this research. Should you withdraw after I have analysed your data, I may still use your information in the project analysis. However, by that stage, this data would be anonymous.

Publication

All data will be anonymous. I will not publish information allowing any participant to be identified. I will not publish quotes that might reveal a participant's identity. I may ask if I could quote something that you have said. If so, in any publication, I will follow the quote with your anonymous research participant number. I will use neither name nor initials.

Summary of Findings

I will ask you if you would like to receive a Summary of Findings when the research is complete. If you would like this, I will ask you to provide an email or postal address so I can send it to you. I will not use your address details for any other purposes. I will destroy any address details immediately after I have sent the Summary.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, you may have grounds for legal action but may have to pay for it. Regardless of this, if you have concerns about how you have been approached or treated during this study please contact the Trust's Patient Advice and Liaison Service (PALS):

PALS@merseycare.nhs.uk or 0151 471 2377 or 0800 328 2941 or write to PALS Office, V7, Kings Business Park, Prescot L34 1PJ.

Sources of support

I will be happy to offer support after the interview should you so wish. Do also feel free to discuss any concerns you may have about the research with any staff member. Alternatively, please speak to your care team or another chaplain who will offer independent support if needed.

Payment

You will not receive any payment for taking part in this research but Mersey Care will reimburse travel expenses in line with their policies. I will not receive any payment but hope to gain a doctorate.

Audit

If you join the study, authorised staff from within the Trust may look at relevant parts of your medical records and the data collected for the study. Authorised people from Durham University may check that I am carrying out this study correctly. All have a duty of confidentiality to you as a research participant and I assure you that I will meet this duty. Your care or treatment will not be affected.

Research ethics approval

An independent group of people, called a Research Ethics Committee, look at all research in the NHS to protect your interests. The North East — Newcastle and North Tyneside 1 Research Ethics Committee has reviewed this study and given it a favourable opinion.

Julian Raffay

Mersey Care *NHS*

NHS Trust

Research Ethics Committee
North East — Newcastle and North Tyneside 1

Version   2

Date   19/11/15

R&D reference number: 2015/17

Consent Form (Service User)

Title of Project: 'Perspectives on the relationship between statutory mental health services and faith communities: a co-produced constructivist grounded theory study.'

Name of Researcher: Julian Raffay

Please initial all boxes

I confirm that I have read and understand the information sheet dated 19th November 2015 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

I understand that my name and Mersey Care patient number may be recorded by the research team. I give permission for Julian Raffay to have this information.

☐

I understand that, for the purposes of auditing this research, relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Durham University, from regulatory authorities or from the NHS Trust. I give permission for these individuals to access my records.

☐

I agree to my nursing team being informed of my participation in the study.

☐

I understand that the interview will be recorded and consent to the recording and storage. I am aware that I can ask for the recording to be paused, stopped, or destroyed at any time. I can ask to review my interview transcript to check for accuracy.

☐

I agree to take part in the above study.

☐

I agree to be quoted anonymously in publications of the study.

☐

Name of Participant   Date   Signature

Name of Person   Date   Signature

taking consent.

Service User Identification Number

_____

Appendix B: Purposive Sampling

Table 7 below (and overleaf) shows my purposive sampling by participant group. Some data has

been withheld to preserve confidentiality.

Participant Group	Notes
Carer	Carer who has been an inpatient and is active in the Trust as a volunteer.
Carer	Recruited at carers' meeting. Son in Secure Division.
Carer	Recruited at carers' meeting. Son in Secure Division. Atheist.
Carer	Recruited at carers' meeting. Son in Secure Division. Pro-faith but with negative experiences.
Carer	Recruited at carers' meeting. Son in Secure Division.
Carer	Vicar whose wife has used inpatient services extensively.
FC leader	Archdeacon interested in mental health issues.
FC leader	Imam and chaplain. (I attempted unsuccessfully to contact other imams in the community).
FC leader	Rabbi with a chaplaincy-related PhD.
FC leader	Recruited through approach to Bishop. Directed to by Diocesan Authorities.
FC leader	Senior NHS management consultant with national involvement.
FC leader	Former nurse. Chaplain who has worked in a GP surgery. Has an interest in NHS–church relationships.
FBO leader	Vicar who ran a mental health project. Former community development worker.
FBO leader	Food bank coordinator.
FBO leader	Methodist FC leader with interest in mental health.
FBO leader	Leader of a church for asylum seekers.
FBO leader	Parish Nurse.
FBO leader	Safeguarding Officer for FBO.
Service user (Pilot)	Member of LEAP. I concluded that one pilot was plenty as research modelled on previously used documentation. Received comment that Patient Information Sheet perhaps longer than necessary. This did not, however, warrant returning to ethics.

Participant Group	Notes
Service user	Isolated individual with a clear understanding of what promotes well-being.
Service user	Recruited on acute ward through contact with occupational therapist. Interviewed in step-down unit.
Service user	Recruited on acute ward. Identifies their faith as intrinsic to their well-being.
Service user	Recruited on acute ward. Identifies their faith as intrinsic to their well-being.
Service user	Chaplain and former service user.
Staff	Nurse researcher.
Staff	Psychologist working with carers with an interest in spiritual care.
Staff	Senior manager.
Staff	Senior ward manager with interest in spirituality.
Staff	Senior nurse, recruited on the suggestion that FCs could exercise a significant role in mitigating suicide after discharge.

Table 7 Purposive Sampling by Participant Group

Appendix C: Participant Demographics

This appendix contains the following data:

- Demographics by participant group

- Sex

- Age

- Ethnicity

- Religious practice and religion

Participant Group

I recruited six each of carers, faith leaders, FBO leaders, service users, staff as detailed in Table 8 (below and overleaf).

Participant group	Sex	Age	Ethnicity	Religion	Practising
Carer	F	55-59	WB[1]	None	N
Carer	F	55-59[2]	Withheld	C of E[3]	N
Carer	F	65-69	WB	Rom Catholic	Y
Carer	F	70-74	White Irish	Rom Catholic	Y
Carer	M	50-54	WB	C of E	Y
Carer	M	65-69	WB	Jewish	Y
FC leader	F	40-44	WB	Christian (Methodist)	Y
FC leader	F	50-54	WB	C of E	Y
FC leader	M	30-34	Asian/Asian British Bangladeshi	Muslim	Y

---

[1] WB: White British

[2] This is based on my estimate.

[3] C of E: Church of England

Participant group	Sex	Age	Ethnicity	Religion	Practising
FC leader	M	55-59	Mixed — Anonymized	Buddhist	Y
FC leader	M	60-64	Withheld	Jewish	Y
FC leader	M	85-89	WB	Rom Catholic	Y
FBO leader	F	45-49	WB	C of E	Y
FBO leader	F	50-54	WB	C of E	Y
FBO leader	F	50-54	Other white	C of E/ Christian	Y
FBO leader	F	55-59	WB	C of E	Y
FBO leader	M	40-44	Other ethnic group — Arab	Christian/ C of E	Y
FBO leader	M	65-69	WB	Methodist	Y
Service user (pilot)	M	65-69	WB	C of E	N
Service user	F	50-54	WB	C of E	N
Service user	F	50-54	WB	Christian	Y
Service user	F	55-59	Other white	Orthodox	Y
Service user	M	50-54	WB	Christian	N
Service user	M	50-54	WB	Christian	Y
Staff	F	30-34	WB	N/A	N
Staff	F	35-39	WB	Humanist	Y
Staff	F	50-54	WB	C of E	Y
Staff	F	50-54	WB	Rom Catholic	Y
Staff	M	40-44	WB	Rom Catholic	Y
Staff	M	55-59	WB	C of E	N

Table 8 Demographics by Participant Group

Sex

Female 17 (57%), Male 13 (43%). Liverpool City Region average = female 51%, male 49%.[4]

Although invited to enter their gender, none of the participants reported that they were transitioning or intersex. I have therefore used the term 'sex' in related tables.

Age

Participant average age = 54. UK mean = 40.4 (2015). Figure 9 shows participants by age band to preserve anonymity.
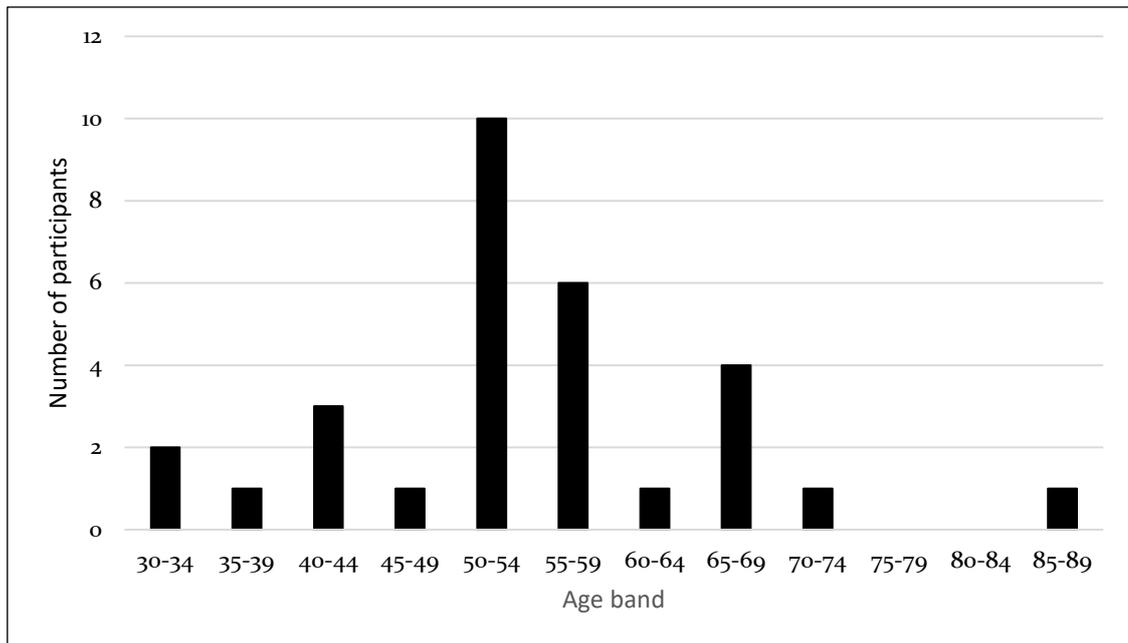

Figure 9 Participants by Age

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[4] All regional and national figures from the following and equivalent tables: Office for National Statistics (ONS), 'Ethnic Group' (Newport: Office for National Statistics (ONS), 2016). Information licensed under the terms of the Open Government Licence [http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2].

Ethnicity

As shown in Table 9, participants were more ethnically diverse than the mainstream population.

Ethnicity	Participants	Percentage	Liverpool City Region
WB and Irish	23	76.7	93.2
Other white	2	6.7	0.9
Mixed	1	3.3	1.5
Asian/Asian British Bangladeshi	1	3.3	0.2
Other — Arab	1	3.3	0.4
Withheld	2	6.7	3.8[5]
Total	**30**	**100**	**100**

Table 9 Participants by Ethnicity

Religious Practice

Since recruiting FC and FBO leaders inevitably skewed the data, I have omitted them from Table 10.

Participant group	Practising	Non-practising	No religious faith
Carer	4	1	1
Staff	3	1	2
User	3	3	0
Total	**10**	**5**	**3**

Table 10 Participants by Religious Practice

Excluding FC and FBO leaders, the proportions are: practising = 10 (62%), non-practising = 5 (31%), no religious faith = 3 (17%). The region's population is: practising = 23 (77%), non-practising = 4 (13%), no religious faith = 3 (10%).

---

[5] This includes 'other'.

Religion

Where participants supplied more than one religion, I assigned them to the most specific choice in Table 11. For example, I assigned 'Christian (Methodist)' as 'Methodist'.

Religion	Participants	Percentage	Liverpool City Region (%)[6]
Christian — C of E	12	40	74.0
Christian — Catholic	5	18	
Christian — other	3	10	
Christian — Methodist	2	7	
Christian — Orthodox	1	3	
Jewish	2	7	0.2
Buddhist	1	3	0.3
Muslim	1	3	1.4
None/humanist	3	6	17.2
Total	**30**	**97**	

Table 11 Participants by Religion

[6] Not all fields were available or corresponded sufficiently.

Appendix D: Analysis Framework

My analysis framework involved four phases. To comply with NHS information governance and create an audit trail, I:

a) transferred the interview recordings from an encrypted recorder to *Winscribe*[1]

b) transcribed each sound file to an encrypted *Word* template, creating codes and memos

c) exported the pseudonymized data to *Excel*, using Visual Basic programming to automate

d) imported the data into *NVivo*.

I used GT's constant comparative method throughout.[2]

Being experienced with GT, I did not feel bound by what Alvesson and Sköldberg describe as 'Glaser's intellectual luggage'.[3] I similarly avoided Coffey and Atkinson's other extreme described as 'a spirit of careless rapture with no principled or disciplined thought whatsoever.'[4] In keeping with Lean Thinking, I designed simple workflows.[5]

Other data included basic demographics and reflective notes around the circumstances of each interview, including the rationale for recruiting the specific participants.

Phase One (Transfer to *Winscribe*)

By using *Winscribe*, I was able to keep my recordings encrypted right up to the point of pseudonymization.

---

[1] An NHS-approved program and data server, mostly used for medical transcripts.

[2] Charmaz, p. 111.

[3] Mats Alvesson and Kaj Sköldberg, *Reflexive Methodology: New Vistas for Qualitative Research*, 2nd edn (London: Sage, 2009), p. 53.

[4] Amanda Coffey and Paul Atkinson, *Making Sense of Qualitative Data: Complementary Research Strategies* (London: Sage, 1996), p. 11.

[5] Westwood, James-Moore, and Cooke.

Phase Two (Coding, Compilation, and Data Reduction)

I transcribed each recording directly to a password-protected *Word* document. I placed

transcription fragments — comprising a chunk of meaning up to around 75 words — into rows

in the first column as in Table 12.[6]

Transcription fragment	Initial coding	Focused coding	Action points/ reading/ early memos
Thank you for agreeing to be interviewed.	1.		
It's a privilege as most research ignores carers.	2. Being concerned about the carer's voice.	2. Carers are often ignored in research.	2. Ensure consideration of carers' perspective. Check of its absence in literature searches.
Let me ask you a question...	3.		

Table 12 *Word* Coding Table

In column two, after Charmaz, I used gerunds for my initial coding, describing actions from the

participant's perspective.[7] I reduced the data by ignoring material where the conversation

wandered off topic. I began the audit trail by numbering each cell in the column (using *Word's*

automatic paragraph numbering).

In column three, my focused coding excluded codes holding little promise.[8] I preserved

the audit trail by manually numbering each focused code to match its transcribed fragment.[9]

---

[6] I worked at text level, omitting inflections and similar. I italicized anything I said to distinguish it from participant contributions. I inserted notes in square brackets to show disruptions, emphasis or laughter. I anonymized potential identifiers. I completed each column before working on the next.

[7] Charmaz, p. 112.

[8] Ibid., p. 138.

[9] For the focused coding (column 3), I used Visual Basic programming to discard empty cells and convert the data into list (**F**) which I placed beneath the previously described table.

Column four received a broader range of data, organized using *Word* paragraph styles for later extraction, using Visual Basic programming.[10] The first paragraph style contained action points, enabling reflection on the interview to guide the research and findings. The second held suggestions for reading, allowing GT's constant comparative method. The third paragraph style consisted of early memos.[11] Again, I numbered each entry to match its transcribed fragment.

I next emboldened focused codes that:

a) engaged the RQs

b) addressed other features of the research, for example, limitations

c) warranted consideration for different reasons.

I then created list (G) containing this subset (using *Word's* 'Advanced Find and Replace'). I similarly created a third list (C) with a maximum of ten focused codes for consideration in the next interview. I repeated these steps for the early memos (in column 4), creating lists (I), (J), and (D). I remained close to the data, building codes, and memos throughout the data reduction cycles.

I exported the focused codes (G) to *Excel*. However, I delayed importing the memos (H) until after I created advanced memos. I took this approach to ensure that early memos could influence later interviews and that axial coding benefited from advanced memos. Summing up, Phase Two generated focused codes, early memos, reduced the data, and deployed the constant comparative method.

Phase Three (Axial Coding and Subcategory Generation)

I imported each interview into an *Excel* worksheet, retaining the numbering necessary for my audit trail (see Figure 10).

---

[10] I used colour-coded Word paragraph styles in collaboration with visual basic programming to transfer the data to *Excel*.

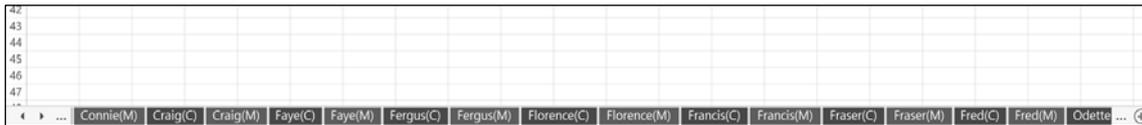[11] Though I have described the paragraph styles in succession, the order of entry varied.

Figure 10 Participant *Excel* Worksheets

I conducted further coding and data reduction within Excel, writing advanced memos

and subcategories as I proceeded (see Figure 11).[12]

Figure 11 Axial Coding and Subcategory Generation

Phase Four (Core Category Generation)

I imported the advanced memos as an *NVivo* dataset. I then conducted further axial coding,

alongside the previously imported focused codes. After Thornberg, I deliberately coded both the

---

[12] To ensure confidentiality, I have deliberately re-pseudonymized this illustration with a name unrelated
any of my participant groups.

interview data and literature in the same *NVivo* project, generating core categories.[13] I preserved

the audit trail throughout (see Figure 12).

Figure 12 Core Category Generation

I subsequently created *NVivo* nodes, allocating material to individual chapters (see

Figure 13). The identifiers I created in the thesis text as in 'Charlie C23' (Section 3.1)

completed the audit trail.

Figure 13 *NVivo* Nodes and Thesis Chapters

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[13] Thornberg, pp. 249, 51-52.

Appendix E: Interview Schedule

Mersey Care **NHS**

NHS Trust

Research Ethics Committee   North East – Newcastle and North Tyneside 1

Version   1

Date   06/08/15

R&D reference number: 2015/17

Service User Identification Number (where appropriate):

Interview Schedule

Please note this is a checklist. As the research will be based on "grounded theory", predefined questions would be unsuitable. The questions will instead emerge from interview to interview.

In practice, interviews will flow less formally than this list might suggest but key areas will be covered.

Preliminaries

	Item	Purpose	Examples/prompts
1.	Welcome	To introduce self (where necessary) and establish (confirm) relationship with participant so that they feel at ease. Reminder that will involve up to an hour's interview.	
2.	Re-establishment of consent and of right to withdraw	To ensure that informed consent has taken placed and to put participant at ease.[1]	
3.	Consent to tape	Reminder that interview will be taped and that tape can be paused, stopped, destroyed. **TAPE ON**.[1]	
4.	Reference to Information Sheet	To further check that the participant is giving informed consent and to address any issues or concerns.	

---

[1] If consent is given. If consent is not given, debriefing to occur at this point.

Item	Purpose	Examples/prompts
5. Confidentiality	Check that terms of confidentiality are clearly understood.	

Introduction

Item	Purpose	Examples/prompts
6. Setting in context	Research title: 'Perspectives on the relationship between statutory mental health services and faith communities: a co-produced constructivist grounded theory study.'	Thank you.
7. Verification	To check what contact (if any) the participant has with faith communities.	Have you been involved at any stage with a faith community (or communities)?
8. Clarification	Checking the researcher and participant have a reasonable shared understanding of what faith communities are.	Can I just check we both have roughly the same understanding of what we are talking about. The people who attend a church or mosque or similar would belong to a faith community.
9. Opportunity	Because this is action research, it is vital that participants shape the structure of the enquiry rather than simply answer questions to a predetermined hypothesis.	Do feel free to use our time together to discuss any issues you feel are important about faith communities and mental health.
10. Validation	To draw on participant experience to ensure that we are focussed on how to improve services from a service user and carer perspective.	Are we talking about the things that are important to you personally?

Detail

In this section, we look in detail at the questions that are currently being asked. If a participant has rejected the question and answer approach, my plan is to ask them how any alternative approach that they suggest would influence their answers to the following questions.

Note, as this is "grounded theory", the questions serve only as illustrations.

Item	Purpose	Examples/prompts
11. Exploration of the status quo.	To check participant's understanding of how things are at present.	Do you consider that present arrangements between mental health services and faith communities are the best possible arrangement for service users and carers?
12. Exploration of possible improvements.	To see what participants would welcome in the ideal world.	What do you think would work better?
13. Concerns/safeguards	Check for concerns.	Do you think there would be any disadvantages to what you suggest? Would you have any concerns.

Conclusion

Item	Purpose	Examples/prompts
14. Opportunity for supplementary questions.	Provides a chance to further capture service user experience.	Are there any other aspects of the relationship between faith communities and mental health services that you would like to discuss?
15. Debriefing	To maximise the likelihood that the participant feels that they have been listened to and respected.	As we move towards the end of this interview, do you mind me asking if you have enjoyed it? How would you say that you are feeling at the moment?
16. Opportunity for support	To let the participant know where they might seek support.	If you find that anything discussed in the interview has caused you any concern, do feel free to ask a member of the nursing team or to discuss matters with any of the groups on the post-interview information sheet.

Item	Purpose	Examples/prompts
17. Confidentiality	Redefinition of confidentiality.	I will not be passing on to anyone anything that you have told me in the course of this interview.[2]
18. Consent and Data Protection	To confirm that informed consent has been obtained.	Just to double-check that you are happy for me to use the data from this interview for the purposes of this research? You may withdraw this at any stage.
19. Reflective practice	Review of interview and procedure thus far.	As we move towards the close of the interview, I would just like to ask you how you felt that the interview or other aspects of this research have gone from your point of view. I would be particularly interested to know if you've got any suggestions for improvement?
20. Conclusion of recording	To mark the formal end of the interview. **TAPE OFF.**	I'm now going to switch the recorder off which marks the end of the formal interview.
21. Thank you	To communicate to the participant that they have made a valuable contribution to this research and thank them for their time.	Thank you. [I have very much enjoyed exploring this with you]2. I believe that this research could make a real contribution to the quality of care received by our Trust and potentially nationally. Without genuinely hearing the views of service users, it is unlikely we will be able to provide the kind of service they want.

---

[2] If appropriate

Item	Purpose	Examples/prompts
22. Dismissal	To ensure that the participant is able to return to what they were doing and to leave the interview room in safety.	Unless there's anything else you would like to discuss outside the interview, I'm going to leave you now. Would you like me to walk back with you to [x location].

Appendix F: SWOT Analysis by Participant Group

The four tables below detail the frequencies of focused codes referencing strengths weakness, opportunities, and threats analysis analysed in Section 3.3.

Strengths

	MHSs	FCs	Other	Total
Carer	0	4	0	4
Faith	0	1	0	1
FBO	0	5	3	8
Patient	0	1	0	2
Staff	2	25	2	29
Total	**2**	**36**	**5**	**44**

Table 13 Focused Codes (Strengths)

Weaknesses

	MHSs	FCs	Other	Total
Carer	4	6	2	12
Faith	2	1	1	4
FBO	7	3	6	16
Patient	1	3	1	5
Staff	46	40	10	96
Total	**60**	**53**	**20**	**133**

Table 14 Focused Codes (Weaknesses)

Opportunities

	MHSs	FCs	Other	Total
Carer	0	2	1	3
Faith	0	5	8	13
FBO	0	9	8	17
Patient	0	2	1	3
Staff	1	12	10	23
Total	**1**	**30**	**28**	**59**

Table 15 Focused Codes (Opportunities)

Threats

	MHSs	FCs	Other	Total
Carer	2	0	2	4
Faith	1	0	2	3
FBO	1	0	8	9
Patient	1	0	1	2
Staff	1	4	5	10
Total	**6**	**4**	**18**	**28**

Table 16 Focused Codes (Threats)

Appendix G: Recommendations

In this section, I make recommendations under four self-explanatory headings: MHSs, FCs, Mental Health Chaplains, and Other Agencies. I group the first three by my three core categories and the ethics of co-production. As mentioned, in Section 7.1, I have deliberately avoided SMART targets. Proposals for research appear in the second half of Section 7.4.

Mental Health Services

My findings suggest that MHSs, FCs (and potentially other organizations) should work collaboratively, organizing services to address the surge in mental health problems. In implementing All Hands on Deck, MHSs should:

a) engage in high-level collaboration with FCs to rediscover value and deliver more effective, more compassionate services

b) consider FCs as assets and support them in improving their offer[1]

c) co-produce care planning to ensure that service users are supported in addressing 'religious and spiritual concerns and practices in their own terms'[2]

d) monitor and co-evaluate MHS–FC referral patterns

e) encourage staff to explore the phenomenon of Flair in training and reflexive practice.[3]

As Critical Friends, MHSs should:

a) rebalance Peplau's 'art and science' as a significant step towards addressing MHSs' target-driven culture and deficit-based perception of service users[4]

b) collaborate with FCs to address the results of aligning themselves with fact and value respectively

---

[1] Linking them to crisis teams or training them in *Mental Health First Aid* might be initial first steps; MHFA England.

[2] Walsh, McSherry, and Kevern, p. 162.

[3] Oxford University Press.

[4] Peplau, p. 8; Forrest and others, p. 53; Francis, p. 3.

c) work critically alongside FCs to ensure both are intrinsically healthy

d)   share learning as a readily achievable first step towards closer collaboration[5]

e) recognize that '"vocational people" need to "outbalance" those lacking vocation to avoid losing humanity'[6]

f) 'challenge entrenched positions'.[7]

As Partners in Health Promotion, MHSs should:

a) transfer resource from treatment to prevention and recovery to address the surge in mental health problems[8]

b) learn from FCs' 'greater understanding and commitment to communities'[9]

c) release nurses to help 'design pastoral care training'[10]

d) allow FCs to teach them interpersonal skills'[11]

e) learn from "FC leaders walking with their people at the heart of the issues that mattered the most and shouting out very loudly and clearly in society"[12]

f) recruitment and trust values could explicitly support staff with lived experience, harnessing insights from their 'mutable' identities to improve services.[13]

Considering the ethics of co-production, MHSs should:

a) recognize that co-production's worth does not lie chiefly in whether it makes MHSs or FCs more efficient[14]

---

[5] Pippa M116; Sharon C537.

[6] Charlie C346.

[7] Orla C54.

[8] Anonymized, senior manager.

[9] Odette C203.

[10] Odette M406.

[11] Otis M539.

[12] Sally C32.

[13] Kara, p. 131.

[14] Baxter, Mugglestone, and Maher, p. 12.

b) consider a more radical commitment to service users' and carers' vital insights in seeking safer services[15]

c) place service user agency rather than profitability centre stage.[16]

Faith Communities

As the sun sets on the welfare state, FCs like the moon, are becoming increasingly visible.[17] Though their total contribution is estimated at £3.3 billion, their diversity may prove their ultimate strength.[18] On present political trends, they could find themselves leading entire areas of provision. I envisage minster churches overseeing charity, as monasteries did in the Middle Ages.

In implementing All Hands on Deck, FCs should:

a) be more confident[19]

b) give prophetic and political support for MHSs around socioeconomic issues causing mental health problems

c) work regionally to develop links with MHSs

d) recognize the need for a Wilberforce-like individual to give FCs the necessary 'kick up the backside', get their own house in order, and 'tell the NHS it's off-message'[20]

e) consider PT's task as lying in service to the world.

As Critical Friends, FCs should:

a) seek faithfulness to their 'true form'[21]

b) recognize their 'true' forms may not be Constantinian in size (as shown by Renew Wellbeing, Strawberry Field, and L'Arche)

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[15] Ibid.

[16] Sullivan, p. 13.

[17] Merrill; Churches Together in the Merseyside Region, Introduction.

[18] Welby, p. 37.

[19] The C of E alone has more than 33,000 social action projects; The Church of England.

[20] Ophelia C898; C388.

[21] Fred C398.

c) denounce quick fixes, recognizing instead the need to repeatedly address inequalities arising from power imbalances (Leviticus 25.50-52)[22]

d) declare that either end of the expertise–compassion MHS–FC spectrum fails to recognize that we are 'treasure in clay jars' (II Corinthians 4.7)

e) implement co-produced joint planning for safeguarding and other relevant training as the norm

f) support Flair in inspiring effective community-transforming projects.

As Partners in Health Promotion, FCs should:

a) raise their game, looking for "a Moses vision of the promised land"[23]

b) ask 'what is the difference between the scourge of mental ill health and the scourge of slavery that led Wilberforce and social reformers'[24]

c) play their 'ethical role in campaigning against failing healthcare provision'[25]

d) 'do a lot more on health promotion', ranging from individual care to shaping thinking to organizing 'health fairs with […] stalls from voluntary organizations'[26]

e) invite MHS staff members to offer consultancy on their pastoral care or theology

f) alert 'hospital or residential establishment[s] to care shortfalls' thus lessening gaps in provision.[27]

In considering the ethics of co-production, FCs should:

a) co-produce Stepped Care with 'people who need extra help but don't meet referral threshold[s]'[28]

b) provide 'safe pathways away from MHSs', thus opening the door for Stepped Care[29]

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[22] Orwell.

[23] Sally C225.

[24] Orla M622.

[25] Fergus C317.

[26] Otis C258; C262.

[27] Otis C24.

[28] Craig M388.

[29] Serena C12.

c) supply pathways through volunteering to recovery and potential employment[30]

d) recognize that carers deserve to be valued

e) find in ordinary theology a ready ally, critiquing academic theology, PT, and positivism[31]

f) recognize their prophetic Christ-centred vocation (Matthew 28.18-20), rather than merely support social institutions.[32]

Mental Health Chaplains

Mental health chaplains and parish nurses are well-placed to support closer MHS–FC collaboration. Quoting Vanier and Swinton, 'the friendship that is given to us in Jesus calls us to move beyond mere inclusion towards belonging. To belong, you need to be missed'.[33] If chaplains can promote a synthesis of Mary and Martha (reflected in MHSs' and FCs' relative strengths), they may achieve far more than through conducting individual spiritual or pastoral care.[34] In implementing All Hands on Deck, mental health chaplains should:

a) help MHSs and FCs recognize that excess activity may paradoxically be a sign of despondency and exhaustion[35]

b) challenge FCs that are '"very ill-informed" about mental health' and support them in including mental health problems within their conversation.[36]

As Critical Friends, chaplains should:

a) embrace Kelly and Swinton's inclusive vision of 'chaplains working as agents of transformation collaboratively with other health and social care disciplines and

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[30] Or meaningful occupation, as appropriate.

[31] Astley, *Ordinary Theology*, pp. 2, 100.

[32] Hauerwas and Willimon, p. 94.

[33] pp. 100-01.

[34] Kelly and Swinton.

[35] Raffay, Follow the Leader, pp. 169-70.

[36] Sharon C167; C215.

agencies, including FCs, to help others to utilize their assets to promote individual and collective well-being'[37]

b)   address problems when FCs insensitively promise healing or MHSs create 'emotional deserts'[38]

c)   take the necessary steps to work with others to address systemic failure as in the Gosport Inquiry.[39]

As Partners in Health Promotion, chaplains should:

a)   embody their institutional role as bridge-builders[40]

b)   collaborate more deliberately with parish nurses, community development workers, and pastoral workers — not to mention people with lived experience and carers — to broker 'prototype posts'[41]

c)   support people around the time of discharge or (ideally as part of their discharge plan) to help them settle into a church (whether for social activities or worship).[42]

In considering the ethics of co-production, chaplains should:

a)   work more prophetically[43]

b)   work to mitigate MHSs' neglect of the contemporary equivalent of Jethro's second piece of advice to Moses: 'You should also look for able men [and women] among all the people […]; set such men [and women] over them as officers over thousands, hundreds, fifties, and tens' (Exodus 18.21)

c)   incorporate co-production within their teams and encourage other disciplines to do similarly

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[37] Kelly and Swinton.

[38] Fred C398; C388.

[39] Jones, Gosport Hospital.

[40] Craig M96; Pam C221.

[41] Odette M516; M541.

[42] Sally M32.

[43] Kelly and Swinton.

d) have conversations with chaplain colleagues, both elsewhere in the NHS and beyond, to explore co-production's wider relevance

e) address the charge that 'PT will always be vulnerable to the criticism of impracticality or uselessness unless it can really demonstrate what it achieves and that it is not simply going around in ever-complexifying methodological circles'.[44]

Other Agencies

Locally planned and ideally co-produced independent services should work alongside FCs and devolved statutory (or privatized) MHSs.[45] Ideally, MHSs and FCs would collaborate with these agencies. Such subsidiarity offers an approach akin to co-production. Based on 'the principle that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level', it potentially removes inefficient bureaucracies.[46] The not inconsiderable disadvantages of regional or local inequality may prove preferable to organizational megaliths.[47]

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[44] Woodward and Pattison, pp. 128-29.

[45] Here, it is difficult to offer detailed recommendations.

[46] Oxford University Press; Pope Pius XI.

[47] We see this where schools in wealthier localities typically have more able governors.

Appendix H: Data Map

Data map

Coding sheet
- File number ⊷
- Transcription
- Initial codes
- Advanced codes
- Initial memos
Passwords ABCDEF

Recording file
- File number ⊷
- Transcription date
- Transcription length
- Date
Winscribe® security

Relationships table
- File number ⊷
- Random number ⊷
Password H

Participant
(Random number ⊷)
Confidentiality

Purposive sampling form
- Random number ⊷
- Participant group
- Consent form date
- Open text field
Password H

Consent form
- Random number ⊷
- Participant group
- Name
Password H/ locket cabinet

Investigator site file
Locked cabinet

Summary of findings request form
- Name
- Address
- Email
Password H/ locked cabinet

Demographics tables (Durham and Mersey Care)
- Random number ⊷
- Age
- Ethnicity
Password H

Pseudonyms table
- File number ⊷
- Pseudonym ⊷
- File duration
- Participant group
Password G

Spreadsheet
- Pseudonym ⊷
- Advanced codes
- Initial memos
Password G

NVivo file
- Pseudonym ⊷
- Advanced codes
- Initial memos
- Nodes
Password G

Thesis

Publication(s)

Passwords file
Passwords ABCDEFGH
Cardiff University server

Key

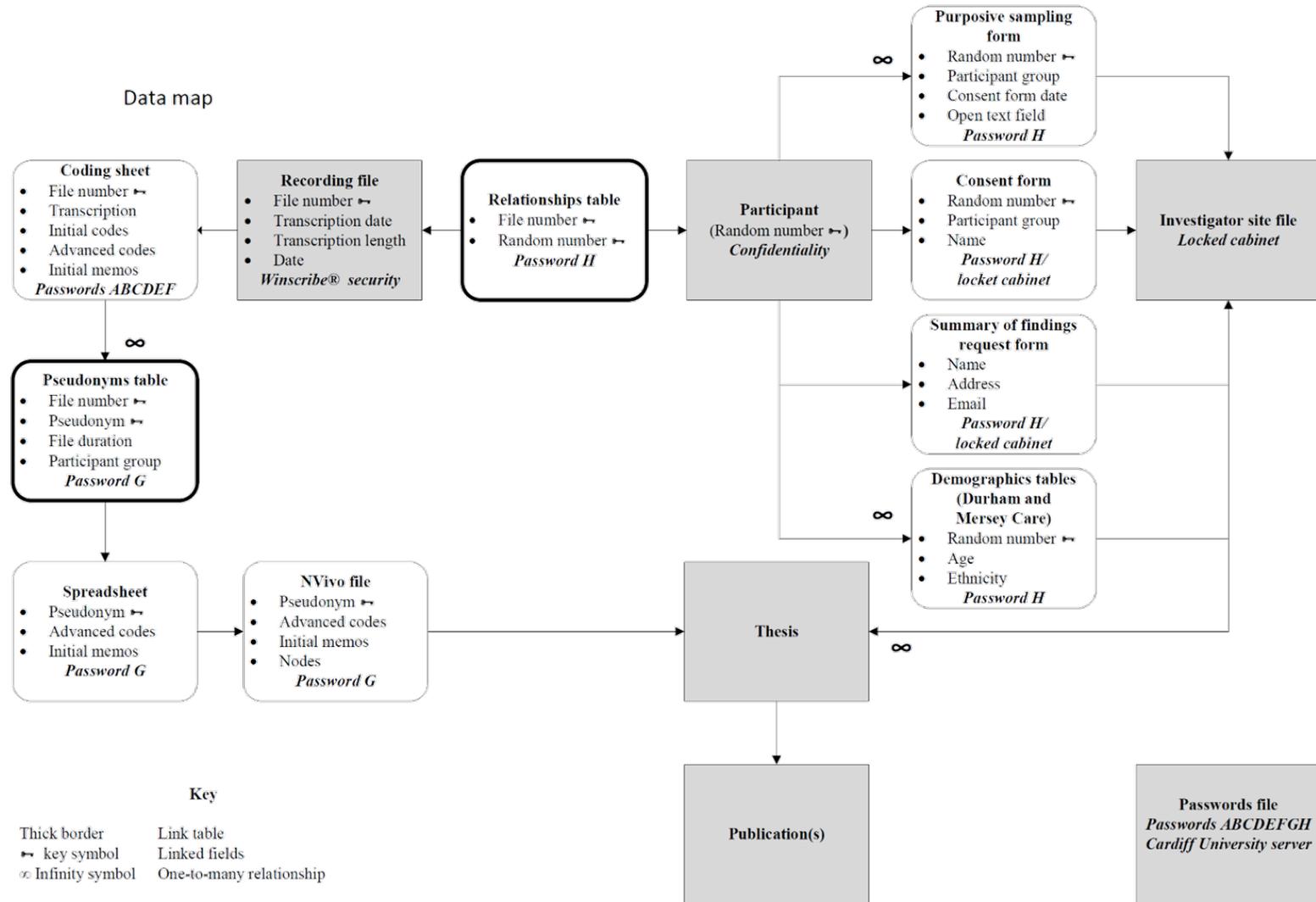|	
Thick border	Link table
⊷ key symbol	Linked fields
∞ Infinity symbol	One-to-many relationship

Figure 14 Data Map

Bibliography

Bible quotations are from the *New Revised Standard Version*, unless otherwise stated.

Abolaji, Sunoiki Olatunji, 'Evaluating a Novel Mental Health Training Programme with a Spirituality Dimension: How Is the Training Used in Practice?' (unpublished master's dissertation, University of Sheffield, 2013).

Akkerman, Sanne and others, 'Auditing Quality of Research in Social Sciences', *Quality and Quantity,* 42 (2008), 257–74.

Alibrahim, Abdullah, and Shinyi Wu, 'An Agent-Based Simulation Model of Patient Choice of Health Care Providers in Accountable Care Organizations', *Health Care Management Science,* 21 (2018), 131-43.

Alvesson, Mats, and Kaj Sköldberg, *Reflexive Methodology: New Vistas for Qualitative Research*. 2nd edn (London: Sage, 2009).

American Friends Service Committee, *Speak Truth to Power: A Quaker Search for an Alternative to Violence* (Philadelphia, PA: American Friends Service Committee, 1955).

Anonymized, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool: 2017).

——, "I'm a Human Being", ed. by Julian Raffay (Mersey Care Life Rooms Focus Group: 2017).

——, 'Senior Management Team ', ed. by Julian Raffay (Liverpool: 2017).

Archbishops' Council, '"Setting God's People Free": A Report from the Archbishops' Council' (London: Archbishops' Council, 2017).

Arnstein, Sherry, 'A Ladder of Citizen Participation', *Journal of the American Institute of Planners,* 35 (1969), 216-24.

Ashworth, Denise, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool: 2017).

Astley, Jeff, Ordinary Theology: Looking, Listening and Learning in Theology, Explorations in Pastoral, Practical and Empirical Theology (Farnham: Ashgate, 2002).

——, *SCM Studyguide to Christian Doctrine* (London: SCM, 2010).

Bailey, Kenneth E., *Jesus through Middle Eastern Eyes* (Downers Grove, IL: InterVarsity Press, 2008).

Banicki, Konrad, 'Positive Psychology on Character Strengths and Virtues. A Disquieting Suggestion', *New Ideas in Psychology,* 33 (2014), 21-34.

Banks, Sarah, I. Ferguson, and M. Lavalette, 'Reclaiming Social Work Ethics: Challenging the New Public Management', *Ethics,* 20 (2014), 1-23.

Barker, Philip J., 'The Tidal Model: Psychiatric Colonization, Recovery and the Paradigm Shift in Mental Health Care', *International Journal of Mental Health Nursing,* 12 (2003), 96-102.

Barker, Philip J., and Poppy Buchanan-Barker, 'All Hands to the Pumps: Group Care', in *The Tidal Model: A Guide for Mental Health Professionals* (Hove: Brunner-Routledge, 2005), pp. 159-75.

Barnes, Helen, 'Does Mental Illness Have a Place Alongside Social and Recovery Models of Mental Health in Service Users' Lived Experiences? Issues and Implications for Mental Health Education', *The Journal of Mental Health Training, Education, and Practice,* 6 (2011), 65-75.

Barnes, Marian, and Phil Cotterell, 'From Margin to Mainstream', in *Critical Perspectives on User Involvement* (Bristol: The Policy Press, 2012), pp. xv-xxvi.

Barnsley, Jennie, 'Grounded Theology: Adopting and Adapting Qualitative Research Methods for Feminist Theological Enquiry', *Feminist Theology,* 24 (2016), 109-24.

Bartley, Mel, *Health Inequality: An Introduction to Concepts, Theories and Methods*. Second edn (Cambridge: Polity Press, 2017).

Baxter, Helen, Mark Mugglestone, and Lynne Maher, *The Experience Based Design Approach: Concepts and Case Studies* (Aldridge: NHS Institute for Innovation and Improvement, 2010).

Bayes, Paul, *The Table: Knowing Jesus: Prayer, Friendship, Justice* (London: Darton,Longman & Todd, 2019).

BBC News (30 March 2018), 'Facebook 'Ugly Truth' Growth Memo Haunts Firm', British Broadcasting Corporation <http://www.bbc.co.uk/news/technology-43594959> [Accessed 2 April 2018].

Beauchamp, Tom L., and James F. Childress, *Principles of Biomedical Ethics*. 7th edn (Oxford: Oxford University Press, 2013).

Beaudoin, Tony, 'Why Does Practice Matter Theologically?', in *Conundrums in Practical Theology: Theology in Practice*, ed. by Bonnie J. Miller-McLemore and Joyce Mercer (Boston, MA: Brill, 2016), pp. 8-32.

Belenky, Mary, *Women's Ways of Knowing: The Development of Self, Voice, and Mind*. 10th anniversary edn (New York: Basic Books, 1986).

Benson, Iris, 'Annual General Meeting' (Aintree: Mersey Care NHS Foundation Trust, 2018).

Bentley, Tom, and James Wilsdon, eds., *The Adaptive State: Strategies for Personalising the Public Realm* (London: Demos, 2003).

Beresford, Peter, 'Mad Studies Brings a Voice of Sanity to Psychiatry' (2014) <https://www.theguardian.com/society/2014/oct/07/mad-studies-voice-of-sanity-psychiatry> [Accessed 6 September 2018].

——, 'User Involvement, Research and Health Inequalities: Developing New Directions', *Health and Social Care in the Community,* 15 (2007), 306-12.

Beresford, Peter, and Fran Branfield, 'Building Solidarity, Ensuring Diversity', in *Critical Perspectives on User Involvement*, ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012).

Beresford, Peter, and Sarah Carr, eds., *Social Care, Service Users and User Involvement*, *Research Highlights* (London: Jessica Kingsley, 2012).

Berne, Eric, *Games People Play: The Psychology of Human Relationships* (London: Penguin, 2010).

Bhugra, Dinesh, and Alex Carlile, 'Starting Today – the Future of Mental Health Services' (London: Mental Health Foundation, 2013).

Blake, Robert R., Jane S. Mouton, and Alvin C. Bidwell, 'Managerial Grid', *Advanced Management - Office Executive,* 1 (1962), 12-15.

Block, Peter, Walter Brueggemann, and John McKnight, *An Other Kingdom: Departing the Consumer Culture* (Hoboken, NJ: Wiley, 2016).

Bonhoeffer, Dietrich, *Life Together* (London: SCM Press, 1954).

Borrell-Carrio, F., A. L. Suchman, and R. M. Epstein, 'The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry', *Annals of Family Medicine,* 2 (2004), 576-82.

Bovaird, Tony, and Elke Loeffler, 'We're All in This Together: Harnessing User and Community Co-Production of Public Outcomes' (Birmingham: 2013).

Boyle, David and others, 'Right Here, Right Now: Taking Co-Production into the Mainstream' (London: NESTA, 2010).

Boyle, David, Julia Slay, and Lucie Stephens, 'Public Services Inside Out: Putting Co-Production into Practice' (London: NESTA, 2010).

Brennan, Damien, 'A Consideration of the Social Trajectory of Psychiatric Nursing in Ireland', *Journal of Psychiatric and Mental Health Nursing,* 11 (2004), 494-501.

Briggs, Richard S., 'Biblical Hermeneutics and Practical Theology: Method and Truth in Context', *Anglican Theological Review,* 97 (2015), 201-17.

Britain Yearly Meeting, *Quaker Faith & Practice: The Book of Christian Discipline of the Yearly Meeting of the Religious Society of Friends (Quakers) in Britain.* 5th edn (London: Religious Society of Friends (Quakers), 2018).

Brown, Louise, 'Forever Strawberry Field', The Salvation Army (2018) <http://www.strawberryfieldliverpool.com/> [Accessed 31 August 2018].

——, 'The Vision', The Salvation Army (2018) <http://www.strawberryfieldliverpool.com/vision> [Accessed 31 August 2018].

Brueggemann, Walter, *Redescribing Reality: What We Do When We Read the Bible* (London: SCM Press, 2009).

Brunner, Emil, *Dogmatik I: Die Christliche Lehre Von Gott* (Zurich: Zwingli-Verlag, 1959).

Buchanan-Barker, Poppy, and Philip J. Barker, 'The Tidal Commitments: Extending the Value Base of Mental Health Recovery', *Journal of Psychiatric and Mental Health Nursing,* 15 (2008), 93–100.

Buck, Deborah and others, 'From Plans to Actions in Patient and Public Involvement: Qualitative Study of Documented Plans and the Accounts of Researchers and Patients Sampled from a Cohort of Clinical Trials', *British Medical Journal Open,* 4 (2014), 1-19.

Burkhart, Lisa, and Nancy Hogan, 'An Experiential Theory of Spiritual Care in Nursing Practice', *Qualitative Health Research,* 18 (2008), 928-38.

Cahn, Edgar, *No More Throw-Away People: The Co-Production Imperative* (Washington, DC: Essential Books, 2000).

Cameron, Helen, '"Life in All Its Fullness" Engagement and Critique: Good News for Society', *Practical Theology,* 5 (2012), 11-26.

Cameron, Helen and others, *Talking About God in Practice: Theological Action Research and Practical Theology* (London: SCM Press, 2010).

Cameron, James, 'Titanic' (20th Century Fox, 1997).

Cameron, William Bruce, *Informal Sociology: A Casual Introduction to Sociological Thinking* (New York: Random House, 1963).

Care Quality Commission, 'Calderstones Partnership NHS Foundation Trust Quality Report' ([London]: Care Quality Commission, 2014).

——, 'The Essential Standards', Care Quality Commission (2015) <http://www.cqc.org.uk/content/essential-standards> [Accessed 30 May 2015,].

Carroll, Lewis, *Alice's Adventures in Wonderland* (New York: Millenium, 2014).

Castle, Tony, *Gateway to the Trinity: Meditations on Rublev's Icon* (Slough: St. Paul, 1988).

Catholic Institute for International Relations, *The Road to Damascus: Kairos and Conversion* (London: CIIR, 1990).

Chambers, Mary and others, 'The Experiences of Detained Mental Health Service Users: Issues of Dignity in Care', *BMC Medical Ethics,* 15 (2014), 1-8.

Champ, Simon, 'Questionnaires from the Heart: National Agendas and Private Hopes', *Nurse Researcher,* 9 (2002), 20-29.

Chan, Cindy and others, 'Narratives of Adults with a Learning Disability and Autism Living within a Secure Forensic Setting', *Good Autism Practice,* 18 (2017), 58-71.

Charities Aid Foundation, 'CAF World Giving Index 2016' (London: Charities Aid Foundation, 2016).

Charmaz, Kathy, *Constructing Grounded Theory*. 2nd edn, Introducing Qualitative Methods Series (London: Sage, 2014).

Church, Kathryn, and David Reville, 'User Involvement in the Mental Health Field in Canada', *Canada's Mental Health,* 37 (1989), 22-25.

Church of England, *Common Worship: Ordination Services*. Study edn (London: Church House, 2007).

——, 'More Than 900 Reports of Potential Modern Slavery Recorded through App', Church of England (2019) <https://www.churchofengland.org/more/media-centre/more-900-reports-potential-modern-slavery-recorded-through-app> [Accessed 8 April 2019].

Churches Together in the Merseyside Region, 'Refugees, Asylum Seekers & Migrants: Welcoming the Stranger' (Liverpool: CTMR, 2016).

Cinnamon Network, 'Cinnamon (2016) Faith Action Audit' (London: Cinnamon Network, 2016).

Circles UK, 'Circles UK', Circles UK (2019) <https://www.circles-uk.org.uk/> [Accessed 12 February 2019].

Clayson, Amanda and others, 'When Two Worlds Collide: Critical Reflection on Co-Production', *Drugs and Alcohol Today* (2018).

Coalition for Collaborative Care, 'A Co-Production Model: Five Values and Seven Steps to Make This Happen in Reality', NHS England <http://coalitionforcollaborativecare.org.uk/a-co-production-model/> [Accessed 11 February 2019].

Coffey, Amanda, and Paul Atkinson, *Making Sense of Qualitative Data: Complementary Research Strategies* (London: Sage, 1996).

Cook, Christopher C. H., *Hearing Voices, Demonic and Divine: Scientific and Theological Perspectives* (Abingdon: Routledge, 2019).

——, 'Spirituality, Secularity and Religion in Psychiatric Practice: Commentary On ... Spirituality and Religion in Psychiatric Practice', *Psychiatrist,* 34 (2010), 193-95.

Cooke, Anne, ed., *Understanding Psychosis and Schizophrenia: Why People Sometimes Hear Voices, Believe Things That Others Find Strange, or Appear out of Touch with Reality, and What Can Help* (Leicester: The British Psychological Society, 2014).

Copeland, Mary Ellen, *Wellness Recovery Action Plan*. Rev. edn (West Dummerston, VT: Peach Press, 2000).

Corbett, Martin, 'From Law to Folklore: Work Stress and the Yerkes-Dodson Law', *Journal of Managerial Psychology,* 30 (2015), 741-52.

Corbin, Juliet, and Anselm Strauss, *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. 3rd edn (London: Sage, 2008).

Costa, Arthur L., and Bena Kallick, 'Through the Lens of a Critical Friend', *Educational Leadership,* 51 (1993), 49-51.

Cox, Laura, 'The Bullying and Harassment of House of Commons Staff: Independent Inquiry Report' ([n.p.]: [n. pub.], 2018).

Cox, Nigel, Amanda Clayson, and Lucy Webb, 'A Safe Place to Reflect on the Meaning of Recovery: A Recovery Community Co-Productive Approach Using Multimedia Interviewing Technology', *Drugs and Alcohol Today,* 16 (2016), 4-15.

Crain, Margaret Ann, and Jack L. Seymour, 'The Ethnographer as Minister: Ethnographic Research in Ministry', *Religious Education,* 91 (1996), 299-315.

Crawford, Mike and others, 'Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services. NICE Clinical Guideline 136' (Manchester: National Institute for Health and Care Excellence, 2011).

Crepaz-Keay, David, 'Evaluating Service-User Involvement in Mental Health Services', in *Empowerment, Lifelong Learning and Recovery in Mental Health: Towards a New Paradigm*, ed. by Peter Ryan and others (Basingstoke: Palgrave MacMillan, 2012), pp. 146-53.

Creswell, John W., and Dana L. Miller, 'Determining Validity in Qualitative Inquiry', *Theory Into Practice,* 39 (2000), 124-30.

Critical Appraisal Skills Programme, 'CASP Qualitative Review Checklist' (2015) <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf> [Accessed 16 May 2015] [2015].

Cross, F. L., and E. A. Livingstone, eds., *The Oxford Dictionary of the Christian Church*. 2nd edn (Oxford: Oxford University Press, 1983).

D'Costa, Gavin, *The Meeting of Religions and the Trinity* (Edinburgh: T&T Clark).

De La Torre, Miguel A., *Doing Christian Ethics from the Margins*. 2nd edn (Maryknoll, NY: Orbis Books, 2014).

——, 'Introduction', in *Ethics: A Liberative Approach*, ed. by Miguel De La Torre (Minneapolis, MN: Fortress, 2013).

de Sousa Santos, Boaventura, *Epistemologies of the South: Justice against Epistemicide* (London: Routledge, 2016).

Deegan, Patricia, 'Recovery, Rehabilitation and the Conspiracy of Hope: A Keynote Address' (Lawrence, MA: National Empowerment Center, 1987).

Department for Communities and Local Government, 'Ensuring a Level Playing Field' (London: Department for Communities and Local Government, 2010).

Department for Health and Social Care, 'The NHS Constitution for England' (London: DHSC, 2015).

Department of Health, 'Culture Change in the NHS' (London: Department of Health, 2016).

——, 'Our Health, Our Care, Our Say: A New Direction for Community Services' (Norwich: The Stationery Office, 2006).

——, 'Transforming Care: A National Response to Winterbourne View Hospital' (London: Department of Health, 2012).

Dickens, Charles, *Oliver Twist* (London: Penguin, 2012).

Dillon, Kyle D., and Fiery Cushman, 'Agent, Patient … Action! What the Dyadic Model Misses', *Psychological Inquiry,* 23 (2012), 150-54.

Dimond, Bridgit, 'The Mental Capacity Act 2005: Mental Capacity and Mental Illness', *British Journal of Nursing,* 17 (2008), 182-4.

Drew, John, 'Drew Review: An Independent Review of South Yorkshire Police's Handling of Child Sexual Exploitation (1997 – 2016)' ([n.p.]: [n. pub.], 2016).

Duncan, Barry L. and others, *The Heart and Soul of Change: Delivering What Works in Therapy*. 2nd edn (Washington, DC: American Psychological Association, 2010).

Durose, Catherine, and Liz Richardson, *Designing Public Policy for Co-Production: Theory, Practice and Change* (Bristol: Policy Press, 2016).

Engel, George L., 'The Need for a New Medical Model: A Challenge for Biomedicine', *Science,* 196 (1977), 129-36.

England, Kersten, 'Health and Well-Being in Britain', in *On Rock or Sand: Firm Foundations for Britain's Future*, ed. by John Sentamu (London: SPCK, 2015), pp. 132-59.

Faith Action, 'Friendly Places: Mental Health', Faith Action (2019) <http://www.faithaction.net/working-with-you/health-and-care/our-projects/friendly-places/> [Accessed 12 February 2019].

Fenton, Siobhan, 'Majority of Britons 'Uncomfortable' Letting Someone with Mental Illness Look after Their Child, Study Finds', Independent Digital News and Media (2016) <https://www.independent.co.uk/life-style/health-and-families/health-news/mental-health-problems-illness-british-social-attitudes-survey-britons-children-marriage-stigma-a7170281.html> [Accessed 12 March 2018].

Ferguson, Kath, *Time to Act: Choosing to Work in Mental Health: The Recruitment of Health and Social Care Professionals* (Mansfield: University of Lincoln, 2005).

Fernandez, Ana and others, 'Evidence-Based Medicine: Is It a Bridge Too Far?', *Health Research Policy and Systems,* 13 (2015), 1-9.

Fisher, Pamela, and Victoria Byrne, 'Identity, Emotion and the Internal Goods of Practice: A Study of Learning Disability Professionals', *Sociology of Health and Illness,* 34 (2012), 79-94.

Flatt, Stephen, 'Making Use of Models of Healthcare Chaplaincy', in *Critical Care: Delivering Spiritual Care in Healthcare Contexts*, ed. by Peter Sedgwick and others (London: Jessica Kingsley, 2015), pp. 37-50.

Foley, Tom, 'Bridging the Gap: The Financial Case for a Reasonable Rebalancing of Health and Care Resources' (London: The Royal College of Psychiatrists, 2013).

Forbat, Liz, 'Practitioner Views on Service User Involvement in Mental Health: Rhetoric and Contradictions', *The Journal of Mental Health Training, Education and Practice,* 1 (2006), 24-31.

Ford, David, *The Shape of Living: Spiritual Directions for Everyday Life* (London: Canterbury Press, 2012).

Forrest, Susanne and others, 'Mental Health Service User Involvement in Nurse Education: Exploring the Issues', *Journal of Psychiatric and Mental Health Nursing,* 7 (2000), 51-57.

Foskett, John, James Marriott, and Fay Wilson-Rudd, 'Mental Health, Religion and Spirituality: Attitudes, Experience and Expertise among Mental Health Professionals and Religious Leaders in Somerset', *Mental Health, Religion and Culture,* 7 (2004), 5-22.

Foucault, Michel, *The Birth of the Clinic* (Abingdon: Routledge, 2012).

——, *Madness and Civilization: A History of Insanity in the Age of Reason.* trans. Richard Howard (London: Routledge, 2001).

Francis, Robert, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary (London: The Stationery Office, 2013).

Frankl, Viktor, *Man's Search for Meaning: An Introduction to Logotherapy.* Rev. and enlarged edn (London: Hodder and Stoughton, (1987 printing), 1962).

Frears, Stephen, 'Philomena' (Venice: Pathé, 2013).

Freire, Paulo, *Pedagogy of the Oppressed.* Rev. edn (London: Penguin, 1996).

Freud, Sigmund, James Strachey, and Angela Richards, *Introductory Lectures on Psychoanalysis, Volume 1.* 2nd edn (London: Pelican, 1973).

Fugini, Mariagrazia, Enrico Bracci, and Mariafrancesca Sicilia, eds., *Co-Production in the Public Sector: Experiences and Challenges* (London: Springer, 2016).

Gafni, A., C. Charles, and T. Whelan, 'The Physician-Patient Encounter: The Physician as a Perfect Agent for the Patient Versus the Informed Treatment Decision-Making Model', *Social Science and Medicine,* 47 (1998), 347-54.

Garven, Fiona, Jennifer McLean, and Lisa Pattoni, *Asset-Based Approaches: Their Rise, Role and Reality* (Edinburgh: Dunedin, 2016).

Geertz, Clifford, *The Interpretation of Cultures* (New York: Basic Books, 1973).

Glaser, Barney, and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (London: Weidenfeld & Nicolson, 1968).

——, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Chicago, IL: Aldine, 1967).

Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmate*s (New York: Anchor, 1961).

——, *Stigma: Notes on the Management of Spoiled Identity* (London: Penguin, 1990).

Gorsky, Martin, ''Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry', *Medical History,* 57 (2013), 87-107.

Graham, Elaine, 'The State of the Art: Practical Theology Yesterday, Today and Tomorrow', *Theology,* 120 (2017), 172-80.

Green, C. A. and others, 'Understanding How Clinician-Patient Relationships and Relational Continuity of Care Affect Recovery from Serious Mental Illness: STARS Study Results', *Psychiatric Rehabilitation Journal,* 32 (2008), 9-22.

Green, Laurie, *Let's Do Theology: Resources for Contextual Theology.* Completely revised and updated new edn (London: Mowbray, 2009).

Green, Stephen, 'Talent Management for Future Leaders and Leadership Development for Bishops and Deans: A New Approach' (London: Archbishops and the Development and Appointments Group, 2014).

Greene-McCreight, Kathryn, *Darkness Is My Only Companion: A Christian Response to Mental Illness*. Revised and Expanded edn (Grand Rapids, MI: Brazos Press, 2015).

Greenfield, Patrick, and Sara Marsh, 'Deaths of UK Homeless People More Than Double in Five Years', Guardian News and Media (2018) <https://www.theguardian.com/society/2018/apr/11/deaths-of-uk-homeless-people-more-than-double-in-five-years> [Accessed 3 January 2019].

Greenwood, Davydd, J., and Morten Levin, *Introduction to Action Research* (London: Sage, 2007).

Griffiths, Sir Roy, *Community Care: Agenda for Action* (London: Her Majesty's Stationery Office, 1988).

Gurioan, Vigen, 'Love in Orthodox Ethics: Trinitarian and Christological Reflections', *CrossCurrents,* 33 (1983), 181-97.

Gutiérrez, Gustavo, *We Drink from Our Own Wells: The Spiritual Journey of a People* (Maryknoll, NY Orbis, 2003).

Hague, William, *William Wilberforce: The Life of the Great Anti-Slave Trade Campaigner* (London: Harper Perennial, 2008).

Hall, Daniel E., 'The Guild of Surgeons as a Tradition of Moral Enquiry', *Journal of Medicine and Philosophy,* 36 (2011), 114-32.

Halliburton, Murphy, 'The Importance of a Pleasant Process of Treatment: Lessons on Healing from South India', *Culture, Medicine and Psychiatry,* 27 (2003), 161-86.

Hallsworth, Michael, and Hannah Burd, 'Spreading Change: A Guide to Enabling the Spread of Person- and Community-Centred Approaches for Health and Wellbeing' (London: Nesta, 2016).

Handy, Charles, *Understanding Organizations* (Oxford: Oxford University Press, 1993).

Hart, Chris, *Doing a Literature Review: Releasing the Social Science Research Imagination* (London: Sage, 1998).

Hauerwas, Stanley, and William H. Willimon, *Resident Aliens: Life in the Christian Colony* (Nashville, TN: Abingdon Press, 1989).

Health and Social Care Information Centre, 'Inpatients Formally Detained in Hospitals under the Mental Health Act 1983, and Patients Subject to Supervised Community Treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16' (Leeds: Health and Social Care Information Centre, 2016).

Heaney, Seamus, *Opened Ground: Poems, 1966-1996* (London: Faber, 2002).

Hedges, Mark, and Stuart Dunn, *Academic Crowdsourcing in the Humanities: Crowds, Communities and Co-Production* (Kidlington: Chandos, 2018).

Hill, Alison, 'From the Patient's Perspective', in *What's Gone Wrong with Health Care?: Challenges for the New Millennium* (London: King's Fund, 2000), pp. 27-39.

Hinings, C. R. (Bob), and Michael K. Mauws, 'Organizational Morality', in *Church Ethics and Its Organizational Context: Learning from the Sex Abuse Scandal in the Catholic Church*, ed. by Jean M. Bartunek and others (Oxford: Sheed and Ward, 2006), pp. 115-22.

HM Government, 'Care Act 2014' (London: The Stationery Office, 2014).

'Holy Bible, New International Version - Anglicized', Biblica (2011) <https://www.biblegateway.com> [Accessed 31 May 2018].

Horgan, Áine, 'Review: Service User Involvement in the Evaluation of Psycho-Social Intervention for Self-Harm: A Systematic Literature Review', *Journal of Research in Nursing,* 18 (2012), 131-32.

Horton, John, and Susan Mendus, *After MacIntyre: Critical Perspectives on the Work of Alasdair MacIntyre* (Cambridge: Polity, 1994).

Hui, Ada, and Theodore Stickley, 'Mental Health Policy and Mental Health Service User Perspectives on Involvement: A Discourse Analysis', *Journal of Advanced Nursing,* 59 (2007), 416-26.

Hull, John M., 'A Spirituality of Disability: The Christian Heritage as Both Problem and Potential', *Studies in Christian Ethics,* 16 (2003), 21-35.

——, *Touching the Rock: An Experience of Blindness* (London: SPCK, 1990).

Ikkos, George, 'Mental Health Service User Involvement: Teaching Doctors Successfully', *Primary Care Mental Health,* 3 (2005), 139-44.

INVOLVE, 'Payment for Involvement: A Guide to Making Payments to Members of the Public' (Eastleigh: NIHR/INVOLVE, 2010).

Islam, Zoebia, Fatemeh Rabiee, and Swaran P. Singh, 'Black and Minority Ethnic Groups' Perception and Experience of Early Intervention in Psychosis Services in the United Kingdom', *Journal of Cross-Cultural Psychology,* 46 (2015), 737-53.

Johnsson, Linus and others, 'Making Researchers Moral: Why Trustworthiness Requires More Than Ethics Guidelines and Review', *Research Ethics,* 10 (2014), 29-46.

Jones, James, 'Gosport War Memorial Hospital: The Report of the Gosport Independent Panel' ([London]: Gosport Independent Panel, 2018).

——, 'The Patronising Disposition of Unaccountable Power' (London: HMSO, 2017).

Jones, Ray, 'Scanning the Horizon: Hopes and Fears for the Future of Children's Social Services and Social Work', in *I4P Public Event: Statutory Social Work with Children,* ed. by Institute for Public Policy and Professional Practice (Edge Hill: Edge Hill University, 2018).

Kalathil, Jayasree, 'Dancing to Our Own Tunes: Reassessing Black and Minority Ethnic Mental Health Service User Involvement' (London: National Survivor User Network in collaboration with Catch-a-Fiya, 2008).

Kara, Helen, 'Mental Health Service User Involvement in Research: Where Have We Come from, Where Are We Going?', *Journal of Public Mental Health,* 12 (2013), 122-35.

Kelly, Ewan, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool: 2018).

Kelly, Ewan, and John Swinton, *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care* (London: Jessica Kingsley, 2020).

Kempster, Steve, Brad Jackson, and Mervyn Conroy, 'Leadership as Purpose: Exploring the Role of Purpose in Leadership Practice', *Leadership,* 7 (2011), 317–34.

Kendall, Tim and others, 'Quality, Bias and Service User Experience in Healthcare: 10 Years of Mental Health Guidelines at the UK National Collaborating Centre for Mental Health', *International Review of Psychiatry,* 23 (2011), 342-51.

Kesey, Ken, *One Flew over the Cuckoo's Nest: A Novel* (London: Penguin, 2005).

Kevern, Peter, 'Ageing, Religion and (in)Equality', in *Ageing, Diversity and Equality: Social Justice Perspectives*, ed. by Sue Westwood (Abingdon: Routledge, 2018), pp. 210-22.

——, 'The Grace of Foolishness: What Christians with Dementia Can Bring to the Churches', *Practical Theology,* 2 (2009), 205-18.

Kevern, Peter, and Lisa Hill, 'Chaplains for Well-Being in Primary Care: Analysis of the Results of a Retrospective Study', *Primary Health Care Research and Development,* 16 (2015), 87-99.

Keyes, Corey, 'The Mental Health Continuum: From Languishing to Flourishing in Life', *Journal of Health and Social Behaviour,* 43 (2002), 207-22.

Kilby, Karen, 'Perichoresis and Projection: Problems with Social Doctrines of the Trinity', *New Blackfriars,* 81 (2000), 432-45.

Kinderman, Peter, *A Prescription for Psychiatry: Why We Need a Whole New Approach to Mental Health and Wellbeing* (Basingstoke: Palgrave Macmillan, 2014).

King's Fund, 'The Patient-Centred Care Project: Evaluation Report' (London: The King's Fund, 2011).

Kirkup, Bill, 'Report of the Liverpool Community Health Independent Review' ([n.p.]: Liverpool Community Health Independent Review, 2018).

Kitwood, Tom M., *Dementia Reconsidered: The Person Comes First*, *Rethinking Ageing* (Buckingham: Open University Press, 1997).

Koenig, Harold G., *Religion and Mental Health: Research and Clinical Applications* (London: Academic Press, 2018).

Koestenbaum, Peter, *Leadership: The Inner Side of Greatness: A Philosophy for Leaders*. New rev. edn (San Francisco: Jossey-Bass, 2002).

Kreitzer, M. J. and others, 'Buurtzorg Nederland: A Global Model of Social Innovation, Change, and Whole-Systems Healing', *Global Advances in Health and Medicine,* 4 (2015), 40-4.

Kristiansen, Arne, 'Rainbow Quality System: User-Led Innovation in Quality Assurance', in *Social Care, Service Users and User Involvement*, ed. by Peter Beresford and Sarah Carr (London: Jessica Kingsley, 2012), pp. 84-95.

Kuennsberg, Laura, 'Theresa May Is Asked Where NHS Cash Will Come From', BBC (2018) <https://www.bbc.co.uk/news/av/uk-politics-44524603/theresa-may-is-asked-where-nhs-cash-will-come-from> [Accessed 20 June 2018].

Lakeman, Richard, 'Talking Science and Wishing for Miracles: Understanding Cultures of Mental Health Practice', *International Journal of Mental Health Nursing,* 22 (2013), 106-15.

Lampard, Kate, and Ed Marsden, 'Themes and Lessons Learnt from NHS Investigations into Matters Relating to Jimmy Savile' (London: Department of Health, 2015).

Lartey, Emmanuel, 'Practical Theology as a Theological Form', in *The Blackwell Reader in Pastoral and Practical Theology*, ed. by James Woodward and Stephen Pattison (Oxford: Blackwell, 2000), pp. 128-34.

Leach, Jane, 'Pastoral Theology as Attention', *Contact,* 153 (2007), 19-32.

——, 'Power and Vulnerability', in *Creative Supervision across Modalities: Theory and Applications for Therapists, Counsellors and Other Helping Professionals*, ed. by Anna Chesner and Lia Zografou (London: Jessica Kingsley, 2014), pp. 145-60.

Leavey, Gerard, 'U.K. Clergy and People in Mental Distress: Community and Patterns of Pastoral Care', *Transcultural Psychiatry,* 45 (2008), 79-104.

Lencioni, Patrick, *The Five Dysfunctions of a Team: A Leadership Fable* (Chichester: Wiley, 2002).

Lennon, John, and Paul McCartney, 'All You Need Is Love' (London: Parlophone, 1967).

Liaschenko, Joan, 'Faithful to the Good: Morality and Philosophy in Nursing Practice' (Doctor of Philosophy, University of California, 1993), p. 318.

Lord Laming, 'The Victoria Climbié Inquiry' (Norwich: HMSO, 2003).

Machi, Lawrence A., and Brenda T. McEvoy, *The Literature Review: Six Steps to Success*. 2nd edn (London: Corwin Press, 2012).

MacIntyre, Alasdair, *After Virtue: A Study in Moral Theory*. 3rd edn (London: Duckworth, 2007).

MacLeod, Gordon, 'The Grenfell Tower Atrocity', *City,* 22 (2018), 460-89.

MacLeod, Tanya, 'Book Review: Patient as Agent of Health and Health Care', *Journal of Evaluation in Clinical Practice,* 23 (2017), 1099-100.

Mahendra, Jackie, 'Wheeling in the Trojan Mice', Stanford Center on Philanthropy and Civil Society (2016) <https://ssir.org/articles/entry/wheeling_in_the_trojan_mice> [Accessed 15 March 2016].

Mair, Robert, Kristen Onos, and Jacqueline Hembrook, 'Cognitive Activation by Central Thalamic Stimulation: The Yerkes-Dodson Law Revisited', *Dose-Response,* 9 (2011), 313-31.

Marriage, Madison, 'Probe Urged into Break-up of Big Four Accountants', Nikkei Inc (2018) <https://www.ft.com/content/911e8184-283d-11e8-b27e-cc62a39d57a0> [Accessed 5 February 2019].

Marsh, Clive, *Christ in Practice: A Christology of Everday Life* (London: Darton, Longman and Todd, 2006).

Maxwell, Joseph A., *A Realist Approach for Qualitative Research* (London: Sage, 2012).

May, Rufus, 'Crossing the "Them and Us" Barriers: An inside Perspective on User Involvement in Clinical Psychology', *Clinical Psychology Forum,* 150 (2001), 14-17.

Maynard, Naomi, 'A Bigger Difference: Social Action and Church Growth in the Diocese of Liverpool' (Sheffield: Church Army Research Unit, 2018).

McCabe, O. Lee and others, 'An Academic-Government-Faith Partnership to Build Disaster Mental Health Preparedness and Community Resilience', *Public Health Reports,* 129 (2014).

McCall, Thomas H., and Michael C. Rea, *Philosophical and Theological Essays on the Trinity* (Oxford: Oxford University Press, 2009).

McCloughry, Roy, *The Enabled Life: Christianity in a Disabling World* (London: SPCK, 2013).

McFadyen, Alistair I., *The Call to Personhood: A Christian Theory of the Individual in Social Relationships* (Cambridge: Cambridge University Press, 1990).

McGrath, Alister E., *Christian Theology: An Introduction*. 6th edn (Oxford: Wiley-Blackwell, 2017).

McKeown, Mick, and Linda Carey, 'Editorial: Democratic Leadership: A Charming Solution for Nursing's Legitimacy Crisis', *Journal of Clinical Nursing,* 24 (2015), 315-7.

McKinley, Stephanie, and Sarah Yiannoullou, 'Changing Minds', in *Critical Perspectives on User Involvement*, ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012), pp. 115-28.

McManus, Sally and others, 'Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014: Executive Summary' (Leeds: NHS Digital, 2016).

Mental Health Taskforce, 'The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England' ([Leeds]: NHS England, 2016).

Merrill, Jamie, 'Church of England to Open Credit Union in Its 'War on Wonga'', Independent Digital News and Media (2014) [Accessed 20 December 2016].

Mersey Care NHS Foundation Trust, 'Annual Report 2017/2018' (Liverpool: Mersey Care NHS Foundation Trust, 2018).

Messer, Neil, *SCM Studyguide to Christian Ethics* (London: SCM, 2006).

MHFA England, 'Training for Your Organisation' (2018) <https://mhfaengland.org/organisations/> [Accessed 20 July 2018].

Milbank, John, 'Stale Expressions: The Management-Shaped Church', *Studies in Christian Ethics,* 21 (2008), 117-28.

Milgram, Stanley, 'Some Conditions of Obedience and Disobedience to Authority', *Human Relations,* 18 (1965), 57-76.

Mindful Employer, 'Be a Mindful Employer', Mindful Employer (2019) <http://www.mindfulemployer.net/> [Accessed 12 February 2019].

Moltmann, Jürgen, *The Open Church: Invitation to a Messianic Lifestyle* (London: SCM Press, 1978).

——, *The Trinity and the Kingdom of God: The Doctrine of God* (London: SCM, 2000).

Money, Carl, 'Mental Health Bulletin: Annual Statistics, 2014-15' (Leeds: Health and Social Care Information Centre, 2015).

Mooij, Antoine, *Psychiatry as a Human Science: Phenomenological, Hermeneutical and Lacanian Perspectives*. trans. Peter van Nieuwkoop, Contemporary Psychoanalytic Studies (Amsterdam: Rodopi, 2012).

Moore, Geoff, *Virtue at Work: Ethics for Individuals, Managers, and Organizations* (Oxford: Oxford University Press, 2017).

Morris, James, 'Parity in Progress?' (London: All Party Parliamentary Group on Mental Health, 2015).

Mudhoni, Catherine, 'Service User Involvement: Development of a Communication Strategy between Service Users and Senior Management in a Healthcare Voluntary Organisation' (unpublished master's thesis, Royal College of Surgeons in Ireland, 2014).

National Association for People Abused in Childhood, 'Supporting Recovery from Child Abuse', NAPAC (2019) <https://napac.org.uk/> [Accessed 12 February 2019].

National Institute for Health and Care Excellence, 'Commissioning Stepped Care for People with Common Mental Health Disorders' (London: NICE, 2011).

Needham, Catherine, and Sarah Carr, 'Co-Production: An Emerging Evidence Base for Adult Social Care Transformation' (London: Social Care Institute for Excellence, 2009).

Newham, Roger A., 'Virtue Ethics and Nursing: On What Grounds?', *Nursing Philosophy,* 16 (2015), 40-50.

NHS England, 'Mental Health Clustering Booklet' ([Leeds]: NHS England, 2017).

Nicholson, Helen, *Applied Drama: The Gift of Theatre*. 2nd edn, *Theatre & Performance Practices* (Basingstoke: Palgrave Macmillan, 2014).

Nouwen, Henri, *The Wounded Healer: Ministry in Contemporary Society* (Garden City, NY: Doubleday, 1979).

Oakes, P., 'Crash: What Went Wrong at Winterbourne View?', *Journal of Intellectual Disability,* 16 (2012), 155-62.

Office for National Statistics (ONS), 'Ethnic Group', Office for National Statistics (ONS) (2016) <http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/guide-method/measuring-equality/equality/ethnic-nat-identity-religion/ethnic-group/index.html#8> [Accessed 30 April 2016].

Orwell, George, *Animal Farm. A Fairy Story* (London: Secker & Warburg, 1945).

Os, Jim van, Gunter Kenis, and Bart Rutten, 'The Environment and Schizophrenia', *Nature,* 468 (2010), 203-12.

Osmer, Richard R., 'Practical Theology: A Current International Perspective', *HTS Teologiese Studies/Theological Studies,* 67 (2011).

——, *Practical Theology: An Introduction* (Grand Rapids, Michigan: William B. Eerdmans, 2008).

Owen, Wilfred, *The Poems of Wilfred Owen (Wordsworth Poetry Library)* (Ware: Wordsworth Editions Limited, 1994).

Oxford University Press, 'Oxford Dictionary Premium. Online Version.', OUP (2015) <http://www.oxforddictionaries.com/definition/english> [Accessed 15 March 2015].

Paloutzian, Raymond, Rodger Bufford, and Ashley Wildman, 'Spiritual Well-Being Scale: Mental and Physical Health Relationships', in *Oxford Textbook of Spirituality in Healthcare*, ed. by Mark Cobb and others (Oxford: Oxford University Press, 2012), pp. 353-58.

Parish Nursing, 'Parish Nursing', Parish Nursing Ministries UK (2018) <http://parishnursing.org.uk/> [Accessed 1 August 2018].

Parker, M., 'Overstating Values: Medical Facts, Diverse Values, Bioethics and Values-Based Medicine', *Bioethics,* 27 (2013), 97-104.

Parker, Simon, and Niamh Gallagher, eds., *The Collaborative State: How Working Together Can Transform Public Services* (London: Demos, 2007).

Parks, Roger B. and others, 'Consumers as Coproducers of Public Services: Some Economic and Institutional Considerations', *Policy Studies Journal,* 9 (1981), 1001-11.

Parsons, Talcott, 'The Sick Role and the Role of the Physician Reconsidered', *The Milbank Memorial Fund Quarterly. Health and Society,* 53 (1975), 257-78.

Pearson, Keith, and Nicki Latham, 'Values Based Recruitment' (Leeds: Health Education England, 2016).

Peplau, Hildegard, 'The Art and Science of Nursing: Similarities, Differences, and Relations', *Nursing Science Quarterly,* 1 (1988), 8-15.

Petrova, Mila, Jeremy Dale, and Bill (KWM) Fulford, 'Values-Based Practice in Primary Care: Easing the Tensions between Individual Values, Ethical Principles and Best Evidence', *British Journal of General Practice,* 56 (2006), 703-09.

Pine II, B. Joseph, *Mass Customization: The New Frontier in Business Competition* (Cambridge, MA: Harvard Business Press, 1999).

Pope Pius XI, 'Quadragesimo Anno: Encyclical of Pope Pius XI.' (Vatican: Libreria Editrice Vaticana, 1931).

Popper, Karl R., *The Logic of Scientific Discovery* (London: Routledge, 2002).

Porteous, Carol, 'Patient and Public Involvement in Health and Social Care Research' (London: Research Design Service, 2016).

Porter, Roy, *Madness: A Brief History* (Oxford: Oxford University Press, 2002).

QSR International, 'Nvivo' ([n.p.]: QSR International, 2012).

Raffay, Julian, 'Are Our Mental Health Practices Beyond HOPE?', *Journal of Health Care Chaplaincy,* 12 (2012), 68-80.

——, 'Checkmate for Chaplains', *Mental Health Chaplains' Newsletter,* Summer (2009).

——, 'Co-Productive Ethics: Bridging the Fact–Value Divide in Mental Health Service Provision', in *Spirituality, Theology and Health Seminar* (Durham: Durham University, 2018).

——, 'Co-Productive Ethics: Transforming Tomorrow's NHS', in College of Health Care Chaplains' Annual Study Conference - Curating Chaplaincy: Envisioning Healthcare Chaplaincy for the Future (High Leigh, Hertfordshire: College of Health Care Chaplains, 2018).

——, 'The Ethics of Co-Production: Bridging Fact and Value in Mental Health Services', in *Critical Perspectives on and Beyond 'Recovery': Ten Years On* (Cork: 2018).

——, 'Follow the Leader? A Viewpoint on the Exercise of Leadership', *The International Journal of Leadership in Public Services,* 7 (2011), 166-78.

——, 'The Francis Report (2013): Neo-Pharisaism in the NHS?', *Health and Social Care Chaplaincy,* 4 (2016), 20-34.

——, 'How Staff and Patient Experience Shapes Our Perception of Spiritual Care in a Psychiatric Setting', *Journal of Nursing Management,* 22 (2014), 940-50.

——, 'The Increasing Role That People Who Use Mental Health Services Play in Governing Services' (unpublished literature review, Durham University, 2015).

——, 'Perspectives on the Relationship between Statutory Mental Health Services and Faith Communities: A Co-Produced Constructivist Grounded Theory Study', in *Spirituality, Theology and Health Seminar* (Durham: Durham University, 2016).

——, 'Symposium Report: Researching Spiritual and Pastoral Care: Measuring the Value of Chaplaincy', *Health and Social Care Chaplaincy,* 5 (2017), 306-11.

——, 'What Are the Factors That Prevent or Enable the Development of a Spiritual Assessment Tool in Mental Health and That Stand in the Way of or Facilitate the Provision of Quality Spiritual Care?' (unpublished master's dissertation, Cardiff University, 2012).

Raffay, Julian, and Don Bryant, 'Co-Production and Promoting Spiritual Wellbeing in Mental Health', in *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care*, ed. by Ewan Kelly and John Swinton (London: Jessica Kingsley, 2019), pp. 232-48.

——, 'Spiritual Care: Understanding Service Users, Understanding Ourselves', in *Essentials of Mental Health Nursing*, ed. by Karen Wright and Mick McKeown (London: Sage, 2018), pp. 232-48.

Raffay, Julian, Mick McKeown, and Tim Thornton, eds., *Co-Production in Mental Health: Lighting up Dark Places* (Monmouth: PCCS Books, 2020).

Raffay, Julian, Emily Wood, and Andrew Todd, 'Service User Views of Spiritual and Pastoral Care (Chaplaincy) in NHS Mental Health Services: A Co-Produced Constructivist Grounded Theory Investigation', *BMC Psychiatry,* 16:200 (2016).

Rafferty, Joe, 'Managers' Forum', in *Managers' Forum* (Ashworth: Mersey Care NHS Foundation Trust, 2017).

Railway Mission, 'Chaplaincy Support', Railway Mission (2019) <http://www.railwaymission.org/chaplaincy-support/> [Accessed 12 February 2019].

Randall, Duncan, and Mick McKeown, 'Editorial: Failure to Care: Nursing in a State of Liquid Modernity?', *Journal of Clinical Nursing,* 23 (2014), 766-7.

Rankin, Jackie, and Julian Raffay, 'More Tea Vicar? More People Than Ever Are Turning to a Faith Community in Times of Mental Anguish', *MCT Magazine* 2018, pp. 13-15.

Ravitch, Sharon M., and Matthew Riggan, *Reason and Rigor: How Conceptual Frameworks Guide Research* (London: Sage, 2012).

Read, John, 'The Bio-Bio-Bio Model of Madness', *The Psychologist,* 18 (2005), 596-97.

Realpe, Alba, and Louise M. Wallace, 'What Is Co-Production?' (London: The Health Foundation, 2010).

Reinders, Hans S., *The Paradox of Disability: Responses to Jean Vanier and L'Arche Communities from Theology and the Sciences* (Grand Rapids: Eerdmans, 2010).

ResearchGate, '200 Reads', ResearchGate (2018) <https://www.researchgate.net/profile/Julian_Raffay/achievement/5bc81f2890c9780a0ec6b4bf> [Accessed 23rd October 2018].

Rice, Ruth, 'Authorized Personal Conversation', ed. by Julian Raffay (Chester: 2018).

——, 'Renew You', Renew Wellbeing (2018) <http://www.renewwellbeing.org.uk/> [Accessed 30 August 2018].

——, 'What We Do', Renew Wellbeing (2018) <http://www.renewwellbeing.org.uk/> [Accessed 30 August 2018].

Rogers, Carl, 'The Necessary and Sufficient Conditions of Therapeutic Personality Change', *Psychotherapy: Theory, Research, Practice, Training,* 44 (2007), 240-48.

Rohr, Richard, and Mike Morrell, *The Divine Dance: The Trinity and Your Transformation* (London: SPCK, 2016).

Rosenberg, William, and Anna Donald, 'Evidence Based Medicine: An Approach to Clinical Problem-Solving', *British Medical Journal,* 310 (1995), 1122-26.

Ross, Sally, 'Mental Health within a Church Context', Diocese of Sheffield (2019) <https://www.sheffield.anglican.org/mental-health> [Accessed 1 January 2019].

——, 'National Organisations and Resources', Diocese of Sheffield (2019) <https://www.sheffield.anglican.org/UserFiles/File///Mental_Health_Links_Resources.pdf> [Accessed 1 January 2019].

Rotheram, Clare, and Julian Raffay, 'The Life Rooms: An Innovative Recovery Approach', *Journal of Recovery in Mental Health,* 1 (2017), 35-41.

Royal College of Psychiatrists, 'Recommendations for Psychiatrists on Spirituality and Religion' (London: Royal College of Psychiatrists, 2011).

Rublev, Andrei, 'The Trinity' (Moscow: Tretyakov Gallery: c. 1410).

Rush, Brenda, 'Mental Health Service User Involvement in England: Lessons from History', *Journal of Psychiatric and Mental Health Nursing,* 11 (2004), 313-8.

Russell, Cormac, 'Asset Based Community Development', in Releasing the Power of Citizens and Communities: The Era of Social and Collaborative Leadership in Health and our Wider System (Leyland: Northwest Leadership Academy, 2017).

Ryan, Ben, 'A Very Modern Ministry: Chaplaincy in the UK' (London: Theos with Cardiff Centre for Chaplaincy Studies, 2015).

Saldaňa, Johnny, *The Coding Manual for Qualitative Researchers* (Los Angeles, CA: Sage, 2010).

Salvador-Carulla, L., S. Lukersmith, and W. Sullivan, 'From the EBM Pyramid to the Greek Temple: A New Conceptual Approach to Guidelines as Implementation Tools in Mental Health', *Epidemiology and Psychiatric Sciences,* 26 (2017), 105-14.

Sandford, Peter Jonathan, 'Responding Well: Growing Individual and Congregational Confidence to Reach out to People with Mental Health Issues' (unpublished master's dissertation, University of Sheffield, 2018).

Scazzero, Peter L., *The Emotionally Healthy Church: A Strategy for Discipleship That Actually Changes Lives*. Updated and expanded edn (Grand Rapids, MI: Zondervan, 2010).

Schizophrenia Commission, 'The Abandoned Illness: A Report from the Schizophrenia Commission: Main Report' (London: Rethink Mental Illness, 2012).

Schön, Donald A., *The Reflective Practitioner: How Professionals Think in Action* (New York: Basic Books, 1984).

Schumacher, E. F., *Small Is Beautiful: A Study of Economics as If People Mattered* (London: Abacus, 1978).

Seedhouse, David, *Ethics: The Heart of Health Care*. 3rd edn (Chichester: Wiley, 2008).

Seligman, Martin E. P., *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment* (London: Free Press, 2003).

Sellman, Derek, 'Alisdair MacIntyre and the Professional Practice of Nursing', *Nursing Philosophy,* 1 (2000), 26-33.

——, 'Professional Values and Nursing', *Medical Health Care and Philosophy,* 14 (2011), 203–08.

Sentamu, John, 'Conclusion: Firm Foundations for Britain's Future', in *On Rock or Sand: Firm Foundations for Britain's Future*, ed. by John Sentamu (London: SPCK, 2015), pp. 236-58.

Shaw, Sara, Rebecca Rosen, and Benedict Rumbold, 'What Is Integrated Care? An Overview of Integrated Care in the NHS' (London: Nuffield Trust, 2011).

Shepherd, Geoff, Jed Boardman, and Mike Slade, *Making Recovery a Reality* (London: Sainsbury Centre for Mental Health, 2008).

Shepherd, Louise, 'Cheshire and Merseyside Sustainability and Transformation Plan' (Leeds: NHS England, 2016).

Sherif, Muzafer and others, *Intergroup Conflict and Cooperation: The Robbers Cave Experiment* (Oklahoma, OK: Institute of Group Relations, 1961).

Shooter, Susan, *How Survivors of Abuse Relate to God: The Authentic Spirituality of the Annihilated Soul* (Abingdon: Ashgate, 2012).

Slay, Julia, and Lucie Stephens, 'Co-Production in Mental Health: A Literature Review' (London: New Economics Foundation, 2013).

Smith, Christian, *To Flourish or Destruct: A Personalist Theory of Human Goods, Motivations, Failure, and Evil* (Chicago, IL: University of Chicago Press, 2015).

Smith, Paul, 'Authorized Personal Conversation', ed. by Julian Raffay (Skelmersdale: 2018).

South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 'Recovery Is for All: Hope, Agency and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists' (London: SLAM/SWLSTG, 2010).

Speak, Barry L., Paula Hay, and Steven J. Muncer, 'HoNOS - Their Utility for Payment by Results in Mental Health', *International Journal of Health Care Quality Assurance,* 28 (2015), 115-28.

Spencer, Nick and others, 'Religion and Well-Being: Assessing the Evidence' (London: Theos, 2016).

Standing, Guy, *The Precariat: The New Dangerous Class* (London: Bloomsbury Academic, 2011).

Staniszewska, Sophie and others, 'Moving Forward: Understanding the Negative Experiences and Impacts of Patient and Public Involvement in Health Service Planning, Development, and Evaluation', in *Critical Perspectives on User Involvement*, ed. by Marian Barnes and Phil Cotterell (Bristol: Policy, 2012), pp. 129-41.

Stevens, Bruce, 'Grounded Theology? A Call for a Community of Practice', *Practical Theology,* 10 (2017), 201-06.

Stickley, Theodore, 'Should Service User Involvement Be Consigned to History? A Critical Realist Perspective', *Journal of Psychiatric and Mental Health Nursing,* 13 (2006), 570-77.

Stodd, Julian, *The Social Leadership Handbook*. 2nd edn (Bournemouth: Sea Salt Learning, 2016).

Stoddart, Eric, 'The Bible and (in)Visibility', in *Doctor of Theology and Ministry Residential School* (Cranmer Hall, Durham: 2015).

——, '(In)Visibility and the Process of Public Theology', *International Journal of Public Theology,* 7 (2013), 45-64.

Storm, Marianne, and Adrian Edwards, 'Models of User Involvement in the Mental Health Context: Intentions and Implementation Challenges', *Psychiatric Quarterly,* 84 (2013), 313-27.

Storm, Marianne, Kjell Hausken, and Aslaug Mikkelsen, 'User Involvement in In-Patient Mental Health Services: Operationalisation, Empirical Testing, and Validation', *Journal of Clinical Nursing,* 19 (2010), 1897-907.

Sullivan, Mark D., *The Patient as Agent of Health and Health Care: Autonomy in Patient-Centered Care for Chronic Conditions* (Oxford: Oxford University Press, 2017).

Sweeney, Damien, and Martin Pritchard, 'Program Logic', Pacific Research and Evaluation Associates (2010) <http://www.evaluationtoolbox.net.au/index.php?option=com_content&view=article&id=30:program-logic&catid=19:formative-evaluation-tools&Itemid=136> [Accessed 21 December 2018].

——, 'Project Evaluation Cycle', Pacific Research and Evaluation Associates (2010) <http://www.evaluationtoolbox.net.au/index.php?option=com_content&view=article&id=16:evaluation-cycle&catid=6:what-is-evaluation&Itemid=20> [Accessed 21 December 2018].

Sweeney, John, 'Wales Accord on the Sharing of Personal Information (WASPI): The Accord' ([Cardiff]: WASPI Service Integration and Development Team, 2013).

Swift, Christopher, *Hospital Chaplaincy in the Twenty-First Century: The Crisis of Spiritual Care in the NHS* (Farnham: Ashgate, 2009).

Swinton, John, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon Press, 2000).

Taleb, Nassim Nicholas, *Skin in the Game: Hidden Asymmetries in Daily Life* (London: Allen Lane, 2018).

Taleb, Nicholas, Anti-Fragile: *How to Live in a World We Don't Understand* (London: Allen Lane, 2012).

Taylor, Charles, *Sources of the Self: The Making of the Modern Identity* (Cambridge: Cambridge University Press, 1992).

Te Pou o Te Whakaaro Nui, 'Assessment: How to Match Talking Therapies to Peoples' Needs' (Auckland: Te Pou, 2015).

Teichmann, Karin, Ursula Scholl-Grissemann, and Nicola E. Stokburger-Sauer, 'The Power of Codesign to Bond Customers to Products and Companies: The Role of Toolkit Support and Creativity', *Journal of Interactive Marketing,* 36 (2016), 15-30.

The Art House, 'Our Aims', The Art House (2019) <http://www.arthousesheffield.co.uk/wellbeing-groups-sheffield/our-aims/> [Accessed 12 February 2019].

The Church of England, 'Full Extent of Church of England Work to Support Local Communities Revealed', The Church of England (2018) <https://www.churchofengland.org/more/media-centre/news/full-extent-church-england-work-support-local-communities-revealed?mc_cid=a9a50f956f&mc_eid=315702a76c> [Accessed 18 November 2018].

Thornberg, Robert, 'Informed Grounded Theory', *Scandinavian Journal of Educational Research,* 56 (2012), 243-59.

Thornton, Sharon G., *Broken yet Beloved: A Pastoral Theology of the Cross* (St. Louis, MO: Chalice Press, 2002).

Toulmin, Stephen, 'Agent and Patient in Psychiatry', *International Journal of Law and Psychiatry,* 3 (1980), 267-78.

——, *The Uses of Argument*. Updated edn (Cambridge: Cambridge University Press, 2003).

Trevithick, Liam, Jon Painter, and Patrick Keown, 'Mental Health Clustering and Diagnosis in Psychiatric in-Patients', *British Journal of Psychology Bulletin,* 39 (2015), 119-23.

Triggle, Nick, 'Shipman, Bristol, Stafford, Morecambe Bay - and Now Gosport', BBC News (2018) <https://www.bbc.co.uk/news/health-44550913> [Accessed 9 October 2018].

Tritter, Jonathan, and Alison McCallum, 'The Snakes and Ladders of User Involvement: Moving Beyond Arnstein', *Health Policy,* 76 (2006), 156-68.

Turner, Michael, and Peter Beresford, 'Contributing on Equal Terms: Service User Involvement and the Benefits System' (London: Social Care Institute for Excellence, 2005).

Tyszkowska, Magdalena, and Magdalena Podogrodzka, 'Stigmatization on the Way to Recovery in Mental Illness—The Factors Directly Linked to Psychiatric Therapy', *Psychiatria Polska,* 47 (2013), 1011-22.

Vanier, Jean, *The Challenge of L'Arche* (London: Darton, Longman, and Todd, 1982).

Vanier, Jean, and John Swinton, *Mental Health: The Inclusive Church Resource* (London: Darton Longman & Todd, 2014).

Verheij, Bart, 'Evaluating Arguments Based on Toulmin's Scheme', in *Arguing on the Toulmin Model: New Essays in Argument Analysis and Evaluation*, ed. by David Hitchcock and Bart Verheij (Dordrecht: Springer, 2006), pp. 181-202.

Voronka, Jijian, 'Peer Work: The Value of Mad Labour', in *Critical Perspectives On and Beyond 'Recovery': Ten Years On* (Cork: CVNI, 2018).

——, 'The Politics of 'People with Lived Experience' Experiential Authority and the Risks of Strategic Essentialism', *Philosophy, Psychiatry, and Psychology,* 23 (2016), 189-201.

——, 'Troubling Inclusion: The Politics of Peer Work and 'People with Lived Experience' in Mental Health Interventions' (University of Toronto, 2015).

Wachowski, Laurence, and Andrew Wachowski, 'The Matrix' (Warner Brothers, 1999).

Wallcraft, Jan, and Mary Nettle, 'History, Context and Language', in *Handbook of Service User Involvement in Mental Health Research*, ed. by Jan Wallcraft and others (Chichester: Wiley, 2009), pp. 1-12.

Wallcraft, Jan, Beate Schrank, and Michaela Amering, eds., *Handbook of Service User Involvement in Mental Health Research* (Chichester: Wiley, 2009).

Walsh, Julia, Wilf McSherry, and Peter Kevern, 'The Representation of Service Users' Religious and Spiritual Concerns in Care Plans', *Journal of Public Mental Health,* 12 (2013), 153-64.

Ward, James, Claire de Motte, and Di Bailey, 'Service User Involvement in the Evaluation of Psycho-Social Intervention for Self-Harm: A Systematic Literature Review', *Journal of Research in Nursing,* 18 (2012), 114-31.

Watt, Graham, 'What Can the NHS Do to Prevent and Reduce Health Inequalities?', *British Journal of General Practice,* 63 (2013), 494-5.

Webber, Martin and others, 'The Effectiveness of Personal Budgets for People with Mental Health Problems: A Systematic Review', *Journal of Mental Health,* 23 (2014), 146-55.

Weir, Peter, 'The Truman Show' (Paramount Pictures, 1998).

Welby, Justin, *Dethroning Mammon: Making Money Serve Grace* (London: Bloomsbury, 2017).

Wells, Samuel, *Incarnational Ministry: Being with the Church* (Norwich: Canterbury Press, 2017).

Westwood, Neil, Mike James-Moore, and Matthew Cooke, 'Going Lean in the NHS' ([Coventry]: NHS Institute for Innovation and Improvement/Warwick University, 2007).

Wiener, Norbert, *Cybernetics: Or Control and Communication in the Animal and the Machine* (Cambridge, MA: Massachusetts Institute of Technology, 1948).

Williams, Hattie, 'Bishops Were 'Perfect Accomplices' for 'Nauseating' Peter Ball, IICSA Hears', Church Times (2018) <https://www.churchtimes.co.uk/articles/2018/27-july/news/uk/bishops-were-perfect-accomplices-for-nauseating-peter-ball-iicsa-hears> [Accessed 10 October 2018].

Williams, Rowan, *Lost Icons: Reflections on Cultural Bereavement* (London: Continuum, 2003).

Wonders, Sarah, 'The Experiences of Those Providing Pastoral Care in the Christian Church Community: Supporting People with Their Mental Health and Interacting with Health Professionals' (University of Sheffield, 2011).

Wood, Emily, 'Authorized Personal Conversation', ed. by Julian Raffay (Liverpool: 2016).

Wood, Emily, Julian Raffay, and Andrew Todd, 'How Could Co-Production Principles Improve Mental Health Spiritual and Pastoral Care (Chaplaincy) Services?', *Journal of Health and Social Care Chaplaincy,* 4 (2016), 51-56.

Wood, Emily, Roger Watson, and Mark Hayter, 'To What Extent Are the Christian Clergy Acting as Frontline Mental Health Workers? A Study from the North of England', *Mental Health, Religion and Culture,* 14 (2011), 769-83.

Woodward, James, and Stephen Pattison, *The Blackwell Reader in Pastoral and Practical Theology* (Oxford: Blackwell, 2000).

World Health Organization, 'Mental Health: A State of Well-Being', WHO (2014) <http://www.who.int/features/factfiles/mental_health/en/> [Accessed 9 April 2018].

Worthington, Alan, Paul Rooney, and Ruth Hannan, 'The Triangle of Care, Carers Included: A Guide to Best Practice in Acute Mental Health Care in England' (London: Carers Trust, 2013).

Yamada, Ann-Marie and others, 'Integrating Spirituality and Mental Health: Perspectives of Adults Receiving Public Mental Health Services in California', *Psychology of Religion and Spirituality,* Mar (2019), 1-12.

Yerkes, Robert, and John Dodson, 'The Relation of Strength of Stimulus to Rapidity of Habit-Formation', *Journal of Comparative Neurology and Psychology,* 18 (1908), 459-82.

Zimbardo, Philip, *The Lucifer Effect: Understanding How Good People Turn Evil* (New York: Random House, 2007).

Zizioulas, John, *Being as Communion: Studies in Personhood and the Church* (London: Darton, Longman and Todd, 1985).