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“Not in the room, but the doctors were”:

An Australian story-completion study about consumer representation

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Abstract

Current mental health policy requires consumer involvement in all levels of health service management (i.e., planning, implementation, delivery, and evaluation). However, current models often limit consumers to 'representation' roles which are criticised for silencing consumer views. This study compares understandings of consumer representatives' and health professionals' participation in decision-making processes in the mental health sector in Australia. Story completion methods were employed, with 34 participants (21 consumers, 8 health professionals, and 5 people identifying both as consumer and health professional) completing a story stem about either a consumer representative or a health professional changing a committee meeting agenda. Using a thematic approach, three overarching themes were developed: how consumer representative roles remain unvalued, how such lack of value translates to not achieving co-production, and how consumer representative roles can be better supported through allyship or subversion against organisational cultural norms. Findings suggest that organisational cultural norms in health settings need to be more inclusive of consumers to maximise the benefits of partnerships and fulfil policy expectations. Two methods for greater empowerment of consumers working in mental health are through allyship with non-consumer health professionals who support the goals of the consumer movement, and subversion of current practices.

Introduction

Since the beginning of the 21st century, empowerment of consumers by ensuring their involvement health organisations' decision-making processes has become a central tenet of international policies and practices (United Nations, 2006; World Health Organization, 2008). Drawing on international approaches to empowering consumers, national-level policies have begun to incorporate similar requirements. Indeed, contemporary mental health policy explicitly emphasises the involvement of consumers in every aspect of mental health services (for examples, see Australian Government, 2012; Ethiopian Ministry of Health, 2012; Health Service Executive of Ireland, 2018; Mental Health Commission of Canada, 2016; UK Parliament, 2012). There are several benefits of consumer involvement in the management of services. Involvement based on the subjective experiences of mental ill health and service use results in the creation of more effective services and policies (Tait, 2005). Specifically, consumer involvement helps to support more holistic, consumer-focused care (Lewis, 2014), greater accountability and quality of services (Sharma, Conduit, & Rao Hill, 2014), and improved public reputation and credibility (Scholz, Bocking, & Happell, 2017). When done meaningfully, without tokenism, and with no co-option of consumer expertise by non-consumers, consumer involvement that increases the 'real' power that consumers have over services and policies is necessary for health services to receive the full benefits of incorporating consumers' perspectives (Storm & Edwards, 2012).

In the current study, the term 'consumer' refers to individuals with lived experience of mental ill health. There have been important critiques about the term, given that its meaning of "a purchaser of goods and services in markets" (Leahy, Löfgren, & de Leeuw, 2011, p. 2) is often in stark contrast to the experiences of consumers whose rights are taken away, or who do not have choices about accessing such services (Our Consumer Place, 2012). Several studies that have explored consumers' views about preferred terms have

focussed only at the individual level of service provision (for examples, see Deber, Kraetshmer, Urowitz, & Sharpe, 2005; Mueser, Glynn, Corrigan, & Baber, 1996), rather than what terms should be used when referring to consumers' systemic partnerships with or leadership in the health sector. While the term 'consumer' is not unproblematic, nor agreed upon by consensus, it is the term currently chosen by the Australian consumer movement which embraces individuals' rights to self-identify as they prefer (Our Consumer Place, 2012).

There are various models of consumer involvement, depending on the aim and resources available to the organisation. In interviews about 'consumer leadership' of health services, participants interpreted such leadership to refer to 'consumer representation', suggesting that consumer representation may be one of the dominant ways of understanding the involvement of consumers (Scholz, Stewart, Bocking, & Happell, 2017). Consumer representation includes models whereby individuals represent themselves, their own communities, or consumers of specific services (Sarrami-Foroushani, Travaglia, Dobono, & Braithwaite, 2014). A consumer representative is a member of a committee, board, or project team within health services who provides consumer perspectives in health service management and takes part in the decision-making process on behalf of other consumers; consumer representatives are often nominated by, and are accountable to, a consumer-run or consumer advocacy organisation (Consumers Health Forum of Australia, 2018).

Existing research exploring consumer representative models indicates the existence of some confusion and a lack of consensus within the mental health services sector about who or what 'consumer representatives' should be representing (Happell & Roper, 2006; Scholz, Stewart, et al., 2017). For instance, some organisations expect consumer representatives to represent their individual experiences, while others require that a broader range of consumer experiences be represented (Scholz, Stewart, et al., 2017). Even in the latter case, it is rare

that extra resources will be provided to the consumer representative to seek out, synthesise, and summarise these views (Happell & Roper, 2006).

There are many challenges or barriers facing consumer representatives that mental health professionals do not face. These come in various forms, such as vague job descriptions and responsibilities, financial and time constraints, lack of structural support and training, and negative attitudes from mental health professionals who resist the notion that consumers are experts and/or assume consumers have low skill sets (Tait, 2005). Consumer representatives are even criticised about their ability to accurately represent ‘the typical consumer’ (Martin, 2008). This appears to be a skewed expectation, as health professionals are not expected to represent the full scope of their discipline in their role. Taken together, these barriers may actually lead to only tokenistic involvement and silence consumer perspectives, despite intentions to the contrary (Happell, 2008).

Theory

The theoretical framework for the current study is derived broadly from organisational culture theory. This approach draws on understandings of organisational culture as a pattern of assumptions that are reproduced through customary ways of acting shared by members (and that are taught to new members as the ‘correct’ way to behave or understand) (Schein, 1990). The reproduction of these assumptions by group members leads to belongingness to the organisation as a unique entity (Marek, 2017). The current study explores organisational culture in terms of the health system and mental health service providers and their systemic interaction with consumers. The organisational culture in the medical system, and particularly in mental health services, has led to numerous barriers preventing the maximum effectiveness of consumer representatives (Gordon, 2005; Happell & Roper, 2006; Scholz, Stewart, et al., 2017).

One of the key organisational cultural barriers to systemic collaboration between health services and health service consumers is related to the implicit or explicit hierarchies of power. Some recent studies (Scholz, Bocking, et al., 2017; Scholz, Stewart, et al., 2017) highlight how consumers and non-consumer health professionals have unequal distribution of and access to resources. Partnerships between consumers and mental health organisations often position consumers themselves as resources for organisations, or limit control of resources to non-consumer partners (Scholz, Bocking, et al., 2017). Through the lens of organisational culture theory, the current study seeks to explore the organisational cultural conditions that position consumers in unequal relationships with organisations.

Aims and Objectives

Power imbalances between consumers and health professionals and the barriers these create have been well documented (for example, see Lewis, 2014; Scholz, Bocking, et al., 2017; Scholz, Bocking, Platania-Phung, Happell, & Banfield, 2018). However, much less is understood about how these power imbalances manifest in common interactions between these two groups. Therefore, the aim of the current study is to develop a clearer understanding about perceptions of consumer representatives and their ability to influence the systems in which they engage.

The objectives to achieve this aim are as follows:

1. To obtain data pertaining to how perceived roles and rights of consumer representatives compare to mental health professionals;
2. To apply the lens of organisational culture theory to these data and focus on the norms that constrain or empower consumer representatives relative to mental health professionals; and
3. To examine the relationship between power held by consumer representatives and their ability to carry out tasks in their roles.

Method

Design

This study applied a qualitative, exploratory design (Stebbins, 2001) to understand the differences in perceptions about mental health professionals and consumer representatives working in health care.

Participants

We recruited participants who had been involved in health services in an official consumer representative capacity as well as health professionals. Emails were sent to the peak consumer bodies in each of the 8 states and territories of Australia (whose purposes include supporting consumers at the individual, service, organisational, and systems levels, and whose memberships include consumers and other stakeholders), as well as professional bodies for psychology, nursing, and general practice, asking for the study details to be disseminated via email, a newsletter, or their website.

A total of 34 participants participated in the study, including 21 who identified as consumers, 8 who identified as health professionals, and 5 who identified as both consumers and health professionals. Participants were given an open choice to share their gender identities, with 24 participants identifying as female, 6 as male, and 4 choosing not to identify their gender. Six participants were aged 18–25, 10 were aged 26–35, 6 were aged 36–45, and 10 were aged 46 or above. Two participants chose not to disclose their age group.

Compliance with Ethical Standards

Ethical approval was obtained by [name of institution hidden for review] Human Research Ethics Committee (approval number 17-267). Upon opening the link to the story completion participation website, participants were informed that they could withdraw from the study at any time or choose not to complete any part of the story, and that completion of

the story implied consent to use the data for research purposes. No identifying data were collected.

Data Collection

A story completion method was used to collect data (Clarke, Hayfield, Moller, & Tischner, 2017). Story completion originally developed as a form of projective test, allowing for responses that may reveal information about the respondents that they may not be aware of or not be comfortable expressing in a more traditional research method. The method involves the researcher presenting an initial story ‘stem’ and asking participants to complete the story in their own words. The story stems for the current study were co-produced by two members of the research team, including one consumer researcher and one critical health psychologist. Each step of the story stems was developed based on organisational theory (specifically, focusing on power, belongingness, and customs), and experiential expertise of consumer representation.

The current study uses a comparative method, where one stem involves a mental health professional bringing an amendment to a committee and the other stem has the same narrative with a consumer leader as the protagonist (full text available in Supplemental Digital Content 1). Participants completed the story stems via an online link that directed them to either story stem at random.

Data Analysis

Data were analysed using the principles of thematic analysis based on the steps outlined by Braun and Clarke (2006). The data were read thoroughly to become familiar with the data and to generate initial codes. As these codes were applied to the data, they are refined and reviewed. Related codes were then grouped into provisional themes. This process was iterative, with codes and themes being refined as data related to each were assessed for fit (or lack of fit) with each theme. Thematic analysis was especially useful in the current

study for its ability to summarise large sets of data and highlight similarities and differences in responses through the underlying themes. A theory- and data-driven approach was used whereby the theory of organisational culture was the framework through which the analysis was conducted and interpreted, however the researchers were careful to attend to new concepts from the data as well.

Results

Three overarching themes were developed through the analytical process: how consumer representative roles are not valued, how that lack of value translates to not achieving co-production, and how consumer representative roles can be better supported.

Not Valuing Consumer Representative Roles

The theme of not valuing consumer representatives comprised of two subthemes: attitudes towards expertise and understandings of identities. Participants' stories contrasted consumer expertise and identities against those of mental health professionals.

Expertise

Participants' accounts of committee meetings constructed consumers' expertise as lesser than the expertise of mental health professionals in several ways. Consumers' expertise was often not brought into the story, even when directly relevant to the discussions of the committee, or it was constructed as only valued when the discussion in question was not about what was seen as the realm of the medical professionals (e.g. occupational health and safety issues within the hospital or when a medical professional was promoting a complementary alternative treatment). Indeed, consumer expertise was often constructed as not 'enough' in and of itself. That is, in participants' stories, consumers had to supplement their expertise with external evidence. This was in contrast to the narratives of mental health professionals' expertise, where qualifications were portrayed as being sufficient to contribute

to projects. Extracts 1 and 2 provide contrasting constructions of consumers' and mental health professionals' expertise, respectively.

EXTRACT 1 (non-consumer participant)

The other committee members listened to Dr Evans intently. Most had heard about similar [occupational health and safety] issues in other buildings, and were not surprised to learn about the issue. Alex also wanted to add his perspective about the way that the issue impacted patients in the building, but the others in the room assumed that Alex, as a consumer representative, wouldn't have anything to add about what they considered a more 'internal' problem.

EXTRACT 2 (consumer participant)

As a new member of the board Dr Evans wants to propose an initiative to run through the health service that raises more attention to problems of obesity. This would include putting up more signage that shows the statistics of obesity and health related concerns, handing out flyers to customers and providing consultation with customers about how they can improve their lifestyle and be at less of a risk of obesity. At his previous job, raising awareness of obesity related problems and consequences was a good deterrent for consumers to be more aware of their weight. Dr Evans writes down examples from his previous workplace to help him explain his idea in the meeting.

The contrast between Extracts 1 and 2 reflect dominant constructions about the expertise of each group (i.e., consumer vs. professional expertise). Consumer expertise (such as how the health and safety issue impacted patients) was often portrayed as being not listened to by other committee members. This is despite consumers' expertise often being constructed as coming from the very core health service (or, in the case of Extract 1, the same building) being discussed. In contrast, in Extract 2, health professionals' expertise was often constructed as something coming from external and previous workplaces. As the extract suggests, health professionals were typically depicted as having a strong background of resources to draw upon to inform their work.

When consumers' expertise did feature in participants' stories, it was portrayed as something threatening to health professionals ("Some [on the committee] are a little threatened [by Alex's proposal] as they have ... been doing things a certain way for a long time"; consumer participant) or something that could be influential in a very slow, incremental, and minimal manner. For instance, in one story, Alex's proposal was to be talked about at the following meeting rather than the current one (consumer participant).

The expertise of mental health professionals, on the other hand, was almost always constructed as valued; even though there was one example in the data corpus of a story where a mental health professional's expertise did not lead to a desired outcome, this was a deviant case (non-consumer participant). Stories most frequently showed mental health professionals being able to use their expertise to decide on consumers' best interests, and constructed committee members as deferential to the expertise of mental health professionals. For example, one story involved a debate among committee members about what constituted "good care", despite the consumer in the story not having any say (consumer participant). Tellingly, while consumers' experiential expertise was often unvalued in participants' stories,

when mental health professionals featured in stories drawing on their own personal experiences, they were praised, as in Extract 3.

EXTRACT 3 (consumer participant)

Dr Evans was passionate about mental health, particularly suicide prevention. He has had personal experience from the trauma of losing a loved one due to depression... At the end of his presentation, he breathed deeply containing his emotions. As he looked around the table, he was surprised to see many other board members with a tear in their eye and a facial expression of sadness. Nobody said anything at first. Everyone felt like they had misunderstood the severity of the problem with young people.

Remarkably, none of the accounts of consumers sharing their personal experiences were valued by health professionals. In Extract 3, however, Dr Evans' sharing of his personal experience led to an emotional response from the other committee members ("many...with a tear in their eye"), as well as buy-in from members to the proposal ("everyone felt like they had misunderstood").

Identities

The other way participants' stories constructed consumers as valued less than mental health professionals was about how consumers' and mental health professionals' identities were contrasted. The most evident way in which consumer identities were marginalised was that the consumer character was not discussed at all by one third of participants. Although participants were given the gender-neutral names of two characters (a consumer representative and a mental health professional) and were told that they could be as creative

and continue their narrative as far in to the future as they like, it was not anticipated that so many (consumer and non-consumer) participants would not explicitly refer to the consumer character at all. The character was largely rendered invisible.

Most consumer identities constructed through participants' accounts positioned consumers as passive (even explicitly so in one case: "The members other than Alex keep a distance from Dr Evans...Alex doesn't have much of an issue since he is a bit passive"; non-consumer participant). They were often regarded as subordinate to mental health professionals who saw them as "not ready" to participate in committee discussions ("Dr Evans even says [to Alex who has just raised their agenda item] 'perhaps you should get the hang of this first'"; consumer participant), or as needing to work much harder to be treated as equals (such as one story in which the consumer representative had to "prepare statistics from various charities and women's health professionals" (consumer participant) to support their argument in the committee). Even in cases where consumers' identities were constructed in a positive way in terms of wanting to bring about change, the consumer characters often needed to consider how to manage their consumer identity (such as one story in which the consumer representative "feeling very unsure about whether this was an appropriate issue to raise with a committee of professionals. He didn't want to upset or offend anyone, but he also wanted to make sure that his thoughts were heard"; non-consumer participant) or how to negotiate their positions in meetings ("Everyone sits in the meeting chatting away, about proposals & general chat. Alex sits thinking to himself 'how will I tell the doctors we need more services?'"; consumer participant).

In the whole data corpus, consumers' identities were not positioned in ways which conveyed effectiveness and autonomy. One exception was Alex being described similarly to a professional by being "on the way to work" before the meeting (consumer participant). Most consumers were not narratively constructed in this way as professionals, yet most

clinicians were. This resulted in constructions of mental health professionals as outcomes-focused, methodical, and busy (e.g., “[Dr Evans] barely gets much time to prepare for these meetings”; non-consumer participant). While this professionalism was not always positive (participants’ stories also drew on repertoires of professionalism as being career-advancing and selfish, as in Extract 4), there were no negative ramifications for mental health professionals who were depicted in these ways. This demonstrates the power imbalance between the two stakeholder groups.

EXTRACT 4 (consumer participant)

Alex on the other hand also does not have a good impression of Dr Evans. Alex believes that Dr Evans only has selfish intentions to make himself look good and that is why he proposed such an idea so early into his career at this organisation.

The subthemes of expertise and identity show how participants’ stories drew on cultural repertoires that position consumers lower in status to mental health professionals.

Co-production

The second theme developed through the analysis related to co-production and the extent to which it was present and absent in participants’ stories. Given that the previous theme highlighting the dominant pattern in narratives was that consumers’ expertise was not valued, the scope for co-production was limited, and the two subthemes explaining this further were a lack of consumer input and a lack of resources.

Lack of Consumer Input

As co-production is about a culture in which the consumer perspective is valued from the outset and where power differentials are acknowledged and potentially challenged

(Roper, Grey, & Cadogan, 2018), the lack of consumer input into committee discussions and decisions in participants' stories was telling.

In every story, there was never more than one consumer representative on the committee and all the other members were health professionals. Throughout the data corpus, there were several examples of the consumer representative being the single voice of dissent against the status quo ("Although most people in the committee praise Dr Evans' idea, Alex seems to be hesitant"; consumer participant).

One story, from a non-consumer participant, actively addressed the issue of there being only one consumer representative present. The agenda item that the consumer representative raised was to discuss increasing the number of consumer representative positions. Based on this narrative, not only were consumer views often marginalised by not being valued by the committees, they were also marginalised in terms of the numbers of consumers present in the room.

Indeed, in some cases, there were no consumers present in the stories at all. Although the story stems mentioned a consumer representative and a mental health professional and asked participants to be as creative as they liked, none chose to introduce other consumer characters, and some even placed the consumer outside of the meeting, as in Extract 5.

EXTRACT 5 (non-consumer participant)

Alex was not in the room, but the doctors were in the room. The situation seemed like the set-up of a bad joke. Alex smirked, composed himself, and walked in to the room full of doctors.

Even when consumers were present in stories, they were often positioned as being less important than mental health professionals. One story, from a participant identifying as a

health professional with some lived experience of mental ill health, addressed this issue explicitly, mentioning that they were “unsure how Alex figures in the story; cannot imagine they would have any power or weight”. As such, most participants’ stories did not challenge the power norms present in relationships between consumer representatives and mental health professionals.

Lack of Resources

Within participants’ stories, the power differential between consumers and mental health professionals was also demonstrated through the control of tangible and intangible resources. Mental health professionals were often the ones positioned as having control over and access to resources. For instance, they were the ones with power over funding decisions (“The other members dismiss [the consumer representative’s] findings because there is no money in it”; consumer participant), and the ones with the ability to influence external organisations (such as in one story where Dr Evans “wanted to present a compulsory subject in schools focusing on mental well-being and psychological techniques” and which was eventually successful as seen through “the difference [after a year] in the statistics of children needing professional help outside of school”; consumer participant). Mental health professionals also controlled the spaces in which meetings took place. As seen in Extract 5, and as discussed above, consumers were often “not in the room” that the mental health professionals were able to use. Similarly, some stories discussed how mental health professionals could talk to each other out of committee meetings (“[Dr Evans] talks to other members of the board privately and they agree that his idea is good”; consumer participant), but consumers did not usually have such privileged access to their colleagues.

Further, consumer representatives’ items were often pushed to the end of agendas and meetings (“Because there was no time to discuss [the consumer representative’s agenda item] in depth, nothing was decided about what to do”; non-consumer participant). Given that there

was only ever one consumer representative present, at most, this demonstrates the use of meeting time was skewed against consumer representatives. Similarly, there was a mention of how consumer representation was organised systematically (with characters in one story unsure if there was “a service user quota that should be met”; consumer participant), suggesting representation was imposed rather than of value in itself.

Taken together, the repertoires participants drew on in the themes of ‘not valuing consumer representative roles’ and ‘co-production’ reflect the organisational cultural assumptions shaping collaborations between consumers and non-consumers. These assumptions lead to consumer expertise not being valued, representatives being seen as less effective than their health professional colleagues, and, in turn, a lack of consumer input and a lack of sharing resources.

Supporting Consumer Representatives

In contrast to the findings of the first two themes, there were some stories in which consumer participation was facilitated, particularly through inclusion in spaces usually allowed for mental health professionals and through subversive means of redressing power imbalances.

Inclusion through Socialising

Although the dominant narrative positioned consumer representatives as “not in the room” with the mental health professionals, some stories did challenge such positioning. One story, from a consumer participant, talked about a future Christmas party in which all members of the committee were socialising together and where the consumer representative and a mental health professional were singing “along to [pop song] Vanilla Ice’s Ice Ice Baby at the Christmas party after a few too many [Japanese beer] Asahis”. This reference to a shared social event constructs the relationship between the consumer representative and other committee members as shifting towards greater inclusiveness. This was the only example of a

consumer character having privileged access to what would have dominantly and normally been thought of as health professionals' spaces.

Subversion

Subversion of the norms of power differentials between consumer representatives and mental health professionals was one of the repertoires that participants' stories were able to draw on, to offer alternatives to consumers being "not in the room". As discussed earlier, consumer representatives often had their agenda item left until the end of the meeting when there was insufficient time available to discuss the item adequately (marginalising them in terms of meeting time) and often had their perspective not valued by their colleagues (marginalising them in terms of attitudes). The following extract provides a narrative about a consumer representative challenging these practices.

EXTRACT 6 (non-consumer participant)

Alex felt disappointed that his input in the issue was not recorded in the minutes. So, prior to the next meeting when the secretary sent the minutes to the committee members, Alex replied by email to add in his perspective that the occupational health and safety issue was not just something that applied to staff of the hospital, but to others using hospital services, too.

Thus, even when Alex had been kept out of the meeting minutes, they were able to use an email out of session as a way to insert themselves back into the discussion and thus into "the room".

The final form of subversion to redress such power imbalances was through allyship of mental health professionals who did value and did want to champion consumer perspectives.

EXTRACT 7 (consumer participant)

Some members are condescending to Alex (after all she is not a professional). Others welcome some feedback on her experience as a consumer and listen intently to her stories of innovation in other countries and medical communities. After the meeting, the room is split: Some with their own agendas and bias toward the “new”; others decide to form a subcommittee (as they too have been battling to be heard) to pursue research on the effectiveness of new treatments.

A common narrative resource that participants drew on was such forms of allyship of the health professionals towards the consumer representatives, to make space for the consumer expertise or perspective to be considered. This theme demonstrates how current organisational cultural norms might be challenged.

Discussion

The current study emphasises that consumer representative positions remain significantly under-valued, do not achieve principles of co-production, and need to be better supported before collaboration between health service providers/professionals and consumers can be considered sufficient and meaningful. The results highlight ways that consumers’ positions on the bottom of the decision-making hierarchies are maintained: through dismissal

of consumer expertise and marginalisation of consumer identities. From the perspective of organisational culture theory (Schein, 1990), engaging with consumers but failing to create spaces in which consumers' expertise is valued illustrates that current organisational culture is prohibiting consumers' contributions (and the concomitant need for organisational culture change).

Previous literature argues that organisational structures need to meaningfully bring consumer expertise into decision-making structures (Scholz, Bocking, et al., 2017). The current study extends this finding by applying organisational culture theory to explore the assumptions underlying collaborations between consumers and health professionals. In taking this perspective, the findings suggest that the resistance to authentic partnership with consumers is reinforced through assumptions leading to organisational cultural norms that devalue consumers and that do not encourage co-production. The common repertoires about participants drew on consumers being marginalised, such as not being given space (or not being "in the room") to collaborate, nor resources for their work. Such repertoires suggest the dominant understanding of partnerships between organisations and consumers still positions consumers in ways that limit their access to or control over resources.

The story completion method has particular strengths and limitations. One of the strengths is that participants are able to construct their own narratives and resolve problems in their stories in ways that might not be feasible in real life. For example, while Extracts 6 and 7 provide innovative solutions to ensure consumer perspectives remain part of organisational processes, these solutions may downplay the power imbalances faced by consumers. Nonetheless, using such methods, participants' stories have illuminated innovative ways to challenge current power structures that other methods might not have been able to fully explore. Importantly, for the current study, another strength of story completion method is the way that it allows researchers to explore the norms of given

practices and interactions. Indeed, story completion allows participants to write about the assumptions and norms influencing given cultures, which is particularly relevant to organisational cultural theory.

A potential limitation of the story completion method, however, is that we cannot know the extent to which participants' stories reflect actual experiences within the types of committees discussed in the study. A further limitation of the study is that five participants identified as both a consumer and health professional, making it unclear which knowledge they are using for their perspective. Regardless, participants' stories are built on repertoires that reflect broader patterns of understanding. Thus, the conclusions drawn from the analysis of the story completion data are useful for improving understandings of consumer representation and power dynamics in systemic partnerships.

Practice Implications

Given the inclusion of consumers was the exception in the data and that some participants had to draw on the repertoire of subversion of norms through allyship between health professionals and consumers, our findings have particular implications for improving organisational cultures for more meaningful partnerships.

Some allies (those who use their privilege to advocate for and support the consumer movement; Juntanamalaga, Scholz, Roper, & Happell, 2019) may be able to facilitate participation, even in cases where organisational culture marginalises consumers and oppresses their input. Extract 7 provided a good example of allies and consumers forming subcommittees to work together when the broader committee did not want to incorporate consumer perspectives. In terms of organisational culture theory, such subcommittees and allyships may influence broader organisational norms to becoming more inclusive. Health

service managers should consider how to support consumer representation through such allyship with consumer representatives whose perspectives are marginalised.

Extending existing research findings about consumer representatives not being provided resources to meet organisational goals (Happell & Roper, 2006; Scholz, Stewart, et al., 2017), the current study expands further on what such resource needs might include. Specifically, given that the resources health professionals take for granted are not shared by consumers (such as being able to discuss issues outside of dedicated meeting times), including consumer partners in extracurricular activities (such as parties, as suggested by one participant) may help to shift organisational norms that position consumers as outsiders. Health service managers might consider ways in which they are able to include consumer representatives meaningfully in events outside of normal working practices, where possible.

The findings suggest that innovative ways of subverting organisational culture might allow consumers the opportunity to have greater ways of influencing processes. Organisational norms might oppress consumer perspectives (through only having one consumer in a room of several health professionals, for instance), and consumers may only have a short time to talk, if at all. However, consumers might be able to mitigate the impact of these limitations by employing deliberate strategies throughout their engagement with health professionals and service providers. For example, they might attempt to ensure that meeting minutes reflect their perspective by proofreading and clarifying them via emails and other forms of communication after the committee meetings. While this does entail a greater burden of work, this, and other innovative and subversive methods (such as forming subcommittees with supportive or aligned health professionals), may be a useful way to redress the power imbalances that have long shaped collaborations between mental health consumers and health services.

In conclusion, consumer representation still seems to be marked by marginalising attitudes and practices, and co-production through such representation does not appear to be being achieved. The findings of this study suggest that two methods for greater empowerment of consumers working in mental health are through allyship with non-consumer health professionals who support the goals of the consumer movement and subversion of current practices. Organisational processes seem to be limiting the systemic contributions made by mental health consumer representatives to health services, and cultural change is needed to fully value consumers' contributions.

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Supplemental Digital Content 1:

Story Stems for the Story Completion Data Collection Method

Participants were randomly allocated to either the first (in which the clinical representative asks to add a new agenda item) or second story stem (in which the consumer representative asks to add a new agenda item). At each step, participants were able to enter as much text as they chose to complete the stem.

Step 1	Alex is a consumer representative on a committee of the local mental health service. Dr Evans, a new clinical representative, has joined the committee and arrives for their first meeting. At the start of the meeting, Dr Evans asks the chair to add a new item to the agenda. Please write about the run-up to the meeting, what the agenda item is about, and how Dr Evans prepares for it.	Dr Evans is a clinical representative on a committee of the local mental health service. Alex, a new consumer representative, has joined the committee and arrives for their first meeting. At the start of the meeting, Alex asks the chair to add a new item to the agenda. Please write about the run-up to the meeting, what the agenda item is about, and how Alex prepares for it.
Step 2	Please write about the meeting and how the other committee members respond to the new agenda item...	
Step 3	Please write about what happens next... (Please feel free to write as much as you like about any characters and as far into the future as you like)	