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Creating a collaborative and impactful research environment: community partner reflections on the DeStress-II study

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Abstract

Background Patient and public involvement and engagement can improve the relevance and impact of research yet 'impact' is often framed narrowly around study findings rather than the experiences of those involved. Understanding how involvement affects individuals is important, particularly in areas such as mental health where there is significant potential for power differentials within the research process. The DeStress-II project co-developed a training resource to help primary care practitioners support people experiencing poverty-related mental distress. Community Partners with lived experience were integral to the project, contributing to training delivery, online resource co-production, and implementation analysis. This paper explores what supported their sustained engagement and the personal and collective impacts of involvement.

Methods A reflective evaluation drawing on two focus groups and individual semi-structured interviews with ten Community Partners from three UK regions.

Results Findings highlight the importance of extending the notion of impact beyond traditional boundaries of academic research to also consider individual and collective patient and public benefits of involvement. Meaningful involvement extends research impact beyond outputs to encompass personal growth, confidence, and a lasting sense of community. Key enablers included: (i) a dedicated Community Connector role; (ii) feeling part of and valued within the research team; and (iii) the development and quality of relationships.

Conclusions Understanding how patient and public involvement in research is experienced broadens how impact is conceptualised. Dedicated facilitation, time, and resources are essential to create inclusive environments that support mutual learning and positive personal outcomes for people with lived experience.

Plain English summary

Patient and public involvement and engagement (PPIE) in research can improve the relevance and impact of research outcomes. However, research 'impact' is often only considered in terms of the study findings. Less attention has been placed on understanding the experiences of those individuals who take part in research

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in a PPIE role, or any impact they feel this has within their lives. Understanding this is important, particularly in areas such as mental health where there is significant potential for power inequalities in the research experience. The DeStress-II project developed a training resource to support primary care practitioners to deliver supportive consultations with people living with poverty-related mental distress. The resource was developed collaboratively with a team of Community Partners with lived experience of poverty-related mental distress.

This paper presents the experiences of the Community Partners who were involved in all aspects of the research: developing and delivering the training, co-producing an online training resource and supporting the analysis of its implementation. We focus on what they feel helped them to sustain their engagement throughout the research, and the impacts of this at both an individual and group level.

Factors that supported engagement were: (i) a dedicated Community Connector role; (ii) feeling part of and valued within the research team; and (iii) the development and quality of relationships. Community Partners identified impact at a personal level, including growth in confidence and a desire to create a legacy of work that continued beyond the life of the research project.

Keywords Patient and public participation, Impact, Mental health, Poverty, Primary healthcare, Co-production.

Background

It is widely accepted that patient and public involvement and engagement (PPIE) in research can meaningfully improve its relevance and impact [1–3]. Whilst PPIE is now mandated by most national research funders in the UK [4], research involvement ‘impact’ is too often considered only in terms of study outcomes and implications for policy and practice [5, 6]. This approach to understanding and capturing impact aligns with a consumerist approach to PPIE in which involvement is a means to securing of research outcomes which in turn can lead to tokenistic involvement practices [7, 8]. However, an alternative framing of public involvement views it through a rights-based lens in which the processes of engagement and involvement themselves and the impacts are wide-reaching, including individual and group-based empowerment [9–11]. In a recent review and narrative synthesis of studies measuring impacts of PPIE, the authors found considerable variation in how the impact was captured and attributed [12]. They generated four types of impact from the included studies; on people, research processes, services and systems and on PPIE processes themselves. Whilst most studies reported positive impacts, some were negative, for the people involved, as well as for the research process and outcome. The review highlighted the inconsistent reporting of impacts from involvement in how PPIE is conceptualised and the mechanisms by which impact can be achieved.

Relatively little attention has been placed on understanding the broader motivations and experiences of those individuals who engage in PPIE roles, the factors which help sustain their engagement, or any impact they feel their involvement in the research has had within their wider lives. An article by Roca and Bates [13] looked at the issue of payments for public participants and surveyed people to understand their motivations for involvement and what principles they felt should underpin payments and recognition for their time. The three

overarching principles were; personal development, volunteering and work and the market place. Understanding people’s motivations and capturing the extent to which they have been realised is important, particularly in areas such as mental health where there is significant potential for power differentials in both clinical settings and research [9, 14].

There is also a need to better understand the relational processes that enhance meaningful involvement, justify the emotional labour required from contributors and inform the supportive conditions researchers must create. Again, this is especially relevant in mental health research where power differentials remain pronounced [15, 16].

In this paper, we adopt a relational approach to capturing the impact of involvement of Community Partners, we wanted to understand whether and how involvement can support individual and collective development. This approach draws on empowerment theory and co-production literature [15, 16], which forefront the importance of mutual trust and respect as well as shared control over the entire research process.

The following section briefly outlines the DeStress-II project to provide contextual background for the reflective evaluation presented in this paper.

The DeStress-II project

The DeStress-II project formed the context for this reflective evaluation. DeStress is an interdisciplinary research programme exploring the links between poverty and mental health to improve how primary care services support people experiencing poverty-related mental distress. This work began with a qualitative study (DeStress-I, 2016–2019) exploring the ways mental distress was experienced in low-income communities and responded to within primary healthcare. The second phase (DeStress-II, 2021–2024) co-designed and delivered a training intervention; to support primary care

practitioners to hold more effective consultations with such patients. Community Partners played a central role in shaping the structure and content of the training as well as in its delivery. A Community Partner (CP) is a person with lived experience of poverty-related mental distress. The first phase of DeStress-II involved training delivered in-person by teams comprising a GP trainer, a CP and an academic researcher. Within the training sessions, CPs spoke to primary care teams about the intersections between poverty and mental health, with most drawing on their own experiences to impart key learning objectives. They also spoke from a patient's perspective about what they felt made for a positive or negative consultation experience (see Methods for details of recruitment and data collection).

Training was delivered in 53 practices across three areas of England. Feedback informed refinements that led to an online resource, now freely available to GP practices (see Thomas et al. [17]). Feedback received from primary care trainees consistently attested to the power of the CP narratives within the training. The online resource therefore includes a wide range of community partner narratives and a simulated consultation demonstrating what CPs felt a positive GP consultation could look like.

This paper reports on the experiences of the CPs who worked alongside academics and practitioners to co-develop and deliver this training resource. We explore how CPs were supported to remain involved over the duration of the research, their experiences of personal development and the resulting peer support and sense of collective purpose.

Engagement and support of community partners

Recruitment and retention of CPs in DeStress-II evolved through a multi-phased, adaptive process beginning in late 2021. Opportunities for involvement in the research were advertised through the networks of three university PPIE teams as well as via a range of local community groups across the three research sites. Those expressing an interest in taking part were invited to attend an initial online workshop to understand more about the study (November 2021) co-chaired by experienced Community Partners from the DeStress-I phase. Nineteen CPs initially signed up and indicated that they were willing to consider co-delivering the training. (See Methods for details of those who took part in the reflective evaluation.) All individuals who expressed interest were welcomed into the DeStress-II CP group. Our aim was to create an inclusive, supportive environment rather than to select for specific demographic or experiential criteria. This approach reflected the project's ethos of open participation rather than representativeness. To address the understandable apprehension raised amongst the CPs, particularly anxiety about speaking to GPs, uncertainty

about how their lived experiences would be received, and fears of not being listened to due to previous negative encounters with medical professionals, the team created dedicated spaces for preparation and peer support before training sessions. Peer-led, online 'drop-ins' were set up to provide regular and sustained support throughout the project, and to build space for collective learning and confidence-building. These were not funded as they had not been anticipated in the original costings. Drop-in sessions were initially held twice-weekly and later moved to a weekly format as the group became more established. In the early stages, these meetings focused on peer support and developing participants' personal stories to share in the training delivery sessions. Over time, they evolved into a space for both project-related discussion and informal mutual support across all aspects of life. An optional WhatsApp group also provided a channel for day-to-day connection between CPs. All drop-in sessions were delivered online via videoconference to support accessibility across geographically dispersed sites. Challenges related to mental health and confidence were often expressed, particularly at the start of the project, necessitating additional one-to-one support alongside reassurances that people could engage flexibly, according to what was possible for them at the time.

The CPs were located across the three study sites and were supported remotely and in person by a Community Connector. The term 'Community Connector' is used here to describe a facilitative role within the research team, distinct from its more common use to refer to community workers linking service users with local activities. This role enabled CPs to design their own ways of working together to support the project (and themselves), during the project and beyond. The Community Connector acted as a link between the CPs, academic researchers and GP trainers supporting both communication and continuity. As the DeStress-II research progressed, the CPs were encouraged to attend weekly meetings with the wider research team to involve them with strategic decision making and to ensure their input into the content and dissemination of the online training resource.

This co-authored paper brings together CP reflections of their experiences of involvement in the DeStress-II, focusing on the factors that sustained their engagement and the impact they felt research involvement had within their wider lives. Specifically, we asked:

- How did CPs describe the personal and collective impacts of their involvement in the study?
- What relational and organisational factors were perceived to support or hinder meaningful involvement?
- How might these insights inform future approaches to co-production in mental health research?

Table 1 Numbers and format of community partners by region

Region	Focus group numbers	Individual interviews
South West	3	0
North West	3	1
North Thames	0	3

The impetus for this paper also came from comments by several CPs who had contributed to other studies but felt that DeStress-II was ‘*very different*’ in the nature and extent of their involvement.

Methods

This section describes the reflective evaluation undertaken to explore the experiences, motivations, and impacts of involvement from the perspectives of CPs involved in the project. They, and the wider research team, felt that understanding and documenting these would provide an important opportunity for reflective learning to inform future research.

Participation in the reflective evaluation was open to all who had been involved in DeStress-II; ten CPs consented to take part in focus groups or interviews. Participants were selected on a voluntary basis and reflected variation in gender, ethnicity, region and prior involvement experience (see Table 1). This approach aimed to capture a diverse range of perspectives rather than to achieve statistical representation.

It was agreed that focus groups would provide an appropriate means of data collection, although individual interviews were also offered when this was more convenient for participants. CPs felt that it was appropriate for the focus groups and interviews to be facilitated by academic members of the research team in each locality. This reflected CPs’ preference to speak with facilitators not involved in peer relationships, allowing them to openly share their experiences. Co-facilitation by CPs was also considered but judged likely to introduce bias, given the close relationships that had developed within the group. In total ten CP participants were included in the data collection (see Table 1). Four participants were male, six were female. Three were from a South Asian background; seven were from a white British background (Table 1).

A focus group and interview schedule were developed with CPs to support the discussions. The questions were broad and open ended but explored multiple aspects of the CPs’ experience with the project, co-production of the research, reasons for sustained engagement and individual and collective impact. Interviews and focus group discussions were audio-recorded via Microsoft Teams and then transcribed verbatim. Transcriptions were uploaded to NVivo 14 to support analysis.

Two authors (JH, AM) individually read the transcripts and identified themes. They then met to discuss and agree

these before re-visiting clean transcripts in NVivo to code with these specific themes in mind and identify quotes they felt exemplified the themes. Direct reflections on the training delivery and development were excluded as this was not the purpose of this paper. Although initial coding was undertaken by academic researchers, CPs reviewed early analyses, contributed to refining theme labels and interpretations, and jointly selected exemplar quotations for inclusion in the paper. CPs were invited to be involved in the analysis to whatever extent they wished. However, this phase occurred near the end of the funding period, when limited resources remained to support additional paid time. Several CPs nonetheless chose to contribute voluntarily by reviewing and sense-checking the themes developed by the academic researchers to ensure they reflected the group’s shared experiences. This iterative process reflected a pragmatic form of co-production that balanced analytic rigour with the lived-experience insight of CPs.

Once coding was completed, the authors agreed an overview of the main themes and anonymised supporting quotes. This was then presented to the CPs at a weekly drop-in session to check they agreed with the findings and to clarify that what they felt was important was represented in the data. Final quotes to exemplify the themes were selected and agreed by all CP co-authors. For this reason, quotes used in this paper are not attributed to any particular participant. This process reflects our approach to collaborative analysis with CPs reviewing interpretations and refining the manuscript to ensure findings remained true to their lived experiences.

Following CP feedback on this overview the manuscript was drafted (AM, JH), shared and re-drafted (FT, KB, KW) with further feedback from all the co-authors. All authors contributed to the final draft of the paper.

Ethics

The study was approved by the Frenchay REC (IRAS 303179).

Results

Reflecting on their work with DeStress-II, it became clear that CP involvement extended beyond supporting research outputs. Initial motivation for involvement was key, alongside factors sustaining engagement, including a dedicated Community Connector; feeling part of and valued within the research team; and the development of supportive relationships. CPs also described increased confidence and a wish to create a legacy of work that continued beyond the project. The analysis generated three overarching themes: [1] motivations for engagement and the meaning of participation; [2] the personal and collective learning generated through collaboration; and [3]

the relationships and relational processes that sustained involvement over time.

Theme 1: Motivations for engagement and the meaning of participation

CPs described varied reasons for joining the project, most grounded in personal experiences of distress, disempowerment, or exclusion, and a wish to ensure these experiences made a positive difference.

Sharing lived experience Across the group there was a strong sense of wanting to use lived experience to improve understanding and reduce stigma. CPs cited poor primary care experiences, the need to raise awareness of the dual challenges of poverty and poor mental health, and the stigma surrounding mental illness in some South Asian communities. They also recognised the pressures faced by primary care providers and wanted to offer constructive insight.

I wanted to feedback, help, in any way I could. Even if it just helps one person, me telling my story, that's why I wanted to be part of the project.

People are not familiar with this type of service, people have not been educated, people feel they cannot share this because the other members of the community will know that somebody has got mental health problems and they're asking for help... these are many barriers.

Several CPs described wanting their difficult experiences to serve a constructive purpose by informing and humanising GP training.

When I got help – which was not through the NHS – and I started to feel better, I knew somehow I had to try and use my voice to share how terrible it [poor mental health] is, because I didn't want anybody to be in that place I was in.

Others reflected that involvement symbolised progress from past negative experiences toward shared learning and understanding.

[It's] the very fact that we're doing it... because of my experiences with having a bad GP and the stigma of mental health... Seeing things change for the better and understanding other people's lives.

Together these accounts highlight how DeStress-II transformed adversity into advocacy and offered CPs a sense of agency within the research process.

CPs frequently contrasted their experiences in DeStress-II with previous research involvement, attributing the difference to two factors: the genuine focus on co-production, and the dedicated support of the Community Connector.

The DeStress project was very thorough and engaging... It wasn't a tick-box exercise for co-production, it actually is full co-production.

Theme 2: The personal and collective learning generated through collaboration

Engagement in DeStress-II offered space for reflection, validation, and learning, helping participants make sense of their experiences in relation to wider social and economic contexts. Several CPs spoke of feeling “validated” by recognising that the difficulties they faced were not personal failings but shaped by structural factors such as poverty, stigma, and limited access to care.

...to have my understanding validated and supported... that depression is understood in a more complex way, that a lot of the distress may never have happened without the context of poverty – it's very healing in a longer-term process to realise.

For others, involvement reaffirmed the value of their perspectives and gave new confidence to talk about mental health. Seeing their experiences reflected in the project helped shift feelings of isolation toward shared understanding and collective purpose.

CPs described a growing sense of optimism as they witnessed small but meaningful changes among primary care professionals. For those who had taken part in the earlier DeStress-I study, these gradual shifts were especially rewarding.

What I think is the doctors' surgeries are changing... from when we first started, I think back in 2016, to now – it's completely different. It was a positive thing to do, not just for my own mental health, but seeing how far they've [GPs] come.

CPs valued seeing tangible evidence that their input had influenced training development.

We've definitely been listened to in shaping the new online training... [Our] ideas have been used. It's been good.

These reflections show how involvement prompted both personal learning and collective efficacy. Empowerment through co-production depended not only on

what was produced but on how people were supported to participate.

Personal impact of being involved as a community partner CPs described a wide range of personal benefits, including increased confidence, new skills, and enhanced self-worth. Many reflected that they had achieved far more than they initially believed possible and that their perspectives were valued as integral to the research.

I saw many of the community partners go from barely believing they could do this process to delivering it with immense power.

I'm a different person from the start of the project – it's been great.

Being treated as equal members of the team helped shift self-perception. The project's ethos of equality and mutual respect enabled CPs to contribute confidently.

As much or as little as you want to be, you're part of the project and the journey... It's an important cog.

Confidence gained through the project often translated into other areas of life.

Seeing other community partners and how brave and confident they have become... they all enjoy it.

DeStress has given me another sort of scope in my private life and work.

For some, involvement opened new opportunities for work, advocacy, and teaching, extending their influence beyond the project.

My personal greatest impact was probably in the community partner forum and legacy work... being able to make complex concepts relatable.

Others described the experience as personally healing.

My experience has been very profound, validating of my experience and how difficult it's been... although challenging, it's been healing.

Encouragement from peers helped quieter participants find their voice.

To begin with, I couldn't talk in the group at all, I never had a voice. I'm thankful for the people who helped me gently... The peer support has been great.

These accounts show that meaningful involvement can generate enduring personal and relational impact, supporting recovery, empowerment, and community building.

Theme 3: The relationships and relational processes that sustained involvement over time

Participants consistently emphasised the project's atmosphere of inclusion and practical care. Consistent communication, empathy, and attention to detail made them feel supported both personally and professionally.

I have been working for the last eight years as a full-time public advisor and never seen this unique technique of having a drop-in session where you can ask for help.

Feeling valued and part of a community CPs described a strong sense of belonging that evolved through shared experiences and regular opportunities to connect informally as well as around project tasks. The weekly online drop-ins offered continuity, emotional support, and a safe space to share experiences and celebrate progress.

Peer support Less experienced CPs valued guidance from more experienced peers. The drop-ins created a psychologically safe environment for practising skills and processing emotions.

I don't think we'd have ever got to that point, of all being able to be that brave, if we hadn't had the drop-in sessions.

Over time, these spaces became more peer-led, fostering camaraderie that extended beyond the formal project.

Community connector role Across all interviews, the Community Connector was described as crucial to sustaining engagement. This role linked CPs, researchers, and GP trainers, combining practical coordination with relational support.

Because I didn't really have anything positive, I didn't want to go in thinking I was being negative... [Community Connector] said, 'There's no right or wrong way of doing this... Try and use some of the ways you did get through it.'

The Connector's warmth, approachability, and consistency helped build trust and confidence.

Meeting her, the way she made it so easy and comfortable to connect... I could be very honest with them and they would be honest back.

CPs contrasted this with less supportive experiences elsewhere.

It's just so different, so exceptional... There's the professional bit and then there's the friendly bit – I've not come across anything like this.

If it hadn't been for [Community Connector] ringing, I probably wouldn't have gone as far as I did.

She also helped CPs overcome anxieties about delivering training by arranging observation of other sessions.

I was worried about giving training... [Community Connector] shared a recorded session so we could see how it was done.

Engaging with the wider research team: Drop-in sessions were also attended by members of the academic research team, helping CPs see them as approachable and collaborative.

It started off as just community partners... then researchers came... It made us realise the bigger team weren't so scary.

This interaction built trust and showed CPs how their feedback shaped decisions, strengthening identification as members of the team.

Overall, these findings illustrate that meaningful involvement arises from both structural supports (e.g., the Community Connector role, flexible engagement practices) and relational processes (e.g., trust, reciprocity, and shared purpose).

Discussion

The findings provide insight into the factors that helped initiate and sustain CP motivation across and beyond the DeStress-II project, as well as the impacts of involvement at both personal and collective levels. They illustrate how the relational and structural dimensions of involvement, particularly facilitation and peer support, can be understood through theories of empowerment and boundary-spanning in community-research partnerships. We show how projects can create an involvement culture that centres lived experience and empowerment, flattening traditional hierarchies. These findings resonate with Roca and Bates' work on motivations for involvement and with recent reviews of public engagement in mental health research [13].

Involvement in DeStress-II provided opportunities for CPs to build knowledge and skills, foster personal confidence and growth, feel heard and valued, and strengthen

individual and collective agency to influence healthcare practice.

The community connector and relational facilitation

The Community Connector role was pivotal, bridging CPs, academics, and GP trainers. She provided dedicated time and resources to support CPs, facilitate communication, and build trusting relationships. This guidance enabled CPs to develop confidence and skills, ensured smooth information flow, and created multiple ways for CPs to influence the research process. Weekly online drop-in sessions further fostered trust and mutual support. These regular interactions, combined with flexible communication and reimbursement, created an inclusive environment embraced by the entire research team.

The effectiveness of this role rested on unobtrusive but skilled facilitation, with the Connector's relational sensitivity, responsiveness, and continuity of presence identified as key enablers of trust and inclusion. From the outset, the DeStress-II team sought to maintain a non-hierarchical approach to planning and delivery. The experience of CPs aligns with frameworks that emphasise power-sharing and trusted relationships reinforced by practical resources [5, 18]. Karlsson et al., similarly identified training, interpersonal skills, remuneration, time, and trust as critical enablers of partnership, noting that flexible and adaptive approaches support power-sharing in decision-making [5].

Beyond quality: wellbeing and impact

While involvement is often promoted as a route to improve research quality, this study illustrates how inclusive participation can also lead to positive changes in personal development and wellbeing. The findings support a model of impact that moves beyond conventional outputs to recognise collaborative benefits for individuals and groups [9, 12, 19]. The approach adopted in DeStress-II aligns with Staley et al.'s framing of involvement as a co-learning process where “conversations that support two-way learning” are central [20]. This suggests that there is no single route to meaningful involvement; rather, that approaches should adapt to context and the needs of those involved.

Flattening hierarchies and sustaining inclusion

The work presented here provides evidence for how allocating resources—such as a Community Connector, time, and meeting spaces—can help flatten hierarchies, foster trust and shared decision-making, and create a transparent, respectful approach to collaboration. This can have a lasting impact beyond the life of a project [5, 7, 12].

CPs also identified positive cultural changes in primary care around poverty-related mental health. We recognise that these occurred within a wider system

transformation, with concurrent initiatives such as social prescribing and trauma-informed practice likely contributing. These findings therefore represent a contribution rather than sole attribution to DeStress-II.

The inclusive environment described by CPs was underpinned by enabling factors including financial reimbursement, sustained facilitation, and visible leadership support. Although CPs were not asked to evaluate these conditions directly, many referred to them as integral to feeling valued and supported. We acknowledge the presence of “hidden work” – the ongoing coordination, encouragement, and relationship maintenance by the Community Connector and research leads, which likely sustained engagement. As noted in the NIHR’s 2024 review [21], this facilitative role merits further evaluation to understand how such staff best support two-way learning and how their development can be strengthened.

Intensity and sustainability of involvement

The intensity of involvement in DeStress-II was distinctive. CPs’ participation extended beyond discrete research activities to include project management meetings, regular contact through drop-ins, and ongoing collaboration throughout the project. However, CPs could determine their own level of involvement, recognising that sustained participation might not be possible for everyone. While formal research activities were reimbursed, the drop-in sessions were largely unfunded, reflecting CPs’ commitment and the strength of relationships formed. Several CPs described friendships and networks that continued beyond the project, highlighting the relational depth and lasting impact of this approach.

The purpose and tone of the drop-in sessions evolved from spaces for peer support and story development for GP training to wider conversations about wellbeing and mutual encouragement. These meetings became more social while retaining a focus on peer support, illustrating how involvement spaces can adapt organically to respond to participants’ needs.

Strengths and limitations

Most CP interactions during DeStress-II were supported online and through social media. Although this partly reflected COVID-19 restrictions, it demonstrated that meaningful, sustained online engagement across a wide geographical area is possible. Previous research suggests that sustained involvement can be facilitated through support from mental health organisations [22, 23]. These findings suggest such support can also come from within the research team when it is properly resourced, relationally informed, and adaptable.

Some strategies CPs valued most, such as weekly drop-ins, evolved organically rather than being planned, which

may limit replication in other contexts. Early meetings focused on supporting CPs to deliver GP training; this constructive focus may not be feasible in all projects. Nonetheless, the drop-ins helped forge collaborative relationships and friendships among diverse CPs across regions.

This paper reflects the strong co-production that existed throughout and beyond DeStress-II. The CP group continue to meet and seek other projects where they can use lived experience to support meaningful outcomes. A final strength is the collaborative analytic process: involving CPs in checking interpretations and selecting quotes ensured analysis was steered by those directly involved. However, this phase took place near the end of funding, limiting paid involvement time. Future projects should ensure dedicated funding to sustain involvement throughout the analytic phase.

Conclusions

This paper demonstrates how allocating resources to approaches that flatten hierarchies, foster trust, and support shared decision-making can have lasting impact throughout and beyond a research project. Key factors supporting ongoing CP engagement included: (i) a dedicated Community Connector; (ii) feeling part of and valued within the research team; and (iii) the quality of relationships.

Supporting collaboration that prioritises relationships can influence participant experiences in ways that extend beyond academic impact. The experience of DeStress-II shows that meaningful involvement requires creating conditions where power and control are shared, enabling CPs to influence all aspects of research over time, although while some relational hierarchies were flattened, structural inequalities in pay, job security, and authority remain. These outcomes were enabled by sustained facilitation, leadership support, and appropriate resourcing, underscoring that co-production depends as much on the relational and material conditions created as on the values that guide it.

Future projects should consider how resources, particularly those supporting relational practice, can be embedded throughout, especially when working with people facing intersecting forms of marginalisation.

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Author contributions

JH, AM, SH, KG, PP, RC, DS, SA, SG, KH, KC, FH: Acquisition, analysis and interpretation of data, drafting of manuscript. FT, KB, KW: study conceptualisation, design and funding; data interpretation; drafting of manuscript. OH revision of manuscript. All authors reviewed the manuscript.

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Data availability

The data are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethics approval was granted by the Frenchay REC (IRAS 303179).

Consent for publication

All authors have provided consent for publication.

Disclaimer

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Competing interests

The authors declare no competing interests.

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