Cite as: Eiroa-Orosa, F. J. (2026). From Evidence to Action: Navigating an Evolving Positionality Towards Transformative Mental Health Research. In *Sage Research Methods Inclusive Research Methodologies*. SAGE Publications.

# From Evidence to Action: Navigating an Evolving Positionality Towards Transformative Mental Health Research

Francisco José Eiroa-Orosa

University of Barcelona

## Abstract

This case study describes a transformative mental health research program that translated citizenship principles into measurable academic outputs and tangible social change. The project engaged people with lived experience of mental distress, relatives, and healthcare professionals to develop frameworks and tools that promote inclusion, rights, and shared responsibility within mental health systems. Drawing on an analysis of the context in which it was developed, the project generated three concrete impacts: (1) improved practitioners' attitudes reducing tolerance for coercive practices, (2) strengthened peer-support capacity, and (3) sustained policy engagement via membership of advisory bodies at regional and European levels. The case offers practical "how-to" lessons on centering lived experience, managing power asymmetries, and designing research that balances academic rigor with social advocacy, making it especially useful for postgraduate researchers planning rights-based, system-focused studies.

## Learning Outcomes

Having read this case study, readers should be able to . . .

1. Describe the methodological foundations of recovery and citizenship-based research for transforming mental health systems.
2. Explain how research can meaningfully involve people with lived, familial, or professional mental health experiences.
3. Identify ethical and practical challenges in collaborative research and strategies to ensure inclusiveness and mutual learning.
4. Reflect on how researchers' positionality and institutional contexts influence participatory research design and implementation.
5. Apply methodological insights from this case to plan inclusive, context-sensitive research that promotes rights-based system change.

# Case Study

## Project Overview and Context

This case study describes a transition from a research career focused on quantitative data collection and analysis, aimed at validating existing mental health and addiction care practices, to one dedicated to using research to support system transformation. This shift took place during a postdoctoral search for an independent academic path and was shaped by a growing awareness of the need for consistency between research ethics and practice. My experiences as a mental health service user, alongside conversations with others with lived experience, exposed gaps between personal autonomy and practices rooted in traditional research frameworks, making the ethical limitations of my earlier methodological approach increasingly clear.

My early academic work took place within predominantly quantitative research projects, shaped by the positivist expectation to generate evidence. Even when studies focused on improving care for people with mental-health challenges or drew on constructivist therapeutic perspectives, the underlying logic prioritized demonstrating that

one intervention outperformed another or that a psychometric tool reliably captured a given construct. Working across various regions, I gathered skills in academic writing and statistical analysis to publish over 20 peer-reviewed articles by the time I completed my doctorate. This level of productivity was both a constraint and a catalyst in choosing my research focus. It was a constraint because professional visibility and stability make it difficult to step outside established areas. Yet it was also a catalyst, as this strong publication record made me well-placed to successfully secure highly competitive European postdoctoral funding, the flexibility of which enabled me to justify a shift in focus. This support allowed me to launch a project grounded in citizenship principles, emphasizing rights, responsibilities, roles, resources, and relationships aimed to redistribute knowledge and power legitimizing lived experiences. This case study explores how this shift in focus led to impactful outcomes, from enhancing people with lived experience' experiences to influencing professional practices and public policy. It marked the beginning of a research agenda focused not just on describing reality, but on transforming it through inclusive methods.

## Section Summary

- This section explains a shift from conventional research aimed at validating existing practices to research focused on supporting system change in mental health care.
- The transition reflects a growing commitment to aligning research ethics with inclusive research methodologies and rights-based practice, while empowering marginalized voices.
- My early research experiences were largely shaped by positivist approaches, even within projects concerned with improving care or recognizing subjectivity.
- European postdoctoral funding enabled the development of a transformative line of research based on citizenship principles.
- The project set out to redistribute not only knowledge, but also power, aiming to influence individual experiences, professional attitudes, and public policy.

## Research Design

To introduce the research design, it is first necessary to clarify the type and depth of involvement sought in this project. The approach was informed by Arnstein's (1969) classic analysis of participation as a continuum of power sharing, which shaped how interactions with partners were enacted in practice. In this context, different actors contributed in three overlapping ways. *Participation* involved engaging in activities within a researcher-led structure, reflecting the tokenistic middle rungs of Arnstein's ladder. *Collaboration* entailed shared decision-making in specific project areas, aligning with Arnstein's partnership. *Cocreation* represented deeper power sharing, with partners helping define aims, methods, interpretation, and dissemination, corresponding to the upper rungs of delegated power and citizen control (Grindell et al., 2022). In this project, most activities were participative or collaborative, with a few approaching full cocreation. This was shaped by several constraints, including the academic and professional emphasis on generating evidence through experimental designs, funding requirements prioritizing quantifiable outcomes, and rigid bureaucratic procedures that required projects to be implemented exactly as approved, often years after submission, leaving little room for modification.

Building on the strategies of participant engagement and shaped by the contextual constraints, the project was designed as a cyclical process, in which methodological decisions evolved through practice and collective reflection. The project was structured into three iterative phases that implied different levels of engagement and allowed collaboration to develop over time (see Figure 1). Each phase combined three types of activities: preparation, involvement, and reflection; allowing partners to shape priorities, contribute to joint decisions, and assess the direction of the work. Details about the context and the different milestones of the process can be found in Eiroa-Orosa and Rowe (2017). The design of all activities prioritized collaboration and, when possible, cocreation with people who could engage as people with lived experience, their relatives, and professionals to ensure inclusivity and address systemic barriers.

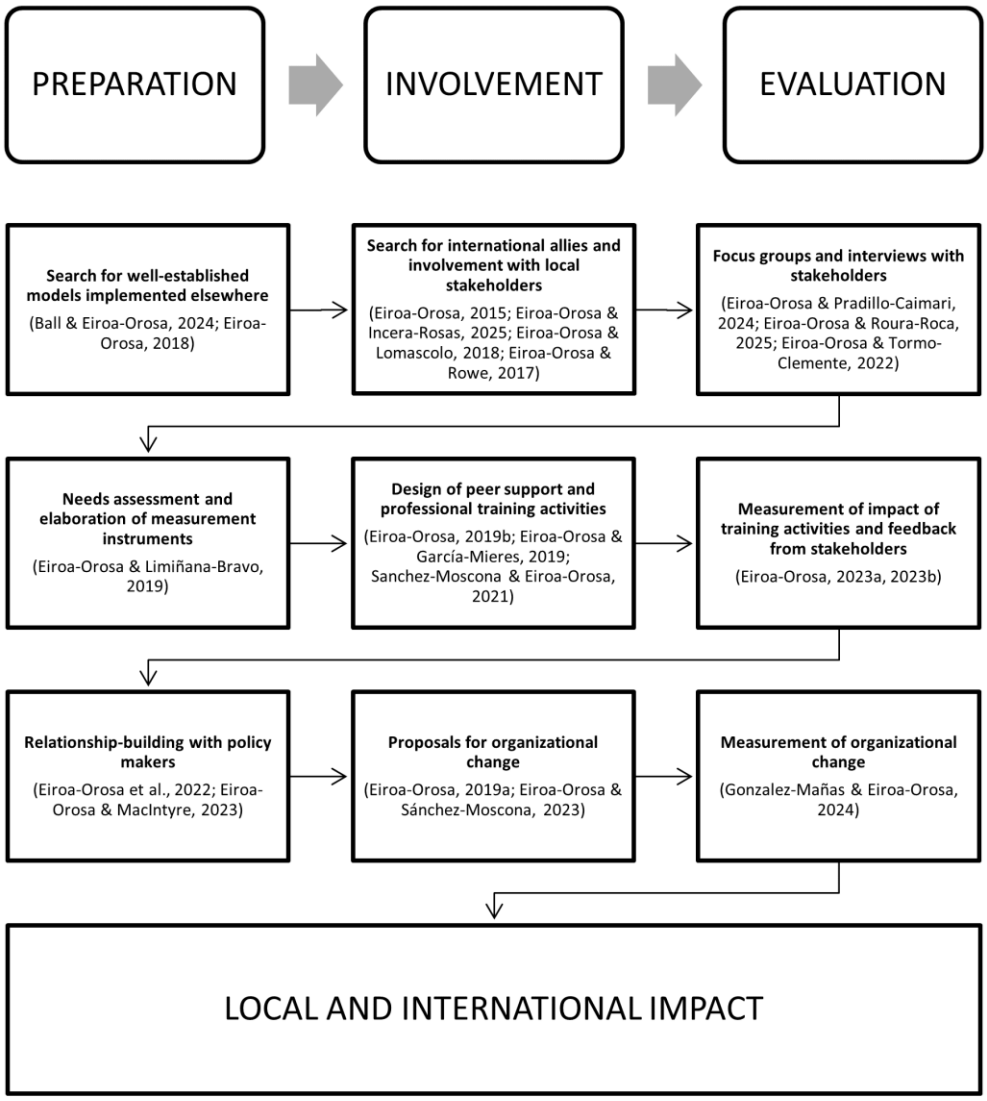


**Figure 1. Cycle of development of our transference project within the mental health care system.**

**Source:** Eiroa-Orosa & Rowe, 2017**.**

The initial phase included a comprehensive search for transformative models in mental health, during which the citizenship model (Rowe, 2015) stood out as the most relevant as it encompassed novelty and potential for systemic change. This model aims to redefine

individuals with mental health challenges as full community members with access to the five Rs: Rights, Responsibilities, Roles, Resources, and Relationships (Rowe & Pelletier, 2012b, 2012a). This phase also involved active engagement with local actors and an initial situational analysis of the local context (Clarke et al., 2016; Green, 2007) using qualitative methods to identify local needs (Allen et al., 2023). Participatory elements included focus groups and consultations involving people with lived experience, relatives and mental health professionals. Our findings revealed that although mental health professionals recognized the importance of people with lived experience' rights and the need for user-centered care, significant challenges remained in translating these values into practice including entrenched paternalistic attitudes, limited resources, and systemic constraints within mental health services (Eiroa-Orosa & Pradillo-Caimari, 2024).

The second phase incorporated stronger collaboration, such as joint review of qualitative data excerpts, and co-developing training content with peers and professionals. This stronger participatory approach was built upon findings from a qualitative needs assessment (Fitzpatrick & Boulton, 1994) conducted in collaboration with the boards of local organizations of mental health survivors, relatives and providers. Findings revealed limited familiarity with both the recovery model, linked to a wider movement that advocates for the possibility for people with lived experience to take on meaningful roles despite the limitations caused by illness, and professionalized peer support, highlighting the need to strengthen capacity in both areas (Eiroa-Orosa & Rowe, 2017). Although our primary interest lay in the citizenship model, the situational analysis carried out in the initial phase had made it clear that introducing such a framework would be difficult in a context marked by minimal awareness of the recovery model and a lack of structured implementation of professionalized peer support. While mutual aid groups did exist and have since expanded, at the time the project began in 2016, only a few voluntary support groups operated beyond periodic meeting spaces. Considering these findings, the project initially aimed to strengthen first-person mental-health activism (Eiroa-Orosa & Lomascolo, 2018), train peer-support worker trainers (Sanchez-Moscona & Eiroa-Orosa, 2021) and provide professional training in the recovery model (Eiroa-Orosa, 2023a). However, funding constraints driven by political instability caused by the Catalan independence process and the COVID-19 pandemic gradually shifted the focus

toward professional training, which could proceed independently without public administration support. Progress in the peer support strand, by contrast, advanced more slowly (Eiroa-Orosa & Sánchez-Moscona, 2023). The professional training stream began with a systematic review and meta-analysis (Page et al., 2021) of existing models for training mental health professionals (Eiroa-Orosa & García-Mieres, 2019). This work, together with qualitative data from eleven focus groups conducted during the earlier exploratory phase (Eiroa-Orosa & Pradillo-Caimari, 2024) and unstructured interactions with members of first-person organizations, informed a novel training model for mental health professionals, accredited for healthcare continuing education (Eiroa-Orosa, 2023a). The training covered four core topics. It began with alternatives to psychiatric diagnosis and approaches to reducing stigma; continued with recovery-oriented goal setting moving beyond symptom reduction; examined rights-based care emphasizing collaboration, individual preferences, and advance directives; and concluded by promoting the integration of peer support and lived-experience roles into mental-health services. Given the constraints mentioned earlier, the effectiveness of the training was evaluated through a randomized controlled trial using the Beliefs and Attitudes towards Mental Health Service Users' Rights Scale (BAMHS; Eiroa-Orosa & Limiñana-Bravo, 2019), a tool specifically developed and psychometrically validated to measure attitudinal change within this project. Results showed that the intervention demonstrated significant reductions in participants' tolerance towards coercive practices (Eiroa-Orosa, 2023a).

The third phase, which continues to the present day, focuses on organizational and public policy transformation (Pinfold et al., 2025). It has been developed through our participation in the Advisory Council on Mental Health and Addictions of the Catalan Government. While some progress has been made, particularly in promoting tools that support recovery-oriented services and the protection of the rights of mental-health service users, the formal evaluation of these efforts has only recently begun. We are now collaborating with Mental Health Europe to assess these developments at the European level, through a project focused on indicators of recovery-based approaches and human rights in mental-health services (Gonzalez-Mañas & Eiroa-Orosa, 2024).

Additionally, thanks to our regular participation in Catalan mental health care advisory bodies, we were invited to deliver a postgraduate course for practicing professionals. A flexible practical session allowed us to introduce a citizenship-framework activity in which participants used the 5Rs reflective grid to assess how their services address rights, responsibilities, roles, resources and relationships, identifying areas for further development (Eiroa-Orosa, 2019). This marked the first formal integration of the citizenship model into our educational efforts with professionals. Subsequently, in 2021, we secured funding for a project fully dedicated to the citizenship framework. This initiative had two primary milestones: the participatory validation of the citizenship measure, inspired by previous work in the United States (O'Connell et al., 2017; Rowe et al., 2012) and Scotland (Cogan et al., 2022; MacIntyre et al., 2019, 2022), and the implementation of an awareness intervention for professionals entirely based on the citizenship model, which is being evaluated through a randomized controlled trial (Eiroa-Orosa, 2023b). We cocreated the curriculum for this activity through a collaborative process involving a committee composed of individuals participating as survivors with lived experience and/or mental-health professionals. This was one of the clearest examples of cocreation in the project, as decisions about structure, content, and delivery were shared rather than exclusively researcher-led. The committee met twice to define learning goals, select methods involving active engagement from participants, and ensure that all materials reflected both lived experience and professional perspectives. Decisions were reached by consensus, with particular attention to balancing different types of expertise and addressing potential power asymmetries within the group. As determined by this committee, the curriculum comprises two main blocks. The first consists of small-group reflective work using the 5Rs grid (Eiroa-Orosa, 2019), in which homogeneous teams systematically analyzed their own services, identified citizenship-promoting and citizenship-limiting practices, and shared findings in plenary. The second block was an experiential workshop in which groups developed and role-played short scenarios drawn from their prior 5Rs analysis, enacting professional and user interactions "as if" citizenship-oriented practices were already in place, a method adapted from George Kelly's (1955) fixed-role technique combined with Watzlawick's (1976) adaptation of Vaihinger's (1911) "as if" philosophy, followed by facilitated group reflection to consolidate

learning. In our view, this approach offers clear advantages over conventional recovery-focused training models, which some professionals may perceive as critical or invalidating. Rather than implying shortcomings in existing practice, this method invites participants to reimagine their roles within a system that centers the 5Rs, rather than symptom remission or narrow definitions of functionality. This allows for a forward-looking and constructive reflection on what systemic change might require, both in terms of organizational support and professional collaboration. Framing the activity around an ideal mental-health system might reduce defensiveness and foster open dialogue, creating conditions that may increase openness to the citizenship model and its transformative potential while promoting critical reflection without relying on direct critique (Eiroa-Orosa & Gonzalez-Mañas, 2025).

## Section Summary

- The project was structured in three iterative phases each including preparation, involvement, and evaluation to ensure that collaboration and, whenever possible, cocreation with people with lived experience, relatives, and professionals promoted inclusivity and directly addressed systemic barriers within the mental health system.
- The first phase identified the citizenship model as a key framework because it provided a rights-based and socially grounded approach capable of addressing structural exclusion through its five dimensions (rights, responsibilities, roles, resources, and relationships) while qualitative research examined local needs and challenges in Catalonia’s mental health system to ensure contextual relevance.
- The second phase addressed limited local knowledge of the recovery model and professionalized peer support by strengthening first-person activism, training peer support worker trainers, and delivering recovery-oriented professional education (including alternatives to diagnosis, recovery-focused goals, rights-based care, and peer support) in order to build capacity and reduce coercive practices, as supported by the findings of a randomized controlled trial.
- The third phase seeks to consolidate impact at the systemic level by promoting organizational change and influencing public policy through engagement in

advisory bodies and collaboration on the development of rights-based indicators, thereby embedding earlier advances into institutional structures.

- In parallel, the citizenship model was integrated into professional education through a postgraduate course and later expanded through a dedicated project involving the participatory validation of a citizenship measure and a randomized controlled trial of a cocreated training curriculum, aiming to generate both educational and empirical foundations for sustainable change.

## Research Practicalities

Conducting transformative research involves navigating important practical and ethical challenges. A key requirement for a project of this kind is a strong personal commitment to the local mental health first-person movement, known internationally as the survivor or consumer movement (Trainor et al., 1997). Although mental health researchers may adopt different levels of engagement, ranging from nonparticipant observation to active advocacy, only the latter is consistent with a transformative research paradigm. My own stance aligned with this position. Becoming integrated into the mental-health first-person movement typically requires either lived experience of severe mental distress and/or a genuine commitment to challenging prevailing understandings and treatment of those who have had such experiences. In my case, both conditions applied. Moreover, postdoctoral researchers in mental health are often seen as valuable assets within the movement, particularly because one of the most persistent (albeit unfounded) objections to the implementation of peer support and person-centered, rights-based, and recovery-oriented approaches is the alleged lack of empirical evidence (Slade et al., 2014). My positionality as a postdoctoral researcher, and thus independent access to funding, with lived experience of mental distress and a commitment to systemic change shaped my approach. This perspective aligned with the ethos of ‘Mad Studies,’ a field that values knowledge from lived experience and has grown since the 2010s, with an increasing number of recognized research groups and a proliferation of academic publications (e.g., Beresford & Russo, 2021; Rose & Cohen, 2022). Despite this growing academic recognition of situated knowledge in mental health, the relationship between academic research and grassroots movements remains complex. Some groups, such as “Recovery

in the Bin," are openly critical of research, particularly quantitative evaluation, viewing it as a form of conceptual colonization (Thomas, 2016). At the same time, the resistance provoked by critiques of mental health care systems themselves should be also considered. Although many administrations have formally endorsed rights-based frameworks such as the Convention on the Rights of Persons with Disabilities (CRPD), this support is often qualified. In particular, Article 12, which upholds equal recognition before the law, has sparked concern among professional associations and legislators, who argue that strict interpretations may restrict clinicians' ability to intervene in life-threatening situations (Appelbaum, 2019; Freeman et al., 2015). These reservations expose the tension between the dominant biomedical model and transformative approaches grounded in autonomy and noncoercion. Thus, engaging people with lived experience and professionals implied building trust within communities wary of academic research. In practical terms, this required beginning with small, low-stakes interactions (e.g., joining training activities, informal discussions, invitations to comment on early ideas) to demonstrate reliability before proposing a more structured collaboration. However, my involvement in collective action for psychosocial disability rights, while essential for situated knowledge, exposed me to the movement's tensions. These dynamics challenged the perceived neutrality of academic research, requiring constant ethical positioning. To address this imbalance, I cofounded the First-Person Mental Health Research Group (https://www.ub.edu/gr1p), a hybrid space bridging social movements and academia. The initiative was supported by the remaining Marie Skłodowska-Curie (MSCA) funding that originally launched the project. This group facilitated inclusive research, training, and outreach, mitigating personal and professional conflicts while sustaining the project's momentum.

These ethical considerations directly influenced several methodological choices made during the project. They shaped decisions about how to analyze and use qualitative data from focus groups and interviews, particularly in balancing rigor with the need to protect participants' trust and ownership of their narratives. This was achieved by reducing the risk of drawing premature conclusions through validating preliminary interpretations with participants, and by disseminating outreach materials containing initial analyses that participants could readily relate to before the results were submitted to academic journals.

The same reasoning guided the use of quantitative methods. While the team developed and validated a psychometric tool to assess professionals' beliefs and attitudes towards service users' rights (Eiroa-Orosa & Limiñana-Bravo, 2019), we chose to apply quantitative measurement more cautiously in work involving people with lived experiences of distress, where standardized instruments risked reproducing power imbalances. When we used scales with lived-experience participants, we always offered a parallel debrief and the option to complete the instrument in dialogue with a peer rather than alone.

Ethical commitments also guided funding strategies, leading to efforts to secure resources that would strengthen the inclusion of colleagues with lived experience and support hybrid roles combining academic work, educational activities, and social activism. Securing even small amounts of flexible funding (e.g. travel stipends or small outreach projects) helped remove structural barriers to participation and ensured that collaboration did not rely on unpaid labor. These decisions illustrate how reflexivity and ethical awareness were embedded not only in data collection but in all stages of the research cycle, shaping a methodology grounded in respect, inclusion, and social relevance.

## Section Summary

- Conducting transformative research in mental health requires both personal commitment and active engagement with the survivor or consumer movement.
- Positionality within social movements brings valuable insights but also exposes researchers to tensions that challenge conventional notions of scientific neutrality
- Ethical and practical tensions arise from the complex relationship between academia and grassroots movements, particularly regarding conceptual colonization, autonomy, and noncoercion within rights-based mental health frameworks.
- These challenges shaped methodological choices prioritizing trust, inclusion, and participant ownership of narratives, often favoring socially impactful engagement over conventional academic outputs.

- Reflexivity and ethical awareness guided all stages of the research process from data analysis and quantitative measurement to funding and collaboration, ensuring the work remained respectful, inclusive, and socially relevant.

## Method in Action

The research unfolded through iterative phases, revealing both successes and challenges in applying inclusive methodologies. The beginning of the project was particularly rewarding. Although my previous experience with qualitative methods was limited, in a context dominated by quantitative research, participants welcomed the opportunity to engage in individual or group discussions about their views and concerns. While these focus groups and interviews with people with lived experience, relatives, and professionals were straightforward to organize, they were designed not merely for data collection (interaction) but as an entry point on Arnstein's (1969) ladder. Beyond their scientific value, these encounters fostered meaningful dialogue and moments of collective growth. Encouraged by this, we delved into the field of trialogues, a form of community-building that promotes open and inclusive dialogue between people with lived experience, relatives, and mental-health professionals as equal voices (Amering et al., 2002). This meant creating facilitated trialogic spaces where these groups met on equal terms to share experiences, question assumptions, and jointly reflect on mental health practices. These sessions differed from data-gathering focus groups and interviews because their purpose was relational rather than analytic, centering on trust-building, mutual learning, and the development of a shared language for collaboration. Equality was not presumed but actively scaffolded through several practical strategies. Sessions were cofacilitated by individuals with lived experience and professional backgrounds, helping to avoid professional dominance. Speaking time was structured using round-based dialogue formats to prevent monopolization. Participants were invited to speak from personal experience rather than professional role, and hierarchical titles were deliberately avoided during sessions. Ground rules were collectively agreed at the outset, emphasizing respect, non-interruption, and the legitimacy of experiential knowledge. These design choices did not eliminate structural power asymmetries, but they reduced their immediate influence within the dialogic space and made imbalances discussable when they emerged. Our findings supported the potential of these activities to challenge institutional power structures, modify attitudes and roles, and promote open communication and mutual understanding (Eiroa-Orosa & Incera-Rosas, 2025).

Concurrently, and somewhat intuitively, we undertook the validation of our Beliefs and Attitudes towards Mental Health Service Users Scale (Eiroa-Orosa & Limiñana-Bravo, 2019), using preliminary versions of the tool to prompt discussion during the focus groups with professionals. This strategy aligns with evidence that structured prompts, such as surveys, can help initiate and sustain dialogue in focus groups by giving all participants a shared starting point (Rinkus et al., 2021). Still, this first phase posed challenges, especially the transcription process, which was highly resource intensive. While today's transcription technologies can alleviate much of this burden, the bilingual nature of the fieldwork setting (Catalan and Spanish) posed additional difficulties. Resource limitations also led us to rely on students to help analyze the large volume of qualitative data. Although the project attracted international students, linguistic nuances required the involvement of local collaborators fluent in both languages.

Once we had collected qualitative data and developed a quantitative evaluation tool, the project entered a phase in which participatory engagement became more structured and intervention-focused. While participation had been embedded in earlier exploratory and design stages, this phase shifted from dialogic inquiry toward collaborative training development and implementation. A pivotal decision was to attend training sessions aimed at people with lived experience, organized by the anti-stigma alliance Obertament. These sessions followed Corrigan's (2011) TLC3 principles (Targeted, Local, Credible, Continuous Contact) and proved instrumental in shaping our positioning within the user movement and our commitment to engaged research. Rather than observing as an external evaluator, I embedded myself within the program as a collaborator, negotiating evaluation goals with organizers and incorporating their priorities into the research design both quantitatively (Eiroa-Orosa & Lomascolo, 2018) and qualitatively (Eiroa-Orosa & Rovira-Gimo, 2024). This experience helped us launch the first peer support training-the-trainers program in Catalonia. The evaluation of this program incorporated participatory elements that went beyond interactive discussion. For example, group debate sessions were structured not merely to collect feedback but to facilitate collective synthesis of learning, with participants identifying key themes, prioritizing recommendations, and contributing to the refinement of future curricula (Sánchez-Moscona & Eiroa-Orosa, 2021). Draft training materials and analytic summaries were returned to participants for

validation, and decisions about future adaptations were made jointly with facilitators from the first-person movement. In this way, participants influenced both the interpretation of data and the direction of subsequent program development, rather than serving solely as respondents. Despite the effort required, this phase ran smoothly due to the enthusiasm within the first-person movement in Catalonia and the availability of pedagogical materials from previous initiatives (Eiroa-Orosa & Sánchez-Moscona, 2023).

Implementing training for professionals, however, was more complex. While the earlier focus groups with over 100 professionals (Eiroa-Orosa & Pradillo-Caimari, 2024) had yielded valuable insights on how to foster dialogue, logistical challenges emerged. The initial plan was to hold training sessions at educational settings such as universities and to randomize participation via a waitlist control design. Although this design may overestimate the intervention's effects (Cunningham et al., 2013), it represented an ethically sound alternative to withholding the intervention from a subset of professionals. The use of a wait-list control ensured that all participants eventually received the training, thus balancing ethical considerations with methodological rigor (Eiroa-Orosa, 2023a). However, low attendance at the first session and feedback regarding professionals' difficulties in attending off-site training sessions led us to shift strategy. We began collaborating with service providers and delivered the training on-site, which proved much more effective. This change allowed us to conduct 15 editions involving over 300 professionals. To optimize resources, we collected evaluation data online via surveys. While efficient, this limited our ability to follow up with participants, resulting in significant attrition. We attempted to address this by accrediting the course through the Catalan Council for Continuing Education of Health Professions, making certification contingent on completing two follow-up assessments. Nevertheless, we lost nearly half of the sample.

The final phase of the project, which focused on public policy and organizational change, required sustained engagement with institutional actors. We joined the Mental Health and Addictions Advisory Council of the Catalan Government and built trust with key actors in the mental health system. This remains an open-ended process as improving mental health services is more a continuous endeavor than a finite goal.

Drawing on our expertise and long-standing involvement in the implementation of peer support worker roles, we were able to make a meaningful contribution in these spaces. Unfortunately, the pace of implementation has been far slower than anticipated. In Catalonia, the number of peer support workers remains in the dozens, with only a few employed in relatively stable positions, an outcome that contrasts with the broader uptake seen in other European countries (Eiroa-Orosa & Sánchez-Moscona, 2023). We also engaged in broader advocacy efforts, including the reduction of coercive practices in mental health care and the promotion of shared decision-making (Eiroa-Orosa & Roura-Roca, 2025). A recent collaboration with Mental Health Europe (Gonzalez-Mañas & Eiroa-Orosa, 2024) has enabled us to begin developing human-rights compliance indicators for mental health services, an important step in aligning service provision with the rights-based framework that underpins this project.

## Section Summary

- The project began with qualitative research that fostered rich dialogue among people with lived experience, relatives, and professionals, and laid the groundwork for later exploration of trialogues and attitudinal measurement tools.
- Training and participation efforts included key collaborations with the user movement, leading to anti-stigma work and the launch of Catalonia’s first peer support train-the-trainer program.
- Implementing professional training presented logistical challenges, prompting a shift from university-based to on-site sessions, which significantly improved participation.
- The project's policy and organizational phase involved sustained institutional engagement, but progress in implementing peer support roles was slower than expected.
- Ongoing collaborations continue to promote rights-based mental-health practices through the development of compliance indicators and broader advocacy initiatives.

## Practical Lessons Learned

Looking back, several aspects of the methodology proved effective, while others posed significant challenges and required adaptation. One of the most positive experiences was the early use of qualitative methods, which created space for participants to voice their perspectives. These encounters fostered trust and collective engagement, laying the groundwork for the project's ethos of inclusion. While I had limited experience with qualitative research at the outset, the openness of participants and the richness of the discussions underscored the value of these methods, especially in settings where dominant approaches have traditionally been quantitative and top-down. Another important decision was to collaborate with existing grassroots initiatives. Partnering with groups that had established practices and shared values made it possible to embed the research within ongoing community processes rather than creating parallel structures. In practical terms, this involved identifying local groups whose aims aligned with the research, approaching them early, and asking what forms of involvement would be genuinely useful to them rather than assuming what participation should look like. This not only made logistical sense but also lent the project credibility and fostered alignment with the broader goals of the first-person movement.

One of the main lessons learned was that when working on a project grounded in empowerment values, time is a critical and often underestimated variable. Creating meaningful dialogue, building trust, and moving towards higher rungs of the co-production ladder required slow, relational work rather than discrete, task-oriented forms of involvement. In earlier phases of the project, stakeholder engagement often took the form of structured participation, where people with lived experience, relatives, or professionals contributed perspectives within researcher-led workshops or focus groups. Although these spaces enabled important dialogue, decision-making authority largely remained with the research team. As the project evolved, some activities moved closer to collaboration, with shared decision-making in specific components, such as refining training content or reviewing emerging interpretations. However, elements that approached fuller co-production emerged only when decision-making power was genuinely redistributed. In these instances, people with lived experience were not only consulted but actively shaped agendas, co-interpreted findings alongside researchers,

and jointly designed training materials, including decisions about structure, content, and delivery. These processes involved extended negotiation and reflexive dialogue, and they positioned lived experience contributors as coauthors of knowledge rather than respondents to researcher-defined questions. While not all aspects of the project reached this level of shared authority, these moments illustrate how co-production in practice differed from interaction or collaboration, as it required a substantive shift in epistemic ownership and control over key outputs.

Each of these steps depended on extended conversations, negotiation, and checking in with partners about confidence, safety, and relevance. These processes unfold at their own pace and are deeply affected by the emotional, political, and institutional contexts in which they occur. At various points, we faced tensions between academic deadlines, funding requirements, and the need to move at a pace that respected the agency and rhythms of participants and partner organizations. In retrospect, advocating more strongly for flexible timelines in the funding design and structuring early phases to focus on relationship-building rather than immediate deliverables might have helped reduce these tensions. These experiences also shaped the methodological decisions taken throughout the project, many of which emerged from negotiating practical and institutional constraints rather than from fully predefined plans. When full co-production was not possible, shared decision-making was prioritized in specific components, and smaller but meaningful opportunities for influence were created, such as co-validating tools or collaborating on dissemination choices. This incremental approach allowed the project to remain aligned with its ethical commitments while adapting to the contextual realities.

Despite our commitment to working closely with the first-person movement, the structural power imbalance between researchers and participants remained a recurring issue. While we actively involved people with lived experience as trainers and coresearchers, this involvement took different forms across the project and did not amount to sustained shared control over its overall direction. In the early qualitative phases, lived-experience contributors helped refine interview guides to ensure that questions reflected their priorities and participated in group discussions of selected excerpts to validate and nuance emerging interpretations. During the anti-stigma and

peer-support strands, they acted as trainers, delivering sessions grounded in their own experiential expertise and contributing to decisions about pedagogical strategies and thematic emphasis. In the later citizenship-focused initiative, individuals with lived experience joined a curriculum committee that defined learning objectives, shaped experiential exercises, and determined how the 5Rs framework would be translated into practice-based activities. These examples illustrate moments of partnership and, in specific components, delegated power. However, responsibility for grant applications, overall project architecture, methodological framing, and final publication decisions largely remained with the academic team. Using Arnstein's (1969) ladder of participation as a reference, the general level of involvement across the project therefore aligned more closely with partnership or delegated power than with citizen control. Structural and institutional barriers, including limited formal recognition of experiential expertise and the precarious employment conditions of many collaborators, prevented deeper and more sustained cocreation. The slow implementation of peer support roles in the mental health system, with only a handful of stable contracts in place, further restricted opportunities for long-term shared leadership. In practice, collaboration tended to concentrate around specific tasks rather than continuous co-governance. Making these boundaries explicit helped avoid tokenism but also revealed the limits imposed by existing institutional structures. This experience highlights the need not only for methodological flexibility but also for structural advocacy in research that seeks to transform systems from within. Researchers must navigate the dual role of generating knowledge while simultaneously challenging the institutional constraints that restrict the very inclusion their methodologies aim to promote

I would advise researchers planning rights-based research projects to consider the emotional and relational labor involved. Facilitating spaces for open dialogue, particularly when involving people who have experienced coercion or marginalization, demands care, reflexivity, and often personal vulnerability. In this project, care was enacted through concrete practices such as preparing participants in advance for sensitive topics, agreeing on boundaries for discussion, checking in informally after difficult sessions, and adjusting the pace of activities when distress became visible. Reflexivity, meanwhile, was supported through regular debriefings with peers and collaborators with lived experience,

whose perspectives helped identify blind spots in facilitation and strengthened the integrity of the process. The potential for mutual growth is immense, but so is the risk of replicating power dynamics if this labor is not acknowledged, supported, and shared. Building a team that included peers, professionals, and researchers with diverse backgrounds and experiences helped us cultivate a more grounded and dialogical approach, but it also required ongoing attention to dynamics of trust, voice, and recognition.

### Section Summary

- Early use of qualitative methods created conditions for trust, participant engagement, and inclusion in a context otherwise dominated by quantitative approaches.
- Collaborating with existing grassroots initiatives strengthened the project's credibility, ensured alignment with the first-person movement, and helped embed the research within ongoing community processes.
- Building dialogue, trust, and co-production required more time than anticipated, leading to adaptations such as flexible pacing, shared decision-making in specific components, and incremental opportunities for participant influence.
- Structural power imbalances and institutional constraints limited the scope of cocreation, highlighting the need for methodological flexibility and structural advocacy within transformative research.

## Conclusion

This case study has explored the methodological journey of a transformative mental health research project grounded in the principles of recovery and citizenship. It illustrates how a deliberate move away from conventional, positivist paradigms towards participatory, rights-based approaches can support system-level change. Rather than presenting research as a detached or neutral process, the project embraced positionality and lived experience as sources of legitimate knowledge and catalysts for social transformation. The methodology, structured in iterative phases of preparation, involvement, and evaluation, combined qualitative and quantitative methods, although the

integration of both was constrained by academic pressures. Despite these limitations, the design enabled meaningful engagement with people with lived experience, relatives, and professionals. The cocreation of experiential techniques such as the constructivist activity in which professionals enacted “as if” citizenship-oriented practice to surface assumptions and explore alternative relational possibilities, and participatory validation of assessment tools are all approaches that may be of interest to researchers seeking to empower marginalized communities and influence mental health systems.

Crucially, the case reveals that the success of participatory and transformative research (i.e., research characterized by shared agenda-setting, co-interpretation of findings, and collective decision-making in training and validation designs) is contingent on more than methodological rigor. It requires time, flexibility, and trust-building. This involved pacing activities according to participants’ availability, adapting methods in response to institutional barriers, investing in repeated low-stakes interactions before requesting deeper involvement, and maintaining transparent communication through which participants could challenge emerging interpretations. These elements are often undervalued or misaligned with institutional funding cycles and academic expectations. Researchers planning similar work should therefore advocate for realistic timelines and prepare to manage tensions between research values and systemic constraints. On reflection, I would recommend the overall approach but with two caveats. First, future projects should prioritize early structural planning to support sustained peer involvement, ideally through formal roles and compensation mechanisms. Second, greater emphasis on mixed-methods integration during the design phase might improve coherence and facilitate dissemination. Ultimately, the approach used here may serve as a guide for those seeking to blend academic research with social advocacy. Centering the perspectives of people with lived experience and embedding research within ongoing advocacy efforts might offer a viable model for researchers committed to inclusive mental health research. These experiences illustrate how participatory research requires translating principles into specific practices, responding flexibly to constraints, and reflecting on one’s positionality throughout the process (Cornish et al., 2023).

## Discussion Questions

1. When institutional or funding constraints make full co-production impossible from the outset, how can researchers still design projects that meaningfully shift power toward lived-experience partners as the work unfolds?
2. What concrete strategies are most effective for moving from consultation or collaboration toward genuine cocreation in mental health research or training projects?
3. How might focus groups or experiential learning activities foster reflection and attitudinal change among mental health professionals?
4. In what ways does active involvement in survivor-led or rights-based movements both enrich and complicate a researcher's positionality, and how can the resulting tensions around scientific neutrality and academic credibility be productively addressed?
5. When fixed funding timelines and rigid institutional requirements clash with the slower, relational work of building trust and sustained collaboration, what practical compromises or creative sequencing of activities can help researchers honor both ethical commitments and external obligations?

## Multiple Choice Quiz Questions

1. In transformative mental-health research conducted with lived-experience partners, what is typically the most pervasive ethical tension?
   A. Protecting participants from over-disclosure in qualitative interviews.
   B. Balancing genuine inclusivity and power-sharing against institutional and funding constraints that tend to preserve researcher control. CORRECT
   C. Choosing between statistical generalizability and narrative depth.
2. Why is early, open-ended qualitative inquiry often methodologically valuable in studies that aim to move toward coproduced mental health research?
   A. It can generate knowledge grounded in participants' perspectives, which may support subsequent participatory decision-making. CORRECT

B. It facilitates a richer understanding of local contexts before quantitative tools are developed.
C. It enables the identification of systemic barriers that might not emerge through surveys alone.

3. How does a researcher's active involvement typically affect methodological design?
   A. It requires the researcher to abandon reflexivity to maintain advocacy credibility.
   B. It obliges the researcher to delegate data analysis to external collaborators to preserve neutrality.
   C. It requires the researcher to integrate experiential knowledge into methodological decisions through reflexive practice, while explicitly acknowledging positionality and potential bias. CORRECT
4. In transformative mental health projects, what factor most commonly drives major adaptations to the original research design over time?
   A. Iterative feedback from participants and partners requires balancing methodological rigor with accessibility and trust. CORRECT
   B. The need to comply with evolving ethical guidelines on data protection and confidentiality.
   C. Changes in mental health policies.
5. What is the primary value of methodological flexibility in transformative research?
   A. Allowing researchers to adjust timelines and resource use to maintain project efficiency.
   B. Facilitating the integration of diverse data sources to support coherent interpretation.
   C. Enabling adaptation to shifting power relations, emerging priorities, and contextual constraints in ways that enhance ethical robustness and social impact. CORRECT

## Further Reading


Barbour, R. S. (1999). Are focus groups an appropriate tool for studying organizational change? In *Developing Focus Group Research* (pp. 114–126). Sage Publications. https://doi.org/10.4135/9781849208857.n8

Faulkner, A., & Thomas, P. (2002). User-led research and evidence-based medicine. *British Journal of Psychiatry*, *180*(1), 1–3. https://doi.org/10.1192/bjp.180.1.1

Mertens, D. M. (2021). Transformative research methods to increase social impact for vulnerable groups and cultural minorities. *International Journal of Qualitative Methods*, *20*. https://doi.org/10.1177/16094069211051563

Rose, D., & Cohen, B. (2022). *Mad knowledges and user-led Research*. Palgrave Macmillan.

Schubotz, D. (2020). *Participatory research: Why and how to involve people in research*. Sage Publications. https://doi.org/10.4135/9781529799682

Wilkinson, S. (1998). Focus groups in health research. *Journal of Health Psychology*, *3*(3), 329–348. https://doi.org/10.1177/135910539800300304


## References


Allen, L. N., Azab, H., Jonga, R., Gordon, I., Karanja, S., Thaker, N., Evans, J., Ramke, J., & Bastawrous, A. (2023). Rapid methods for identifying barriers and solutions to improve access to community health services: A scoping review. *BJGP Open*, *7*(4), 1–19. https://doi.org/10.3399/BJGPO.2023.0047

Amering, M., Hofer, H., & Rath, I. (2002). The “First Vienna Trialogue”—experiences with a new form of communication between users, relatives, and mental health professionals. In H. Lefley & D. Johnson (Eds.), *Family interventions in mental illness: International perspectives* (pp. 105–124). Praeger.

Appelbaum, P. S. (2019). Saving the UN Convention on the Rights of Persons with Disabilities—from itself. *World Psychiatry*, *18*(1), 1–2. https://doi.org/10.1002/wps.20583

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners*, *35*(4), 216–224. https://doi.org/10.1080/01944366908977225

Beresford, P., & Russo, J. (2021). *The Routledge international handbook of madsStudies* (P. Beresford & J. Russo (Eds.). Routledge. https://doi.org/10.4324/9780429465444

Clarke, A. E., Friese, C., & Washburn, R. (Eds.). (2016). *Situational analysis in practice*. Routledge. https://doi.org/10.4324/9781315420134

Cogan, N., MacIntyre, G., Stewart, A., Harrison-Millan, H., Black, K., Quinn, N., Rowe, M., & O'Connell, M. (2022). Developing and establishing the psychometric properties of the Strathclyde Citizenship Measure: A new measure for health and social care practice and research. *Health & Social Care in the Community*, *30*(6). https://doi.org/10.1111/hsc.13789

Cornish, F., Breton, N., Moreno-Tabarez, U., Delgado, J., Rua, M., de-Graft Aikins, A., & Hodgetts, D. (2023). Participatory action research. *Nature Reviews Methods Primers*, *3*(1), 34. https://doi.org/10.1038/s43586-023-00214-1

Corrigan, P. W. (2011). Best practices: Strategic stigma change (SSC): Five principles for social marketing campaigns to reduce stigma. *Psychiatric Services*, *62*(8), 824–826. https://doi.org/10.1176/ps.62.8.pss6208_0824

Cunningham, J. A., Kypri, K., & McCambridge, J. (2013). Exploratory randomized controlled trial evaluating the impact of a waiting list control design. *BMC Medical Research Methodology*, *13*(1). https://doi.org/10.1186/1471-2288-13-150

Eiroa-Orosa, F. J. (2019). Analyzing community mental health programs through the citizenship framework: A learning experience. *American Journal of Psychiatric Rehabilitation*, *22*(1–2), 64–81.

Eiroa-Orosa, F. J. (2023a). Beyond recovery: Toward rights-based mental health care—A cluster randomized wait-list controlled trial of a recovery and rights training for mental health professionals with or without first person accounts. *Frontiers in Psychology*, *14*. https://doi.org/10.3389/fpsyg.2023.1152581

Eiroa-Orosa, F. J. (2023b). Citizenship as mental health. A study protocol for a randomised trial of awareness interventions for mental health professionals. *Journal of Public Mental Health*, *22*(3), 117–126. https://doi.org/10.1108/JPMH-09-2022-0089

Eiroa-Orosa, F. J., & García-Mieres, H. (2019). A systematic review and meta-analysis of recovery educational interventions for mental health professionals. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(6), 724–752. https://doi.org/10.1007/s10488-019-00956-9

Eiroa-Orosa, F. J., & Gonzalez-Mañas, D. (2025). Building Citizenship: An Experiential Awareness Intervention for Mental Health Professionals. *Journal of Constructivist Psychology*. https://doi.org/10.1080/10720537.2025.2609970

Eiroa-Orosa, F. J., & Limiñana-Bravo, L. (2019). An instrument to measure mental health professionals' beliefs and attitudes towards service users' rights. *International Journal of Environmental Research and Public Health*, *16*(2), 244. https://doi.org/10.3390/ijerph16020244

Eiroa-Orosa, F. J., & Lomascolo, M. (2018). Training mental health activists increases the well-being of participants with high baseline levels of self-stigma: Results of the Obertament training evaluation. *American Journal of Orthopsychiatry*, *88*(6), 617–625. https://doi.org/10.1037/ort0000376

Eiroa-Orosa, F. J., & Pradillo-Caimari, C. (2024). A qualitative study exploring mental health professionals' perspectives, opinions, and attitudes on the state of service users' rights. *Irish Journal of Psychological Medicine*, 1–8. https://doi.org/10.1017/ipm.2024.36

Eiroa-Orosa, F. J., & Roura-Roca, I. (2025). An interview study with professionals on shared decision-making in child and adolescent mental health. *Child and Adolescent Social Work Journal*. https://doi.org/10.1007/s10560-025-01035-9

Eiroa-Orosa, F. J., & Rovira-Gimo, M. (2024). Activism against stigma: Exploring awareness-raising activities in the health care context. *Quaderns de Psicologia*, *26*(1), e1963. https://doi.org/10.5565/rev/qpsicologia.1963

Eiroa-Orosa, F. J., & Rowe, M. (2017). Taking the concept of citizenship in mental health across countries. Reflections on transferring principles and practice to different sociocultural contexts. *Frontiers in Psychology*, *8*. https://doi.org/10.3389/fpsyg.2017.01020

Eiroa-Orosa, F. J., & Sánchez-Moscona, C. (2023). Implementing the figure of peer support workers in mental health: An international perspective from the context of its implementation in Catalonia. *Salud Colectiva*, *19*, e4252. https://doi.org/10.18294/sc.2023.4252

Eiroa-Orosa, F. J., & Incera-Rosas, M. (2025). Correction: A qualitative analysis of trialogues between people with lived experience, their relatives, and mental health professionals. *Community Mental Health Journal*, *61*(4), 775–775. https://doi.org/10.1007/s10597-024-01436-7

Fitzpatrick, R., & Boulton, M. (1994). Qualitative methods for assessing health care. *Quality in Health Care*, *3*(2), 107–113. https://doi.org/10.1136/qshc.3.2.107

Freeman, M. C., Kolappa, K., de Almeida, J. M. C., Kleinman, A., Makhashvili, N., Phakathi, S., Saraceno, B., & Thornicroft, G. (2015). Reversing hard-won victories in the name of human rights: A critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. *The Lancet Psychiatry*, *2*(9), 844–850. https://doi.org/10.1016/S2215-0366(15)00218-7

Gonzalez-Mañas, D., & Eiroa-Orosa, F. J. (2024). *Recovery-based human rights indicators in mental health services*. Mental Health Europe.

Green, A. (2007). Situational analysis. In *An Introduction to Health Planning for Developing Health Systems* (pp. 185–200). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198571346.003.0007

Grindell, C., Coates, E., Croot, L., & O'Cathain, A. (2022). The use of co-production, co-design and co-creation to mobilise knowledge in the management of health conditions: A systematic review. *BMC Health Services Research*, *22*(1), 1–26. https://doi.org/10.1186/s12913-022-08079-y

Kelly, G. A. (1955). *The psychology of personal constructs*. Norton.

MacIntyre, G., Cogan, N., Stewart, A., Quinn, N., O'Connell, M., & Rowe, M. (2022). Citizens defining citizenship: A model grounded in lived experience and its implications for research, policy and practice. *Health & Social Care in the Community*, *30*(3), e695–e705. https://doi.org/10.1111/hsc.13440

MacIntyre, G., Cogan, N., Stewart, A., Quinn, N., Rowe, M., O'Connell, M., Easton, D., Hamill, L., Igoe, M., Johnston, G., McFadden, A.-M., & Robinson, J. (2019). Understanding citizenship within a health and social care context in Scotland using community-based participatory research methods. In *SAGE Research Methods Cases Part 1*. Sage Publications. https://doi.org/10.4135/9781526484918

O'Connell, M. J., Clayton, A., & Rowe, M. (2017). Reliability and validity of a newly developed measure of citizenship among persons with mental illnesses. *Community Mental Health Journal*, *53*(3), 367–374. https://doi.org/10.1007/s10597-016-0054-y

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., . . . Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, n71. https://doi.org/10.1136/bmj.n71

Pinfold, V., Burgess, A., Couperthwaite, L., Garavini, E., Gibson, J., Kamvar, R., Kenny, A., MacKay, T., Naughton, G., & Temple, R. (2025). Emerging practice in mental health patient and public involvement research advisory groups: A narrative review. *BMC Psychiatry*, *25*(1). https://doi.org/10.1186/s12888-025-07120-8

Rinkus, M. A., Donovan, S. M., Hall, T. E., & O'Rourke, M. (2021). Using a survey to initiate and sustain productive group dialogue in focus groups. *International Journal of Social Research Methodology*, *24*(3), 327–340. https://doi.org/10.1080/13645579.2020.1786240

Rose, D., & Cohen, B. (2022). *Mad knowledges and user-led research*. Palgrave Macmillan.

Rowe, M. (2015). *Citizenship and mental health*. Oxford University Press.

Rowe, M., Clayton, A., Benedict, P., Bellamy, C., Antunes, K., Miller, R., Pelletier, J.-F., Stern, E., & O'Connell, M. J. (2012). Going to the source: Creating a citizenship outcome measure by community-based participatory research methods. *Psychiatric Services*, *63*(5), 445–450. https://doi.org/10.1176/appi.ps.201100272

Rowe, M., & Pelletier, J.-F. (2012a). Citizenship: A response to the marginalization of people with mental illnesses. *Journal of Forensic Psychology Practice*, *12*(4), 366–381. https://doi.org/10.1080/15228932.2012.697423

Rowe, M., & Pelletier, J.-F. (2012b). Mental illness, criminality, and citizenship revisited. *The Journal of the American Academy of Psychiatry and the Law*, *40*(1), 8–11.

Sanchez-Moscona, C., & Eiroa-Orosa, F. J. (2021). Training mental health peer support training facilitators: A qualitative, participatory evaluation. *International Journal of Mental Health Nursing*, *30*(1), 261–273. https://doi.org/10.1111/inm.12781

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12–20. https://doi.org/10.1002/wps.20084

Thomas, P. (2016). Psycho politics, neoliberal governmentality and austerity. *Self & Society*, *44*(4), 382–393. https://doi.org/10.1080/03060497.2016.1192905

Trainor, J., Shepherd, M., Boydell, K. M., Leff, A., & Crawford, E. (1997). Beyond the service paradigm: The impact and implications of consumer/survivor initiatives.

*Psychiatric Rehabilitation Journal*, *21*(2), 132–140. https://doi.org/10.1037/h0095328

Vaihinger, H. (1911). *The philosophy of "as if": A system of the theoretical, practical and religious fictions of mankind.* Reuther & Reichard.

Watzlawick, P. (1976). *Wie wirklich ist die Wirklichkeit? Wahn, Täuschung, Verstehen*. Piper Verlag.