

# Can Co-production Really Transform UK Mental Health Services?



By **Sarah Carr, PhD**

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**“Every revolution evaporates and leaves behind  
Only the slime of a new bureaucracy”**

**— Franz Kafka**

If you can't quite get a grip on co-production, you're not alone. Much of the literature dating back as far as [1984](#) suggests that it's something of a greased pig and that efforts to define it end up like a policy pig scramble. Is it democratic citizen involvement public services? Is it individual, 'responsibilised' health and social care consumerism? Is it power shifting to communities through participatory governance? [Some authors](#) have said that 'neither on the level of interactions between organisations nor on the level of servicing users, has co-production a fixed meaning' and [others](#) have noted its 'excessive elasticity.' Perhaps it's the ultimate post-modern policy concept. But can it work for mental health?

In 2000 the American law academic and social justice activist, Edgar Cahn, wrote a book called '[No More Throwaway People: The Co-production Imperative](#)' in which he set out perhaps the clearest and most radical set of proposals for the 'co-production' of public services. Under the New Labour government, his co-production theories became very influential for UK health and social care policy, including mental health.

Cahn's conceptualisation of 'co-production' seems to make a lot of sense to mental health service users and survivors, and often appears to be consistent with many service user and survivor movement values. It's about social justice, 'the transformation of power and control' and giving equal status to service user and survivor knowledge and expertise. It means shifting relationships between professionals and service users and their communities from 'one of subordination and dependency to parity, mutuality and reciprocity.' Cahn acknowledges that the process won't be easy and may involve 'hellraising' and disruption as an integral part of power realignment and change processes.

## User Participation on Anabolic Steroids?

If this type of co-production is like service user participation on anabolic steroids, for mental health what's not to like? Politicians and central government policy makers in the UK were certainly keen, (although possibly less keen on actually directly co-producing policy with service users and their organisations). Influenced by Cahn, left-leaning think tanks such as the [New Economics Foundation](#), [Compass](#), and [Nesta](#) took up the co-production cause, redefined it and actively influenced New Labour health and social care policy.

The term began to proliferate in UK national social care and mental health 'transformation' policy documentation, firstly in 2008's '[Putting People First](#),' which boldly proclaimed that it 'seeks to be the first public service reform programme which is co-produced, co-developed, co-evaluated and recognises that real change will only be achieved through the participation of users and carers at every stage.' Eight years later, the [NHS Five Year Forward View for Mental Health](#) recommends co-production as a treatment for a critically (f)ailing system.

But, as with its modernising big sister '[personalization](#),' and its revolutionary cousin, '[recovery](#),' there are serious questions to be asked about the realities of implementing a radical type of 'transformative' co-production in mainstream UK mental health services. Cahn's co-production concept means fundamental policy reform that relocates power to mental health service users, survivors, their organisations and communities. But how possible is this in a medicalised system that is riven with vast and varied inequalities, engrained stigma and has a history of strict power and role relations?

## The Fate of Revolutions

The dominant medical psychiatric paradigm appears to pose a fundamental challenge to achieving co-production in mainstream mental health services. People with mental health problems in UK are subject to compulsion and containment under the Mental Health Act. How then can the assets, expertise and knowledge of service users and survivors be regarded as equal and valuable when, as [Peter Beresford](#) has observed, 'their processing in the psychiatric system is related not only to them being seen as defective, but also frequently dissident, non-conformist and different in their values'?

In order to understand what the prospects are for co-production to transform mainstream UK mental health services, it may be sensible to look at the fate of revolutionary mental health reform ideas originating with the service user and survivor movement. This is what a small collaborative working group of mental health service users, survivors, carers, practitioners, researchers and policy workers did recently for a [position paper](#) asking questions about co-production in mainstream UK mental health services.

The group looked at evidence on what has happened to user-defined empowerment, personal recovery, user participation and choice and control through direct payments once they were implemented into the mainstream. They found that their potential to transform the mental health system was significantly limited by the legacy of old institutional cultures and control mechanisms. This was often through limitations on service users exercising their agency and power and through the maintenance of professional or service influence and power. Institutional control also affected the way practitioners were able to work equally and collaboratively with service users.

### The Legacy of the Old Institutions

The overview of evidence on the introduction of personal recovery, user participation, direct payments and user-defined empowerment showed that there are several specific challenges for achieving transformative co-production in current mainstream NHS mental health services associated with the legacy of the old institutions. Many of these are bad for staff and general quality of care and support too. They were:

- **Institutional resistance to change:** Often traditional systems and practices remained the same, or with superficial or short-term changes. In the case of direct payments or personal recovery, evidence showed that co-option and control are at play, where clinical and organisational goals drive the agenda. Because they can pose a collective challenge and alternative power base, service user and survivor organisations were not always welcomed in mainstream mental health service user participation and support provision initiatives.
- **Restrictive administrative procedure and professional practice:** People were still being judged by their diagnosis, psychiatric history or administrative categories in any initiatives aimed at increasing influence, choice and control. This power dynamic is maintained by medical and professional role dominance. However, the medical model, professional role rigidity and risk aversity are also bad for staff who are expected to work in co-production with service users as equals.
- **Avoidance of challenge, confrontation or emotional expression:** Service users may initially want to tell uncomfortable stories in participation forums, make criticisms of services or practice, express anger about bad experiences or want to take control of their own recovery or care and support plan. However, within mental health system participation initiatives this can result in the exercise of professional control, the marginalisation and pathologisation of service user voices or the translation or modification of those voices by professionals, all of which represent aspects of institutional control.
- **The demand to conform by institutional rules and cultural norms:** Service users who are invited into service spaces to participate in decision-making or in their own support or recovery planning are often expected to obey certain institutional rules and cultural norms about behaviour, choices and use of language. This can mean they are expected to remain in an 'obedient patient' type role in order to be accepted. Revolutionary concepts like recovery and direct payments can be co-opted and transformed into part of standard administrative or decision-making procedure.

### Dismantling Institutions

From the evidence examined, it seems that there is a risk of co-production being absorbed into and defined by a mainstream mental health system that has the characteristics of the institution and becoming part of institutionally or professionally defined procedure. However, Edgar Cahn's original revolutionary idea of transformative co-production was about dismantling institutions, changing their cultures and practices and rebalancing power.

His foundational view of co-production is about social justice and inclusion, with the fundamental conviction that there should be no 'throwaway people' because everyone has assets, knowledge, strengths and contributions to make. It is about disrupting traditional fixed roles and power relations between professionals and service users and should not be determined by what the institution or organisation wants.

Depending on the context co-production may be collaborative, but it may also be confrontational. It may result in small but significant changes to individual relationships between practitioners and service users, or it may mean larger service or system reforms. Radical change in mental health through transformative co-production can mean that 'hell-raising' and challenge can be a necessary part of the process.

Is it the complex legacy of the institution that we need to address for co-production in the mainstream UK mental health system as it appears to have been a barrier to all previous attempts by service users and survivors to revolutionise their support and improve their lives. Perhaps, as [Mary O'Hagan](#) has observed, it is time for mainstream mental health services to finally 'see how their well-funded services run by experts squeeze the resourcefulness out of mad people, their families and their communities,' if co-production is to fulfil its revolutionary potential.

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