Co-Production is Good, but Other Things are Good Too

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Abstract

The world of mental health has become used to the notion of co-production as a good thing. While the paper is not a critical analysis of co-production, the authors make the case that while it is a good thing, it is not the only good thing; and it is neither sufficient, nor necessary for good things to happen in mental health services. Alternative concepts of progressive innovation in this field are introduced. Real world case studies (most of them previously unpublished) are then worked through to test which concept(s) – co-production, or the alternatives, or neither – are the better fit, bearing in mind the complex relationships to be negotiated, not just between service users and mental health professionals, but between service users and members of other professions, and of the general public. Finally, the question is raised as to whether there is anything (such as the flattening of hierarchies or stigma reduction) which all these innovations – co-production and the alternatives – have in common.

1. Introduction

There is a complex political dynamic – that's small-p political – between mental health service users[1] and philosophers. A number of service users have for a long time felt disempowered relative to a (relatively) high-prestige profession – psychiatry. So the prospect of having an ally in the shape of another (relatively) high-prestige profession – philosophy – is understandably attractive. At the same time philosophers often feel disempowered relative to government funding policies which put pressure on them to generate 'impact' from their work, and an alliance with service users offers the hope of impact. Thus while (some) service users feel they need philosophers, (some) philosophers also need to be needed. A similar

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[1] The same could also be said of some people with mental health difficulties who have successfully avoided services ('survivors': Kalathil and Jones, 2016), but since the focus of this paper is on services and how and by whom they are produced, we stick to 'service users', while acknowledging the complex pressures on terminology choice in this area.

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dynamic may be presumed to affect other academic disciplines too, and indeed stakeholders beyond the academy. But there is a risk involved in such a mutual dependence: the risk of forming an uncritical alliance, an alliance in which key concepts or terms are waved through without due critical scrutiny.

The aim of this paper is to ask whether an uncritical alliance has formed round the concept of *co-production* in mental health services. Please note: the aim of the paper is *not* to launch a critique of co-production. On the contrary, the concept of co-production has been a useful banner under which many campaigns by and on behalf of service users have been fought. The question is not whether co-production is a good thing – we agree it is – but rather whether, thanks to an uncritical alliance – never mind who the partners are – the label has been over-used. Are all the things (including all the good things) put in place or being campaigned for as making a positive difference to service users instances of co-production, or are they good for some other reason?

Our methodology is both conceptual and empirical. As with many cases of interdisciplinary work, what's needed are both concepts and real-world examples: real-world examples sharpen concepts and then concepts sharpen our description of the world. We sharpen our concepts by thinking about whether or not they're fit to capture what we encounter on the ground, and thanks to that, end up with more accurate and critically refined descriptions of it.

2. Co-Production

Mental health services have traditionally been provided by mental health professionals to patients, with little or no input from the patients themselves.[2] However, the concept of co-production has gained prominence in the UK mental health system over the last decade, with the publication of several key policy documents, such as the NHS Five Year Forward View and the Five Year Forward View for Mental Health (NHS, 2014; Mental Health Taskforce, 2016). These documents highlighted the need for greater user involvement and co-production in mental health services and set out a vision for transforming mental health care in the UK. This has been reinforced by more recent policy developments, such as the

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[2] The same points apply *mutatis mutandis* to patient involvement in research, but mental health services are our focus here.

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NHS Long Term Plan and the Mental Health Act Review (NHS, 2019; Wessely *et al.*, 2018).

That said, terminology can be difficult here. In some places, service user involvement and 'co-production' mean one and the same thing. In others, 'co-production' contrasts with 'mere' service-user involvement, on the grounds that you can truthfully say you are 'involving' someone while in fact giving them a very marginal role, thereby confirming their subordinate status in a knowledge or power hierarchy (Baklien and Bongaardt, 2014; Voronka, 2016). In such contexts, 'co-production' is a kind of gold standard, where clinicians and service-users are equal partners. While we recognise that service user involvement comes in degrees and can be more or less thoroughgoing, we use 'co-production' to refer to any approach that aims to empower patients by giving them a voice in the decision-making process, as well as to improve the quality and effectiveness of mental health services by drawing on the knowledge of both mental health professionals and patients.

One of the key benefits of co-production in mental health services is that it can help to address the power imbalance between service users and healthcare professionals. Co-production can also help to promote recovery and well-being by empowering service users and carers to take an active role in their own care and support. This can improve engagement and reduce stigma, which are both key factors in promoting mental health and well-being (Needham, 2009).

To the extent that we argue that certain attempts to change mental health services for the better don't exemplify 'co-production', that's not because we think they don't live up to the label in the 'gold standard' sense – that's a different problem. Our point is rather that, granted that co-production has the benefits described, it doesn't follow that anything and everything that has these benefits constitutes co-production.

3. Other Good Things…

Notwithstanding the emergence of co-production as a powerful approach to service improvement, it is important to be open to the multiplicity of ways of achieving improvements in services (and other positive outcomes). There are other ideas of progressive patient-focused care and/or services which have recently appeared in the literature and some that predate co-production, and this paper will discuss four: evidence-based practice, service user-led service development, community involvement, and user-centred

design. However, the fact that they are known by different names does not prove that they are not, in an underlying way, the same as what is intended to be captured by 'co-production'. So we will introduce each in turn, and then discuss with reference to some real cases whether or not they are genuinely different and which of them, naming conventions apart, it is illuminating to describe as co-production as opposed to some other concept. To the extent that they do not all fit the co-production model, we will then ask whether there is anything more general – beyond being broadly beneficial – that they all have in common.

The four other progressive approaches to mental health services we will consider are evidence-based practice, service user-led services (*etc.*), community involvement, and user-centred design (UCD). *Evidence-based practice* involves using the best available research evidence to inform decision-making about service design, delivery, and evaluation. By using evidence to inform decisions, practitioners can ensure that services are based on the latest research and have the best chance of being effective. In *service user-led services*, service users take control of their own care, rather than simply being partners with healthcare professionals. This approach recognises that service users have a unique perspective on their own needs and experiences, and that they are best placed to make decisions about their own care. Service users take the active role in decision-making processes, such as service planning, policy development, and resource allocation. They also take the lead in the recruitment and training of staff, and the development of interventions. *Community involvement*, meanwhile, is an approach to service provision that emphasises the participation and engagement of communities in the design, delivery, and evaluation of services. It recognises that communities are experts in their own needs and experiences, and that involving them in the service provision process can lead to more effective and sustainable outcomes. Community involvement can take many forms, depending on the needs and priorities of the community. For example, community members may be involved in needs assessments, programme planning, service delivery, and evaluation. They may also participate in community-based research or advocacy efforts to improve access to services and resources. Finally, *user-centred design (UCD)* involves designing products, services, and experiences with the needs, preferences, and behaviours of users in mind. This approach places a strong emphasis on understanding the user's perspective and involves users in every stage of the design process, from ideation to testing. By involving users in the design process, user-centred design can lead to more usable and effective products and services.

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4. Some Worked Examples

With these concepts in mind, in this section we will examine a number of case studies. We make the assumption that these case studies are broadly progressive and that they exemplify good models of improving outcomes in services for people with diagnosed mental health conditions (that is to say, they deliver good things). We can then examine them against the yardstick of co-production and the other models of practice outlined above.

4.1 SleepWell

Sleep is an area of concern both to and for people using mental health services, but it is rarely seen as a priority area.

Regular overnight nursing observations are designed to enhance care and reduce risk but may also increase sleep disturbance, and so have unintended negative effects on patient welfare. But to date, little research has focused on the effect of and need for regular overnight observations within psychiatry. Understandable concern about patient safety is one reason for frequent physical checks, despite no direct evidence that fixed timing checks reduce risk.

The SleepWell programme, introduced on psychiatric wards in Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust in 2019, was designed as a pilot scheme in a large mental health trust after reviewing the current observation policy (Novak *et al.*, 2020). This programme included strategies such as reducing overnight noise and light, providing staff education about sleep and sleep disorders, and screening for sleep disorders such as sleep apnoea and restless legs syndrome. Additionally, a protected sleep period was introduced for patients who were considered safe. As the programme explicitly contradicted existing policy and practice, a pilot scheme was run.

Seven adult wards across the Trust were used for the pilot. To ensure a range of patients they included a 16-bed male and two 16-bed female adult acute in-patient units based on two separate sites, a 26-bed long-stay rehabilitation unit with shared house, a 16-bed mixed neurorehabilitation ward, a 12-bed in-patient dementia service, and an 18-bed psychiatric rehabilitation and recovery unit.

The pilot scheme was evaluated by assessing adverse events, including harmful behaviours, before and after the change in observation policy. Detailed feedback from patients, staff, and carers was also collected. Cognitive-behavioural therapy for insomnia (CBTi) was

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available on two of the seven wards that participated in the pilot. The use of hypnotic medication was also evaluated before and during the pilot period.

Post-pilot feedback from ward staff regarding the implementation of the SleepWell programme was overwhelmingly positive. Ward staff members observed that the ward environment became more peaceful and settled as a result of the intervention. They particularly noted that emphasising bed-time routines contributed to improved sleep among patients, a sentiment that was widely supported by staff.

However, prior to implementing the SleepWell programme, staff experienced initial anxiety regarding the shift away from frequent patient checks and risk assessment. This led to some disagreement among staff regarding which patients were suitable for the protected sleep period. Given that the evaluation primarily focused on safety and feasibility, it was not possible to conduct standardised sleep assessments. To address staff concerns and provide reassurance, a documented multidisciplinary team decision-making process was implemented, involving the night coordinators.

Patients who provided feedback on the intervention expressed positive views about being on protected sleep time. Some patients reported not noticing any significant differences and stated they had not been disturbed during the night. However, others described feeling safer without staff members looking into their rooms. Patients who had experienced readmissions also mentioned that the protected sleep time was an improvement compared to previous admissions.

Carers, too, had a positive perception of the intervention, with none of them requesting the reinstatement of more frequent observations. Neither patients nor carers expressed any concerns about the protected sleep time.

During the evaluation, all in-patients were asked about their experiences with the SleepWell programme. Comments from patients included statements such as 'better than last admission', 'I feel safer now', and 'I don't worry about people looking into my room at night'.

So, the programme was beneficial. But was it co-production? Neither the development, nor the implementation of the SleepWell programme involved the patients who participated in it. The programme was multidisciplinary in nature involving sleep specialists, ward staff, and the Trust estates department. The latter is, at time of writing, also working on environmental noise issues (soft closing doors and bins for example).

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As a result, SleepWell would be better described as an example of evidence-based practice (EBP). The EBP process involves several key steps. First, topic experts identify a clinical question or problem that requires an evidence-based solution. Once the clinical question has been identified, a thorough search of the existing literature is conducted to identify relevant research studies. Following the evaluation of the literature, the evidence is applied to clinical practice. EBP has become an essential component of modern healthcare delivery, as it provides a systematic and rigorous approach to clinical decision-making. While there is no reason that patients cannot be involved in either the practice or the generation of evidence, this is not a necessary component of EBP.

In the case of SleepWell, it was the evidence that drove the case for change and a desire to test and develop the evidence base that led to the pilot programme.

4.2 Mental Health Foundation Self-Management Intervention, Wales 2009–2012

The Mental Health Foundation (MHF) developed a self-management intervention tailored to the needs of people with severe mental health diagnoses, using significant funding from the 2009 Big Lottery Fund's Mental Health Matters funding stream for Wales (Crepaz-Keay and Cyhlarova, 2012). The aim was to develop, deliver, and evaluate a testable intervention, which enabled people with a diagnosed psychiatric condition to manage their own mental health and support their peers to do the same. The key elements of the approach were goal setting and problem solving; everyone set and shared goals and the peer groups would work collectively to enable people to achieve their own goals and solve problems that may get in the way.

Development

In order to ensure that the intervention accorded with the needs of people who have used secondary mental health services, a development model was chosen that had a high degree of service user involvement. The initial development phase took place at a four-day residential workshop in Cwmbran, South Wales. This workshop was facilitated by experienced ex-service users who were research and development experts. The event brought together 24 people who had used secondary mental health services in Wales. Of these,

two had been involved with Bipolar UK's long established self-management course, two had other training experience, 12 belonged to self-help groups, and eight had no previous connection to self-help or training. The majority had no previous training or self-management experience. The group as a whole was typical of the target group we wanted to benefit from the intervention, in that they had lived with a diagnosed psychiatric condition and had received treatment for the condition from mental health services.

The workshop participants recognised the essential importance of peer support in self-management. There is evidence suggesting that peer support for people who experience mental ill health can have many benefits for their mental and physical health and well-being (Repper and Carter, 2011). The key conclusions from the development group were that self-management training needs to be goal-orientated (people chose their own),[3] and needs to be followed by peer support. The model that emerged from the workshop was a three-stage intervention in the following format:

1. Two days of self-management training with a focus on goal setting and problem solving.
2. Six half-day follow-up sessions, usually fortnightly.
3. Ongoing peer support, at least monthly, for six months.

This would be delivered to a group of ten to fifteen people, and the whole series of sessions – from the two-day training to the last facilitated follow-up – would take about nine months to run. The inclusion of peer support as an additional component, alongside self-management training, was incorporated to try to increase the long-term effectiveness of the intervention.

Once this initial design was converted into a draft training manual and participant materials, all materials were reviewed by a group of service users from North Wales. The materials were then adjusted for a real-time pilot of the initial two-day training. This training was delivered in North Wales, by the facilitators of the workshop. The first pilot led to significant revisions, particularly on the volume of content; the schedule and materials were also adjusted

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[3]   Some goals were directly related to people's diagnoses, but most weren't. The most common goals were: returning to education, improving relationships, losing weight/exercising more, giving up or reducing smoking, getting a job. There were many goals of differing levels of difficulty (simplest was 'paint kitchen door', most challenging was 'climb Everest'), but the important thing was that people set their own: they weren't chosen for them.

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for a second pilot. The second pilot was run in South Wales and was facilitated by two people who participated in the first pilot. The development process took about 12 months from the recruitment of the initial team to the completion of the second and final pilot.

Delivery

Recruiting participants took a great deal of effort. To promote the courses, MHF held local launch events, often in collaboration with a local service user group. The events drew in a wide range of local people including mayors, community police, local companies, and clinicians. These events also succeeded in encouraging people to talk about mental ill health in public settings. A national campaign by Hafal (a leading Welsh mental health charity), to which MHF also contributed, significantly increased the profile of MHF's work and reached a greater number of people than would otherwise have been possible.

An average of 20 people were recruited for each course. Of these, typically a dozen would actually attend the first two-day training, and the final peer support group tended to include six to eight regular attendees. The dropout rate was lower where MHF worked with existing local groups, but there were no obvious indicators to suggest why some groups seemed more sustainable than others.

Between December 2009 and January 2012, 62 courses were delivered and 647 people trained across Wales. Of the total, 35 courses were the new courses developed by the MHF which reached 320 people. A further 27 courses were commissioned from Bipolar UK, an organisation run for and by people with a Bipolar diagnosis, in order to broaden the evidence base; these trained an additional 327 people. This also enabled potential beneficiaries to be reached from an early stage, and people to be offered a choice of courses.

The newly developed courses were entirely delivered by people who had previously been course participants (with the exception of the first pilot). This ensured that the facilitators had a good understanding of the materials and of the experience of learning self-management skills. It also enabled participants to identify closely with the facilitators, rather than perceive them as remote authority figures. It also offered encouragement for participants who wanted to go on to develop facilitation skills.

Peer support

In order to keep peer support groups going over time, the characteristics of a good peer support group needed to be established, and the

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potential blocks to sustainable groups identified. The consultation was conducted in two stages: a questionnaire, and two consultation days. A questionnaire was developed with the aim of gauging ideas about what would make people want to attend a peer support group, what makes it successful, long-lasting, and what the barriers are to playing a full role in the group. In total, 176 questionnaires were sent out; of these 146 went to self-management participants and 30 to other relevant organisations. 41 and 8 responses, respectively, were received. Building on the questionnaire responses, the two consultation days were carried out in South and North Wales (five and six participants, respectively). This process identified the following issues:

- One (or ideally more than one) person needs to take responsibility for keeping a group going. This person (or people) should come from the group, not from outside the group.
- The group needs to have a clear purpose: setting and reviewing goals was regarded as a good purpose.
- Groups need to have agreed ground rules.
- Groups need to have opportunities to share learning with other groups.

Once again, the question arises whether or to what extent this is a case of co-production. The answer is that the intervention exemplifies a mixed model, indeed mixed along several different dimensions.

The original intention was that the intervention would be co-produced with Welsh mental health services so that it would complement existing services and be easy to access for people while they were using them. But despite attempts MHF were unable to establish any co-production partnerships with mental health services. If co-production signals a partnership between service users and mental health professionals, then, the answer has to be 'no'.

As a result, this endeavour might best be characterised rather as service user-led, and illustrates the challenges associated with this model.

Nonetheless, in this case every step of the process was developed and delivered by service users. There were certainly barriers both to the service user leadership, and to professional acceptance of it. The latter is likely to have contributed to the failure to engage effectively with mental health services. The former was largely overcome by the fact that resource allocation was also service user-led once Lottery funding had been granted. Thus, although the service user-led nature of the intervention originated in failure to live up to expectations of co-production with health services, it arguably

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ended up exceeding even the 'gold standard' notion of co-production by putting service users in sole charge.

It may also be helpful, however, to think of the intervention in terms of user-centred design rather than co-production. The UCD process involves several stages: the research stage, to understand the perspectives, needs, and challenges of users; the ideation stage, to generate ideas for addressing user needs and challenges; the prototyping stage to test and refine the design before its finalisation.

Perhaps a key difference from co-production is that user-centred design, like any design process, involves a three-cornered relationship between designer, client, and end-user. Design becomes user-centred to the extent that different iterations of a design are responsive to end user needs. However, there is nothing intrinsic to this model which requires either designer or client themselves to be service users – indeed, typically they are not.

In this case, however, the intervention was initiated by the Mental Health Foundation (the client). The Mental Health Foundation is not service user-led, though strongly informed by attention to service user needs and interests. Moreover, the original idea came from a member of Foundation staff with existing psychiatric diagnoses and was then supported by a team of people, all of whom had used mental health services (bar one external consultant).

In addition, as already described, the development phase involved a four-day residential workshop facilitated by experienced service users who were research and development experts (the designers). The workshop brought together people who had used secondary mental health services in Wales, representing the target population of the intervention. This high degree of end user involvement ensured that the intervention's design and content were informed by the perspectives and experiences of those who would benefit from it. Consequently, while user-centred design may sometimes fall short of the equitable partnership ideals of co-production because of power differentials between client, designer, and end user (with end users at the bottom of that hierarchy), in this case, it did not.

There is one further complexity here. While co-production with mental health services did not take place, there was more success with community involvement. One key benefit of community involvement is that it can help to ensure that services are culturally appropriate and responsive to the unique needs and experiences of the community. By involving community members in the service provision process, we can gain a deeper understanding of the community's values, beliefs, and customs, and design services that are more

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in line with their needs and preferences. Community involvement can also help to build trust and strengthen relationships between service providers and community members. By involving community members in decision-making processes, we can demonstrate a commitment to listening to and responding to the needs and priorities of the community. This can help to foster a sense of ownership and investment in the services, leading to greater participation and engagement over time.

In this case community involvement was valuable in a number of respects: it helped to understand the need for support in communities MHF were not familiar with, it increased awareness of and facilitated access to the services, it made the service feel like part of the community, and it provided us with access to expertise that supported the problem solving component of the intervention. This once again draws attention to the complexities in applying the concept of co-production: co-production with whom? Certainly there was a collaboration by two different categories of stakeholder, but the intervention doesn't fit the usual co-production profile because the partnership was not between service users and mental health professionals – which was attempted and failed – but between service users and community members.

4.3 East Lille

A particularly rich case study comes from Lille in Northern France, where the Eastern Lille Public Psychiatric Sector has seen a number of progressive developments in community psychiatry over the last 30+ years (Roelandt *et al.*, 2014).[4] These developments were based in turn on Basaglia's work (Basaglia, 2010) in Gorizia and Trieste. Here is an (incomplete) list of the innovations in question:

1. Asylum closure, with service users' housing integrated into the town at large, including with host families
2. Open wards (though there is still involuntary detention)
3. Short waiting times for services
4. Transparency – patients have access to their own records
5. Wide range of therapies and rehabilitation interventions, including art therapies

[4] We set this out more schematically than the other case studies because, unlike the others, it has been published before.

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6. Involvement of ex-patients in staff training and allocation of housing
7. User-run self-help groups
8. Interventions to overcome a negative image of mental illness in the population of East Lille

Arguably these features all have the potential to positively affect patient welfare, and therefore represent positive models for service improvement. But to what extent do they fit the co-production concept?

In 7, service users themselves deliver the intervention. Thus, arguably, it isn't co-production. That is not because service users are not involved (obviously enough) but because it exceeds the aspiration of equalising the relationship between service user and mental health professional, by absenting the mental health professional from the scene. (Cp the previous case study.) It would thus be more accurately described as a service user-led service. Notice however that we only know (from the evidence of Roelandt *et al.*, 2014) that it is service user-led at the level of delivery. Informal conversations with professionals involved in leading services in East Lille suggests that the initial design was primarily led top-down, by professionals. 6 fits the co-production label well up to a point, in that service users are involved in doing something which they might have been excluded from (allocating housing), but with two qualifications. First, what is being delivered is not strictly speaking a mental health service, but a housing service. Secondly, it isn't clear to what extent service user involvement in housing allocation makes the allocation more sensitive to service user needs, as opposed simply to constituting one pathway to enabling service users to be meaningfully employed, and thus empowered. It thus could be seen as a means to social inclusion, or to equalising differences between clinical and non-clinical populations (i.e., something co-production is also good at), but without itself constituting co-production.

Something similar can be said, but with more certainty, about 4. Allowing patients access to their records is a way of addressing asymmetries between patient and mental health professional, and thus points once again in the direction of social inclusion. But it is not clear that in accessing a record, anything is 'produced', and so *a fortiori* not co-produced. On top of which, both the contents of the record and the transparency policy itself could, for all we know, have been produced top-down. 1 is also about equalising relationships, social inclusion, and stigma reduction, but the relationships in question are not between service users and mental health professionals but between service users and other non-clinicians, i.e., other

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inhabitants of East Lille. (Compare the community involvement in the previous case study.) Once again, it is not clear how living in a place constitutes 'producing' something, so living in an integrated or non-segregated way ought not to be classified as co-production even though its inclusive ambitions are shared by initiatives which should be so classified. And, at risk of being repetitive, we are not given any reason to suppose that the integrative housing *policy* was itself produced with service users as opposed to being arrived at top-down by enlightened mental health professionals, or by a coalition of various different professionals including East Lille local politicians and housing officials. Moreover, the role differentiation of service user/ clinician is maintained, with the important exception that the 'clinical' role is broadened so as to include the host families as well as psychiatrists, psychiatric nurses, *etc*. This challenges conventional notions of who or what can deliver therapy, but not the asymmetric conception of therapy as somebody delivering something to someone, as against a 'doing with' or co-production model.

5 also bears some similarities to 4 and 1. Roelandt *et al*. (2014) stress that art was not only used as a therapy, but also designed as an activity service users could engage in together with other people, 'establishing equality between patients and non-patients'. So once again, there is an ambition to equalise relationships or even out hierarchies of knowledge and power. But as in 1, the relationship being equalised was between service users and non-clinical members of the population, not, as usually understood in discussions of co-production, between service users and clinicians or other mental health professionals. Indeed, in so far as art *was* used as a therapy, while the therapeutic method may have been innovative, the role differentiation between clinician and service user is preserved. Finally, the same is true of 8. Artists played a role in addressing negativity about mental illness among the population at large. Again the goals were social inclusion and the removal of stigma, but the relationship in focus was that between clinical and non-clinical populations as a whole, not between clinical populations and clinicians. And again, the drive towards doing so was organised 'by psychiatry teams and municipal authorities' (Roelandt *et al*., 2014, p. 11), with as far as we can tell no service user involvement at that particular point of intervention.

5. Conclusion

We have reviewed a number of progressive innovations in mental health services and indeed in services more broadly (e.g., housing)

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designed to benefit those with mental health difficulties. We have also argued that while some of these exemplify co-production, others do not, and indeed for various contrasting reasons. Some fail to fit the co-production model because they are more purely service user-led, i.e., service users do not create something *with* others ('co'), but on their own – indeed perhaps because co-production with professional services was not possible. Some fail to fit it for the opposite reason, i.e., the new service is designed top-down, either without service user involvement at all, by an enlightened multi-professional group excluding service users, or involving them in the manner of 'end user/consumer testing' – but with results modified for the better by the contingency that clients and designers were also service users (or included a number of service users) as described in UCD. So, is there anything these progressive innovations have in common with those innovations which *are* properly described as co-produced? Co-production is fundamentally about equalising relationships between service users and clinicians or other mental health professionals, since it is here that hierarchies of power and prestige in the absence of co-production may be most keenly felt. But some of our examples show that, for example with regard to social inclusion or the reduction of stigma, there are other relationships which it is good to equalise too, such as service user relationships with members of a local population who are neither service users nor mental health professionals; or, service user relationships with services other than mental health services. When that happens, the term 'co-production' is an uncertain fit. But other good features of progressive mental health services we have touched on show respect and humanity either in service design or service delivery, but where this doesn't involve equalising relationships of any sort. As Basaglia appears to have said, 'taking care of a person, not leaving him to his own devices under the cloak of some abstract notion of liberty, but at the same time avoiding controlling him and imposing on him preconceived therapeutic objectives' (Roelandt *et al.*, 2014, p. 16). The hypothesis that humanising isn't always equalising deserves further investigation.

References

Franco Basaglia *et al.*, *L'Istituzione Negata. Rapporto da un Ospedale Psichiatrico*, Baldini Castoldi Dalai (2010).

Børge Baklien and Rob Bongaardt, 'The Quest for Choice and the Need for Relational Care in Mental Health Work', *Med Health Care Philos*, 17 (2014), 625–32.

David Crepaz-Keay and Eva Cyhlarova, 'A New Self-Management Intervention for People with Severe Psychiatric Diagnoses', *The Journal of Mental Health Training, Education and Practice*, 7:2 (2012), 89–94.

Jayasree Kalathil and Nev Jones, 'Unsettling Disciplines: Madness, Identity, Research, Knowledge', *Philosophy, Psychiatry & Psychology*, 23:3–4 (2016), 183–8.

NHS Mental Health Taskforce, *The Five Year Forward View for Mental Health* (2016), accessed 7 July 2023: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

Catherine Needham, *Co-Production: An Emerging Evidence Base for Adult Social Care Transformation* (London: SCIE, 2009).

NHS, *Five Year Forward View* (2014), accessed 7 July 2023: https://www.england.nhs.uk/five-year-forward-view/.

NHS, *The NHS Long Term Plan* (2019), accessed 7 July 2023: https://www.longtermplan.nhs.uk/.

Chloe Novak, Emma Packer, Alastair Paterson, Ambrina Roshi, Rosie Locke, Patrick Keown, Stuart Watson, and Kirstie N. Anderson, 'Feasibility and Utility of Enhanced Sleep Management on In-Patient Psychiatry Wards', *BJPsych Bulletin*, 44:6 (2020), 255–60.

Julie Repper and Tim Carter, 'A Review of the Literature on Peer Support in Mental Health Services', *Journal of Mental Health*, 20:4 (2011), 392–411.

J.L. Roelandt, N. Daumerie, L. Defromont, A. Caria, P. Bastow, and J. Kishore, 'Community Mental Health Service: An Experience from the East Lille, France', *Journal of Mental Health and Human Behaviour*, 19 (2014), 10–18.

Jijian Voronka, 'The Politics of "People with Lived Experience"', *Philosophy, Psychiatry & Psychology*, 23:3–4 (2016), 189–201.

Simon Wessely, Steve Gilbert, Mark Hedley, and Julia Neuberger, *Modernising the Mental Health Act – Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act 1983* (London, 2018).