INSTITUTIONAL CEREMONIES?
The (im)possibilities of transformative co-production in mental health

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Introduction
This chapter is a critical examination of ‘transformative co-production’ in mental health services and systems, with a particular focus on British mental health policy and practice. The policy critique is located within the discipline of Mad Studies. I am writing both as a survivor and an academic, discussing the challenges for co-production operating both within and beyond the limits of psychiatric culture, institutions and clinical paradigms. I look at the origins of co-production, the purportedly radical approach to service, system and social reform, and the associated policy construction, which occurred outside the service user and survivor movement. Inherent power asymmetries and risk of co-option and neutralization within traditional mental health services are explored, with reference to the precedents of recovery and peer support. The effect of the historical legacy of the asylum on the possibility of achieving co-production between service users and survivors and mental health service staff and managers within psychiatric systems is critically examined using Rosenhan’s study of psychiatric hospitals and Goffman’s theory of the ‘total institution’. Finally, I conclude with the argument that co-production will not work without thorough attention to the underlying epistemic injustices that continue in the mental health structures and systems it is supposed to transform, and that Mad Studies offers an important new development here.

The faulty policy
The meanings and origins of co-production as a general concept are somewhat complex and contested. It has been critiqued for its ‘excessive elasticity’ (Needham and Carr, 2009). This has often proven to be problematic for its practical application in health and social care research, policy and practice, leading to frequent and repeated attempts to define the approach. Nonetheless this ‘elasticity’ can open up a space for critical discussion of co-production and the possibility of its applications in mental health. Farr has noted that ‘the theoretical roots of … concepts of co-production and co-design are distinct from other radical participatory literatures that have politically emancipatory aims such as feminist, post-colonial, indigenous knowledge and critical theory’ (Farr, 2018:625). Mental health has been the most challenging field for co-production to gain traction and have an impact on the ability of politically positioned service
users and survivors to determine and lead on system transformation (Carr, 2016). However, there is some agreement, based in evidence and policy analysis for mental health, that co-production between service users/ survivors and practitioners as equals means ‘the transformation of power and control’ (Slay and Stephens, 2013:4) and it is therefore a ‘potentially transformative way of thinking about power, resources, partnerships, risks and outcomes, not an off-the-shelf model of service provision or a single magic solution’ (Needham and Carr, 2009:1). This implies that the co-production project is not just to improve mental health service provision and research, but to fundamentally transform systemic power relations. The challenges here are clear, given the ‘power asymmetries’ that persist in mental health systems and biomedical psychiatry, most recently highlighted by the UN Special Rapporteur on the right to health. He reported that three major obstacles stood in the way of mental health reform: power asymmetries, the biased use of evidence in mental health research and the dominance of the biomedical model. Of power asymmetries he noted that ‘at the clinical level, power imbalances reinforce paternalism and even patriarchal approaches, which dominate the relationship between psychiatric professionals and users of mental health services’ (UNHRC, 2017:6). Nonetheless he recommended that States ‘ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies’ (UNHRC, 2017:21). But is this possible given the relational, systemic and structural power asymmetries?

Elsewhere I have explored the origins of co-production in US and UK public administration and health service reform (Carr, 2018). It is important to understand this aspect because such a critical analysis reveals some of the fault lines inherent in co-production policy construction, not least because it largely excluded the knowledge and contributions of the service user and survivor movement (Beresford, 2019), and has its roots in a different place (Carr, 2014). It could even be argued that co-production was imposed by the British government on health and social care service users. Here, I will briefly outline two key points from my examination of the policy of co-production: public service delivery vs. social justice and the problems of control and citizenship.

Firstly, it appears that two conflicting models of co-production were absorbed into British health and social care policy in the late 2000s. One is concerned with citizens engaging with public services to improve delivery and outcomes, and the other has a more radical and broader focus on social justice and achieving a ‘core economy’ where social and emotional contributions are valued as much as financial ones. The model developed by the economist Elinor Ostrom in the 1970s determined the importance of relationships between public services and citizens because the latter has valuable knowledge that is important for the effective and efficient operation of those services. This requires certain relationships and behaviours from the human actors within the system (Ostrom, 1996; Garn, 1973). This type of co-production is led by public service administrators and professionals, with the citizen and service user role determined by them (Bovaird, 2007). The later approach was developed by US legal academic and citizen advocacy campaigner, Edgar Cahn whose experiences as a hospital patient following a heart attack made him critical of the operation of a health and care system in which he felt ‘declared useless’ and which created ‘throw-away people’ (Cahn, 2000). Rather than improving service efficiency and effectiveness, his focus was on relocating power and worth with the service user or patient as a citizen and fundamentally challenging the services and systems that declared them useless. He argued for the disruption of the conventional power relations between service users or patients and professionals, promoting ‘reciprocity: stop creating dependencies and devaluing those whom you help whilst you profit from their troubles’; ‘an asset perspective: no more throw-away people’ and ‘social capital: no more disinvesting in families, neighbourhoods and communities’ (Cahn, 2008:31). There is a basic tension between the two approaches: while one
calls for the system to be improved, the other calls for the system to be dismantled. However, based on both these models, a ‘hybrid version of co-production coalesced as a core health and social care reform concept’ in the UK (Carr, 2018:79), with Edgar Cahn’s model as the policy brand but Ostrom’s approach implemented in practice. By 2008 co-production had entered into the ‘language of the ruling regime’ (LeFrançois et al, 2013:25). As Beresford observed in his historical account of the co-production of knowledge and change in health and social care, this tension is reflected in, and perhaps related to, the inherent conflicts between ‘consumerist and democratic’ participation where the shared language of participation ‘disguises fundamental difference between them, which have blurred and confused the issues’ (Beresford, 2019:6).

The second point concerns control and citizenship. The case of the contested and partial citizenship of the mental health service users/survivors has been well made, by describing the ‘illusion of citizenship’ for those with a diagnosis of ‘mental illness’ (Sayce, 2000). This is a particular impediment to achieving political citizenship as ‘people with mental health challenges do not have the same legal rights as other citizens: in particular the UK’s mental health laws permit compulsory treatment of people even when you have “capacity”’ (Sayce, 2015:4). Despite this, policy makers assumed that mental health service users/survivors could fulfil the role of active citizen or pseudo-management consultant (Scourfield, 2007; Carr, 2014). They are expected to act as ‘patient leaders’ and be willing to collaborate, ostensibly in equal partnership with professionals, to ‘improve the patient experience’, rather than challenge systemic and wider structural problems. This was despite the fact that service hierarchies, ‘current system configurations … and processes can actively prevent them from exercising their citizenship’ (Carr, 2014:31).

Such a tendency towards the ‘mobilisation of bias’ (Farr, 2018) and the imposition of ‘normative citizenship’ (Voronka, 2017) was foreseen by Brudney in 1985 who warned that it may …lead to service delivery arrangements in which citizens undertake activities that fit administrators’ preferences for citizen involvement and/or for the convenience of their present positions – rather than those that might augment service effectiveness or contribute to a restoration of communitarian values and citizenship.

(Brudney, 1985:252–253)

A key obstacle to achieving the ‘restoration of communitarian values and citizenship’ for mental health service users/survivors is the continued absenting and marginalization of user-led organizations from both the original policy conceptualization and the active implementation of co-production. Both remain led by professionals with their own collective power bases and organizations (Carr, 2018). Pestoff has argued that co-production is not entirely possible without the collective, independent power bases and separate platforms provided by user-led and community organizations, saying that they ‘can prove very important for facilitating the participation of persons with serious physical, mental or social problems and for retaining their participation over time’ (Pestoff, 2013:394). However, the Ostrom-Cahn tension has been borne out in practice, as Farr observes

service user movements may create more disruptive innovations that challenge institutions, whereas co-production and co-design processes tend to work within institutions. The emphasis on partnership with public service institutions may overlook the importance of observable conflict, agonism and contentious opposition.

(Farr, 2018:626)

This reflects Cahn’s assertion that ‘hell-raising is a critical part of co-production’ (Cahn, 2008:4).
The neutralizing formula

Of academia and Mad Studies, LeFrançois warned of ‘what might happen when partnerships harm more than help, or when our goals lose their initially unabashed political grounding, or when we become corrupted by a hierarchical and competitive … culture detached from the mad community and people’s everyday lives’ (Le François, 2016:vii). In mental health systems there are a number of precedents to the co-option and neutralization of transformative co-production where radical, transformative ideas in mental health originating with service users and survivors have been absorbed and defined by hierarchical mental health services, administrative systems and biomedical understandings (Carr, 2016). This of course includes the value placed on and the acceptance of, survivor knowledge (Beresford, 2019). A classic example of this is personal recovery in mental health, which like co-production, services and professionals have found ‘difficult to define’ (Le Boutillier et al, 2015). Despite this, the approach has been absorbed into the mainstream and in Britain at least, administratively splintered into three different types of ‘recovery’: clinical recovery with the defining power remaining with the clinician who determines recovery in terms of symptom reduction; personal recovery in line with original thinking on hope, identity, autonomy, social recovery and citizenship; and service-defined recovery with the practice determined according to the ‘service goals and financial needs to the organisation’ (Le Boutillier et al, 2015:1). The ultimate challenge of recovery, as defined by pioneer US survivor and disability rights activist, Deegan (1987) and others, was to mental health and psychiatric theories, systems and structures, which require ‘a transformation of services, practices and the paradigm within which they are delivered’ (Slade et al, 2014:12) (emphasis added). However, that paradigm is yet to shift. This situation has led Morrow to set out a critique of the co-option of recovery in Canada, in which she explores the implementation of recovery frameworks in ‘neoliberal political regimes’ and governmentality. Her analysis reveals a very similar situation to that of co-production where there are competing and incompatible models and where ‘recovery as a concept and a paradigm is poised to either disrupt biomedical dominance in favour of social and structural understandings of mental distress or to continue to play into individualistic discourses … which work against social change’ (Morrow, 2013:323). Just as co-production which only serves to ‘improve the patient experience’ within services and is unable to progress broader social justice issues, Morrow argues that ‘recovery suffers from its individualistic framing as a personal journey which has neglected a wider analysis of social and structural relations in mental health that signal systemic discrimination…’ (Morrow, 2013:325). Drawing on her critical recovery research with service users and survivors, Morrow surfaces the continued importance placed on independent peer support in recovery by people who experience mental and emotional distress.

Mad Studies scholars have also analysed the journey of peer support from its roots in mutually supportive service user and survivor relationships, networks and initiatives as a response to experiences of powerlessness and the harms of the biomedical model, to its co-option and operationalization in traditional mental health systems and hierarchies (Russo and Sweeney, 2016). Research from the Netherlands on the experience of peer workers in mainstream mental health services suggests that their work can be impeded by professional routines and concepts of ‘good care’ and that they can struggle with a conflicted sense of identity, crisis oriented cultures without service user involvement and with administrative procedures that compromise peer support values (Vandewalle et al, 2015). Elsewhere research has shown that the rules and constraints of mainstream mental health services are at odds with the recovery philosophy as rooted in the service user and survivor movement (Gillard et al, 2014). This situation has led Brown and Stastny to ask if peer support is a ‘transformative or collusive experiment’ (Brown
and Stasny, 2016:183). In their examination of the co-option of survivor knowledge, Penney and Prescott focus on peer support and the familiar dynamics when movements for social justice by marginalised and oppressed groups often face the challenge of co-optation by powerful institutions seeking to protect the status quo … [it] is a process by which a dominant group attempts to absorb or neutralize a weaker opposition that it believes poses a threat to its continued power. (Penney and Prescott, 2016:35)

Consistent with the research cited here, the authors discuss the challenges of maintaining peer support practices that are rooted in the service user and survivor movement in traditional psychiatric environments where practitioners do not understand the foundational value base of the approach and its original transformative ambitions are undermined. Further to this Voronka asserts that involvement and co-production determined by mental health professionals and systems, specifically peer support, amounts to madness, mad identities and marginalized knowledge being ‘harnessed as a commodity for exchange in neoliberal care and service markets’ (Voronka, 2017:334). According to Voronka, mad movements have been turned into ‘models’ to be co-opted by dominant mainstream mental health services and practices, where ‘our inclusion does little to disrupt structural violence, and rather allows psy powers to proceed’ in managing, controlling and administering madness (Voronka, 2017:336).

In an attempt to answer the question ‘are mainstream mental health services ready to progress transformative co-production?’ I assessed the mechanisms for the co-option and neutralization of service user and survivor originated ideas for fundamentally transforming understandings of madness and mental distress, along with the support for people experiencing these. I examined the fates of empowerment, personal and social recovery, service user and survivor participation and direct payments. On the basis of this analysis I concluded that despite or because the aim of transformative co-production is to dismantle institutions, it is at risk of being absorbed into traditional mental health service culture and of becoming ‘part of institutionally or professionally defined procedure’ (Carr, 2016:1). Even though the transformative co-production project is to ‘transform power and control’ thereby involving professionals in the process of disruption, ‘institutional control in the form of traditional rules and roles can negatively affect the way practitioners can work equally and collaboratively with service users and survivors’ (Carr, 2016:2). It appears, from the evidence examined here, that the continued operation of the ‘total institution’ and its control and administration of madness is one of the biggest challenges for achieving transformative co-production in mental health.

The legacy of harm

The New Zealand survivor activist Mary O’Hagan has described the ‘legacy of harm’ left by psychiatry and its institutions, and the consequent continuation of psychiatric harm in contemporary practice and community settings (O’Hagan, 2016). Does this historical legacy of harm make co-production largely impossible unless it is recognised and addressed in the process, particularly where mental health service users/survivors and professionals are expected to work together to transform concepts of and responses to madness and distress? Scull wrote in his book on the experimental atrocities carried out in ‘mad-houses’ by the American ‘mad-doctor’ Henry Cotton in the early twentieth century: ‘cultures and … institutions cling to retrospective illusions, substitute them for a fuller record of the past, and fiercely resist reconstructions that would disturb and displace the myths we … live by’ (Scull, 2007:274). In researching and
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writing the book his stated aim was to promote an understanding of the history of material and structural violence in psychiatry to avoid inflicting symbolic violence in the present day. Voronka and other Mad Studies scholars are very clear that structural and symbolic violence against mad people continues in mental health services (Voronka, 2016; LeFrançois et al., 2013). To understand the origins of this structural violence that makes equal partnerships between professionals and service users/survivors (or mad people and mad doctors) almost unrealizable for co-production, it is worth revisiting two foundational critiques of psychiatry and its institutions – those of the sociologist Goffman and the psychologist Rosenhan. Both authors have attracted criticism (Cummins, 2017), but their research and theories remain useful for analysing the problems the historical legacy of the institution poses for transformative co-production in mental health.

In 1877, L S Forbes Winslow wrote and published a slim volume for use by British county asylum and hospital staff called *Handbook for Attendants on the Insane* (Forbes Winslow, 1877). This manual set out a strict set of rules for treating and administering ‘lunatics’ in the institution, from restraint and seclusion to force feeding via the mouth, nose and rectum, to bathing and corpse dressing. Although Forbes Winslow instructs against the gratuitous ‘ill-treatment of patients’, the manual clearly sets out the rules for material violence in asylums and the associated tasks and roles for staff. Violence was part of the everyday working routine and patients were entirely powerless and dehumanized. Nearly a century later Rosenhan revealed the continuation of this legacy in his famous psychological experiment ‘On Being Sane in Insane Places’ (Rosenhan, 1973), research which would probably not be ethically permissible today. The study focused on the experiences of eight ‘pseudopatients’ who had tricked their way into various American psychiatric institutions and received ‘sticky’ and stigmatizing psychodiagnostic labels that determined how their behaviour was perceived by staff and resulted in dismissal and depersonalization. Among other things, Rosenhan concluded that staff operated in a hierarchical institution which caused the depersonalizing responses to patients and where nurses and attendants were subordinate to frequently absent or removed psychiatrists who retained the most power and influence. He asked readers to ‘consider the structure of the typical psychiatric hospital. Staff and patients are strictly segregated…staff keep to themselves, almost as if the disorder that afflicts their charges is somehow catching’ (Rosenhan, 1973:254).

In his re-reading of Rosenhan, Cummins argues that the findings of the experiment are still relevant for understanding ‘relational attitudes within institutional settings’, dividing practices and ‘toxic organisational cultures’ in the ‘closed worlds’ that still exist in mental health systems today (Cummins, 2017:9–10). Such ‘toxic cultures’ and ‘closed worlds’ remain sites for contemporary examples of depersonalisation and abuse in the psychiatric system, from difficulties for patients raising safety concerns (Berzins et al., 2018) and reporting incidences of sexual violence on wards (Foley and Cummins, 2018) to the targeted violence and abuse of people with mental distress by staff in closed environments and in the community (Carr et al., 2019).

The themes of segregation, administration and dehumanization continue in Goffman’s seminal volume, ‘Asylums’ (Goffman, 1961). In it he describes the function and operation of the ‘total institution’ (of which the asylum is one) its discourses and structures of power and how staff and ‘inmates’ are expected to behave within it: ‘all phases of the day’s activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials’ (Goffman, 1961:17). Important for understanding the extent to which equal collaboration or alliances can be achieved between staff and service users/survivor in the transformative co-production project is Goffman’s assertion that ‘total institutions vary … in the amount of role differentiation found within the staff and inmate groupings, and in the clarity of the line
between the two strata’ (Goffman, 1961:110). Like Rosenhan’s research findings, Goffman’s theory is that asylums had very clear lines of differentiation between staff and patients and operated on dominance and subjugation, with discipline and punishment power dynamics throughout the hierarchy. Communication was limited and strictly formalized where ‘not only will acts be required, but also the outward show of inward feelings. Expressed attitudes … will be explicitly penalised’ (Goffman, 1961:108). If we are to accept Goffman’s analysis and theory, it can provide an explanation for the situation in service user/survivor involvement and consequently co-production where discussion and deliberation is subject to ‘a significant exercise of power … in the context of an institutional setting … where the ability to exercise power in a meeting is linked to the institutional power relations in operation’ (Hodge, 2005:174). Furthermore, the service users/survivors whose expressions are testimonial, emotional or disruptive during mental health involvement initiatives can be penalized by being discredited and marginalized (Barnes, 2002; Carr, 2007).

**The question of (in)justice**

Among many other aspects of Mad Studies, other chapters in this book explore the important idea of ‘epistemic injustice’, a theory that is highly relevant for our assessment of the possibilities for transformative co-production to work in mental health. The most basic ‘epistemic practice’ is ‘the practice of gaining knowledge by being told’ (Fricker, 2003:154). Developed by the philosopher Fricker (2007), the theory of epistemic injustice is a way of explaining how and why some people’s knowledge is given less credibility than others based on social and individual prejudice. Fricker argues that this often happens to people who are the most powerless in society. This powerlessness and the damaging social identities given to certain groups of people (such as those deemed mad or those who are racialized) makes speaking and asserting their knowledge problematic. Epistemic injustice therefore happens when someone is ‘wronged specifically in her capacity as a knower’ (Fricker, 2007:18). In other words, a person’s status and social identity determines whether or not their knowledge is seen as reliable and credible, and the decision about what is legitimate and true is often made by the more powerful in society (Fricker, 2003). Fricker describes this as ‘testimonial injustice’ which arises when prejudice on the part of the hearer leads to the speaker receiving less credibility than he or she deserves’ (Fricker, 2003:154) and is a form of oppression or even ‘epistemic violence’ (Dotson, 2011). According to Fricker if a ‘hearer’s prejudice wrongly deflates her judgement of credibility, then the flow of knowledge is blocked, and truths fail to flow from knower to inquirer’ (Fricker, 2008:69). Fricker also describes ‘hermenutical injustice’ as part of epistemic injustice, which LeBlanc and Kinsella explain as being ‘the art of interpretation, which affects people’s ability to express themselves or to be understood’ (LeBlanc and Kinsella, 2016:67). They assert that ‘hermenutical injustices are revealed in the lack of opportunities for Mad persons to participate in the generation of interpretive resources for making sense of madness’ (LeBlanc and Kinsella, 2016:67). Although this theory is relevant for exploring the shortcomings of co-production to generate new understandings of and responses to madness, for the purposes of our exploration of transformative co-production, the notion of ‘testimonial injustice’ is most relevant because in the co-production process we are looking at ‘testimonial exchange’ where the speakers’ knowledge can be discredited in the process by hearers (inquiring) who retain particular social and individual prejudices about the speakers (knowers).

Newbigging and Ridley argue that ‘the testimony of people experiencing mental distress is … at high risk of being viewed as irrelevant or unreliable and, therefore ignored, downgraded or rejected’ (Newbigging and Ridley, 2018:37). Not being believed and having ‘voices of less
eligibility’ when people are victims of crime is an example of this (Carver et al., 2017). The
same could be said of the co-option, neutralization and ‘silencing’ of service user/survivor
generated approaches such as recovery and peer support, which are not deemed credible until
controlled by professionals. If the service user/survivor is the discredited speaker in the co-
production process (as the evidence here suggests), then the professional fulfills the role of the
hearer. For formulating explanations for mental distress with the service user in clinical settings,
Lakeman asserts that ‘forms of epistemic injustice can be perpetuated in subtle ways, but with
far-reaching consequences. Obviously health professionals need to be scrupulous in their deter-
minations of decisional capacity and acknowledge its dynamic nature’ (Lakeman, 2010:152).
The same is even truer of transformative co-production between service users/survivors and
professionals in mental health working in culturally institutional environments with historical
legacies of material violence and continuing problems with structural and symbolic violence,
and where people have been accorded social otherness and dehumanized because of their
psychodiagnostic labels. Resisting systematic epistemic injustice in such an environment will
be overwhelmingly challenging, particularly if madness tropes such as ‘hysterical’ are being
used to dismiss women’s testimony in general circumstances (Fricker, 2003). Fricker makes an
important point about the position of the hearer in moving towards epistemic justice, when
she says: ‘But it is not simply a matter of failure to properly accommodate the speaker’s social
identity … the hearers fail to adjust for the way in which their own social identity affects the
testimonial exchange’ (Fricker, 2003:169) (emphasis added). This is played out in LeBlanc and
Kinsella’s argument about epistemic justice and ‘sanism’ where service users/survivors have a
received social identity of ‘pathological’ and professionals’ received social identity is ‘normal’
(LeBlanc and Kinsella, 2016). In terms of epistemic injustice, one is accorded a ‘credibility
deficit’ and the other, a ‘credibility excess’. If we return to Rosenhan’s assertion that staff in
the psychiatric hospital fear of catching madness and so strictly segregate themselves from the
patients and refuse to listen to them, we can see how this was engrained in everyday practice
and the legacy will affect co-production. This illustrates how ‘stereotypes informing testimo-
nial exchange will tend to imitate relations of social power at large in the society’ (Fricker,
2003:164), a society which has demanded the incarceration and segregation of the mad. So is
there any way to overcome this epistemic injustice to achieve the type of testimonial exchange
needed for transformative co-production for mental health?

Farr has argued that co-production requires ‘constant critical reflective practice and dialogue … to facilitate more equal relational processes’ (Farr, 2018:623). Again we can look to Fricker
for a theoretical solution to the epistemic injustice potentially inherent in the transformative
co-production project. Her idea of ‘reflexive critical openness to the word of others’ appears to
offer a helpful perspective on solving the seemingly intractable ethical and practical problems
between professionals and service users/survivors in the testimonial exchange. This openness
relies on what she calls ‘testimonial sensitivity’. She writes that ‘an appropriately trained testi-
monial sensibility enables the hearer to respond to the word of another with the sort of critical
openness that is required for a thoroughly effortless sharing of knowledge’ (Fricker, 2003:163).
Testimonial sensibility is influenced by the hearers’ socialization and through their individual
experience. Fricker clarifies that ‘testimonial sensibility, then, needs to be shaped by collective
and individual experiences described in rich, socially specific terms relating to the trustworthi-
ness of the speakers of different social types in different contexts’ (Fricker, 2003:161). For trans-
formative co-production, then, the professionals involved in co-production need to be aware
of the context in which they are operating. They also need to be aware of their own position
as hearer and remain sensitive to their own influences and socialization in institutional practice
on their perception of the speaker and the degree of credibility accorded to their knowledge.
Fricker says this sensibility is also dependent on the cultural-historical setting of the testimonial exchange, such as that of the asylum where there was no meaningful critical awareness of the institutionalized prejudices that led to epistemic injustice and violence. In this case Fricker would argue the staff were not yet in a position to know better. Arguably professionals are now in a position to know better, despite the reproduction of the dynamics of the asylum in contemporary mental health practice, and in co-production.

**Conclusion**

Perhaps the fundamental question for transformative co-production is, ‘how can professionals and service users/survivors exist within an institutional system with such a track record and historical legacy as discussed here, and then be expected to function as allies and equals within the same system in order to dismantle it?’ The operation of rules and roles in institutional cultures and hierarchies, past and present can also be damaging to professionals. Goffman describes the ‘institutional ceremonies’ such as social events held in the asylum and the ‘role release’, which may occur as staff–patient boundaries become momentarily blurred: ‘Given the usual roles, given the pervasive effect of inmate–staff distance, any alteration in the direction of expressing solidarity automatically represents a role release’ (Goffman, 1961:90). The notion of the role release is an important one, but co-production cannot work as an ‘institutional ceremony’. Needham’s research with housing officers and tenants showed that co-production needs to be facilitated away from institutional cultures or service settings. Service users/survivors and ally professionals need to ‘move away from the point of delivery and create forums in which officials and citizens can articulate service experiences [and] recognise common ground’ (Needham, 2008:229). Additionally, professionals may have their own experiences of mental distress that they cannot disclose in their institutionalized role. In his commentary on Rosenhan, Cummins notes that ‘there is a danger of using only one aspect of a person’s identity as a means of classification. All of us have many roles and identities’ (Cummins, 2017:9). In this respect Mad Studies could offer a way of developing radical forms of co-production because it ‘treats survivors’ first-hand knowledge with equality’, but ‘is a venture we can all work for together in alliance. So it includes the experiential knowledge/wisdom of workers and the knowledge of those offering support...’ (Beresford, 2019:10). With an emphasis on plurality, the discipline operates beyond the limits of the biomedical model and the psychiatric paradigm. It can therefore challenge and resist the oppressive rules and roles that are the legacy of the institution as described here, and promote equal collaboration with mad-positive allies and scholars. As LeFrançois has argued, ‘this form of knowledge production and activism also acknowledges not needing to resist and toil wholly on our own to dismantle what has become an all too economically powerful and deeply entrenched psychiatric system’ (LeFrançois, 2016:v).

Transformative co-production in mental health can be usefully reframed as an ethical project, underpinned by epistemic justice and the idea of the testimonial exchange in the co-productive process. In order to undertake this exchange with service users/survivors, professionals who are the hearers need to exercise what Fricker calls ‘testimonial sensibility’ in order for the speaker’s knowledge to be rendered credible in the exchange. Awareness of the historical legacy of the asylum as total institution and the associated power dynamics between staff and patients where strict rules and roles applied and violence was permitted as standard practice must inform the development of this testimonial sensibility. Attentiveness to the mechanisms of co-option and neutralization to resist disruption as forms of epistemic injustice is equally important. Finally, professionals should retain a sensitivity to their own testimonies and experiences in the
exchange, particularly if those relate to their own experiences of mental distress. These factors still affect the positioning of the hearer and speaker and the credibility accorded to their relative testimonies and knowledge in co-productive processes within the phantom institutions of contemporary mental health services. They must therefore be overcome before service users/survivors and our allies can begin to collaborate on the dismantling of our contemporary institutions because ghost asylums still haunt our actions and our minds.

References


Mad Studies and knowledge equality


