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## Co-production: what is it and where do we begin?

Co-production, in my view, involves genuine power-sharing and therefore a fundamental democratising of relationships between professionals and service users in mental health. Understood this way, co-production is more radical than shared decision-making which can leave power imbalances intact (Slay & Stephens, 2013). As a general rule authentic power-sharing has yet to become established in mental health care (Webber et al., 2014). Here I consider how power imbalances may be redressed through the wider organisational adoption of relationship-centred practice. At the same time, I argue that cultural change is inextricably linked to individual actions and behaviour. Cultural transformation is not merely contingent on 'change from above', it is also facilitated by individuals 'on the ground'.

Before proceeding further, I should explain that my interest in co-production came about through my experience as a sociologist conducting research with a range of people marginalised for reasons related to social disadvantage, disability, mental health, and political stigma. People whose identities are constantly devalued in their interaction with others can become fixed in positions of helplessness. Powerlessness can be internalised so that people no longer see themselves as citizens with legitimate values, thoughts and expertise. Hope and self-belief are eroded, and people suffering from mental distress are less likely to move on positively in their lives (Fisher and Lees, 2015). In other words, power imbalances are often injurious to recovery.

Whilst co-production could be justified purely on the principles of natural justice, there is a body of qualitative evidence which suggests that co-production promotes recovery by addressing stigma, improving skills and employability, and by enhancing mental and physical wellbeing outcomes (Slay & Stephens, 2013). To be clear, co-production is not synonymous with recovery, however, co-production is a strategy *towards* recovery which is based on a belief that recovery is possible (see, for example, Barker and Buchanan-Barker, 2005). But co-production is also more than this: it is about viewing service users first and foremost as citizens who can legitimately inform mental health care commissioning and policy (Needham and Carr, 2003). That said, it follows that for a variety of reasons some citizens may prefer *not* to engage in co-production, and it is important to acknowledge this. If co-production is an obligation it is *de facto* no longer co-production, but yet another form of coercion.

Co-production requires changes to organisational cultures and management strategies. A first step in the right direction might be greater organisational recognition of the value of relationship-centred approaches in mental health. Relationship-centred approaches were first developed in the care of people with dementia (Nolan et al, 2003). From a relationship-centred perspective therapeutic relationships are seen as enriching the lives of professionals and service users alike. Relationship-centred care is arguably the starting point for co-production. Once therapeutic relationships are viewed as mutually rewarding, this enables a re-distribution of power towards service users.

Nolan et al (2003) argue that relationship-centred practice can be best promoted through an adoption of a 'senses' framework. The latter captures important subjective and perceptual aspects of care that should be experienced by *both* service users and professionals. In brief, both service users and professionals should all benefit from a

sense of security, belonging, purpose as well as a sense of fulfilment and/or achievement. Crucially service users and professionals should feel that what they do matters and that they are valued as a person of worth. In order to create these 'senses', professionals have to experience them for themselves. This is why cultural change within services and policy making organisations is crucial (Dewar and Nolan, 2013).

Some may argue that a relationship-centred approach is transferable only to mental health care environments which have been significantly shaped by the values of postpsychiatry (Bracken and Thomas, 2001). Whether or not this is the case requires in-depth consideration which is beyond the scope of this editorial. Nevertheless, it seems self-evident that relationship-centred care requires professionals to think beyond the reason/madness binary which fixes service users in a position of powerlessness and dependence. Equally, relationship-centred care will not flourish if professionals remain closed to alternative perspectives. At its core, relationship-centred care is about a way of being human, one which aspires towards relationships of equality based on a willingness to be open to others' perspectives.

If the widespread adoption at organisational levels of relationship-centred care offers the best hope for the realisation of co-productive services based on power-sharing with service users then change may take a long time. That said, professionals sometimes wait for change from above whilst failing to recognise that they have a role to play in the *evolution* of organisational culture. According to the moral philosopher Charles Taylor (1989), the formation of individual identities and social environments are interlinked processes. In *Sources of the Self*, (see Fisher and Freshwater 2015), Taylor (1989) argues that a person's identity develops through an ongoing process of critical evaluation in which they are prepared to subject personal convictions and identification to scrutiny. This is achieved through a particular way of engaging with others and being open to others' perspectives. This does not involve casting personal convictions aside in order to accommodate others, but it demands an openness to a readiness to revise convictions as a continuous process of identity development. In other words, critical evaluation requires professionals to engage with service users as equals and to have the openness to subject professional practice and values to ongoing scrutiny informed by their encounters with service users

Whilst calling for openness may seem an obvious appeal to make, the point is that openness is often extremely difficult to achieve, painful even. Professionals who apply critical evaluation in their work with service users would be open to perspectives which may confront professional 'regimes of truth' central to their sense of self. 'Received wisdoms' would not necessarily be overturned but would be viewed as revisable in ways that cannot be anticipated. This would be lived co-production *in action*. Co-production, through critical evaluation, recognises that personal development and cultural change are enmeshed processes.

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