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Developing *recovery* oriented services and co-production in mental healthcare: Building-up on existing promising organisational practices

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Abstract

Recovery, as a patient-centred emergent transformative concept in mental healthcare, requires a change in the culture and practice of organisations at different levels. This paper investigates the potential of nurturing existing *recovery* oriented initiatives as promising practices for the re-orientation of mental healthcare provision.

In the field of social innovation, promising practices are intended as very context-linked sustainable practices which open up possibilities of societal radical transformation based on people's real needs and existing assets. Similarly, in mental healthcare services, the authors argue that emergent promising *recovery* oriented and co-produced practices can favour the shift from a traditional top-down culture to a more collaborative one.

This paper is based on an experimental action-research project, *Recovery CO-LAB*, developed in collaboration with the Mental Health Department of *Spedali Civili di Brescia*, aiming to explore how service design could help the organisation to increase its orientation toward *recovery*.

KEYWORDS: service design, mental healthcare, *recovery*, social innovation, promising practices, co-production, co-design

Introduction

Recovery as a concept, in its developing application in care systems globally, promotes patient participation and it is characterised by a strengths-based and life-oriented approach.

In a *recovery* logic, instead of being underused and undervalued, personal skills and experiences of patients and professionals are seen as resources with a meaningful influence on the design - and also the delivery - of services (Repper & Perkins, 2013). In this perspective *recovery* is strictly related to co-production which by nature is “*appreciative, collaborative, respectful and active*” (Lewis et al., 2017) and based on the concept that everyone has something to contribute within a shared context.

The idea of recovering from mental disorders as a personal journey different, gained strengths from patients’ stories about their own lived experiences that contributed to spread positive expectations about the possibility of an independent and fulfilling life even in presence of severe conditions. In parallel, a more *recovery* oriented mental healthcare system was pursued thanks to the achievement of some key steps in policy-making and mental healthcare management including the deinstitutionalization and the consequent evolution toward a community-based psychiatry.

This article considers the combination and mutual influence of these bottom up and top down initiatives as fundamental assets for a deep transformation of mental healthcare services. In fact, starting from the periphery and militant movements, some autonomous practices of peer support had gained credibility in the system, and are now a core component for the development of *recovery* in established systems. However, these emerging user-led and co-produced practices, even if recognised and indicated as desired healthcare models, are struggling to spread and become the norms, motivating this research project.

After reviewing the multiple origins of *recovery* and linking it with challenges and opportunities of co-production in mental healthcare, the paper focuses on exploring the concept of promising practices as discussed in Design for Social Innovation theory. The authors use this as the starting point to summarise the Recovery CO-LAB project experience and to reflect on the strategies applied to favour the development of *recovery* and co-production in a mental healthcare department in Italy.

Origins of *recovery* in mental healthcare: a bottom-up and top-down movement

The *recovery* concept originated in US during the ‘60s as an anti-psychiatry movement led by professionals and promoting a more consumer-driven approach. Then in the following years, people with severe mental illness - initially spearhead by professionals - started writing about their personal experiences of *recovery* initiating the consumer/survivor movement and patient-controlled initiatives with the aim to protect the patient's rights on being informed about their condition and on participating to treatment decisions, care planning and delivery.

The establishment of a *recovery* oriented mental health system should be searched also in the phenomenon of deinstitutionalization - meaning the move from the long-stay in psychiatric asylums to more distributed and community-based solutions for patients with severe mental health illness (Tomes, 2006). The transition toward deinstitutionalization, in US and Western Europe, necessarily created the need for new forms of community-based support systems. The 1970s saw the expansion of welfare programs and national legislation - like the Basaglia’s experience and Law 180 in Italy; the lack of funding and coordination between medical and social services though left many patients to stand for themselves.

In parallel, the World Health Organization developed the rehabilitation model that was aligned with the community-based support programs and represented an effort to keep together within the same conceptual framework the traditional approach, based on interventions to overcome or reduce symptoms and disabilities, and the *recovery* vision that gives more importance to people's assets, choices and capabilities (Anthony, 1993).

Notwithstanding these significant steps, moving from *recovery* as an individual self-managed process to *recovery* oriented services is still an ongoing process that implies several challenges. The transformation toward *recovery* calls for a paradigmatic change of infrastructure and performance of the mental healthcare system that is difficult to envision (Ostrow & Adams, 2012).

Challenges and opportunities when fostering *recovery* oriented services and co-production in mental healthcare

As suggested in literature, the authors start from the assumption that co-production, with its different levels of patient involvement - from being informed to participating in the planning, co-design and co-delivery of services - is a fundamental trigger for service transformation toward *recovery*.

Currently, the most mature experiences stemming out from a synergistic view of *recovery* and co-production can be found in UK (Slade et al., 2014; Frost et al., 2017); experiences are also developing in countries like New Zealand, Australia and Ireland (Shepherd et al., 2008) where a system of coordinated services is well-established around concepts like individual treatment plans and coordination among different services.

According to the perspective of the UK ImROC (Implementing Recovery through Organisational Change) group, *recovery* oriented services and co-production are based on mutual and reciprocal relationships in multidisciplinary teams and consider people as having human assets, resources and networks that go far beyond their institutional roles. Here co-producing services means enabling people to lead their own *recovery* journey and empowering them in developing personal resources in peer networks and communities (Lewis et al., 2017).

Notwithstanding these significant steps, developing *recovery* oriented services based on co-production faces resistances from organisations and professionals who have difficulties to clearly define and recognise the values of *recovery* (Davidson et al., 2006); issues relate also to the limitation of available resources, risk management and the devolvement of responsibilities (ibid). There is a general fear of devaluing professional knowledge and expertise often accompanied by the limited trust in users' capabilities and on the sustained motivations behind their active participation.

Nevertheless, reviews of existing studies on the engagement of users and carers in the delivery and evaluation of mental healthcare have documented the feasibility and potential of involving users also with a history of severe disorders given the right support (Simpson & O House, 2002). There is a growing recognition of the role played by self-help and peer support services to enhance the potential of *recovery* within official mental healthcare services or independent peer-operated programs (Ostrow and Adams, 2012). At the same time empirically validated *recovery* oriented practices are starting to be formalised, evaluated, promoted and replicated (Slade et al. 2014). Examples are the *Recovery colleges* or *recovery* education programs, in which services users (but also citizens) can acquire and co-produce competencies and tools to be used along their personal journey to *recovery* through an educational approach.

Exploring how public sector organisations can leverage bottom-up and outside in processes of innovation is now a matter of debate (Hartley, 2005). Starting with the assumption that innovation can happen with the transfer of bottom-up elements to broaden organisational levels (Boyle & Harris, 2009), the possibility to use innovative practice prototypes seems to be a fundamental element to be nurtured (Lucchi et al. 2016).

This article found an analogy between the interplay of bottom-up and top-down initiatives for mental health care transformation and the evolution of social innovation. We refer in particular to studies investigating how to support and scale social innovation initiatives as a driver for the transformation of public services (Manzini & Staszowski, 2013). The next session will review some of these studies, highlighting some of the concepts used by the authors to revisit their work with mental health.

Building up on promising cases of social innovation

Social innovation has been described as “*a process of change emerging from the creative re-combination of existing assets, the aim of which is to achieve socially recognized goals in a new way*” (Manzini, 2013: 57). Often these changes have been associated with behaviours and initiatives growing out of problems posed by everyday life (Jégou & Manzini, 2008) and addressing the transition toward a more sustainable future, such as micro-nurseries, purchasing groups or co-housing, also described as “promising cases”. Most of these initiatives are forms of collaborative public services, led and co-produced by citizens, that “to endure and diffuse beyond local communities must be recognized and supported” (Manzini & Staszowski, 2013: page i).

As for *recovery*, also social innovation initiatives can be viewed as top-down and bottom-up movements, depending on where the change starts and who the original drivers are: if they are experts and decision makers (top-down) or people and communities directly involved in the transformation (bottom-up) (Manzini, 2013).

Concerning the top-down social innovation Manzini (2013) actually uses as an explicative case, the experience of the Italian psychiatrist Franco Basaglia who, in 1970s, founded the Democratic Psychiatry movement opening up the psychiatric hospital where he was director in Trieste. As a result of Basaglia’s effort, in 1978 a national law opened up all psychiatric hospitals and led to new forms of assistance for people with mental health disorders. An interesting result was the birth of economically effective commercial enterprises which actively involved patients - with their individual capabilities (e.g. restaurants and cafes, carpentry workshops, etc.).

Bottom-up initiatives in social innovation are on the contrary generated by the so called “creative communities” (Meroni, 2007) who collaborate in the co-creation based on commonly recognised values. They break up with mainstream models proposing new forms of collaborative services based on an original combination of existing products, services, and knowledge. These solutions can be considered as “promising cases” with the potential to be scaled up and replicated in different contexts if they find a tolerant environment and if supported by an appropriate design intervention (Jégou & Manzini, 2008).

Starting from this analogy with social innovation bottom-up and top-down movements, the authors identified some key factors described in literature favouring the growth of these promising cases: their recognition and observation, the identification of common values and favourable environmental conditions and the use of design methodologies to make these values more recognisable, shared and practicable.

Recognition and observation

As Meroni (2007) recommends, the first step to support creative communities in fostering promising practices is their recognition. Aligned with Meroni's perspective, Manzini (2013) identifies as a fundamental initial step, the observation of the existing cases (ethnographic on field research) and the consequent analysis of their success in terms of sustainability, replicability and their capacity to involve more people (degree of tolerance) (Jégou & Manzini, 2008).

Defining common values

To support social innovation, it is also crucial to nurture the sense of belonging and commitment of people involved in the practices, working on commonly recognised values. As Morelli (2015) suggests, only service offerings with a perceived local and personal relevance are considered as valuable. In highly localised services the sense of trust – linked to social proximity, personal acquaintance and geographical proximity– works as main catalyst for user attention and as main driver to build up a successful scaling up strategy. As discussed in service research literature, “value” is always co-created and situated (Grönroos, 2008), but needs to account for a multiplicity and at times conflictual “values”. When aiming to scale up collaborative services, service design is proposed as contributing to the co-creation of “experiential values” in a specific social context (Arvola & Holmlid, 2016), amongst which: social significance meaning a contribution to the person's status and identity; mutual advantage, where design supports the cooperation and coordination between actors; and collective welfare, leading to organisational change.

Supporting different stages of growth

After the recognition of common values the following question is: “*Is it possible to consolidate and replicate these promising cases?*” (Jégou & Manzini, 2008: 33).

In the design for social innovation literature, design can intervene at different stages of the development process, namely the solution prototypes, mature solutions - spread internationally by imitation - or implemented solutions - supported by specifically designed “enabling solutions” (Jégou & Manzini, 2008).

The very early stage of solution prototypes is a frequent form of collaborative services in public sector as they test if a service is feasible and if it can be implemented: it is very context-dependent and very much reliant on people who started it. In order to transform these initial ideas into mature ones, the design intervention can help reframing the initial promising solutions, working to preserve the winning features while increasing their accessibility and effectiveness. According to Manzini (2013) professional designers could play an important role designing with or for the communities. In particular, “designing with” includes: co-design and consensus-building, where design methodologies and tools help to define common values and agree on the strategy to follow; designer as mediator and facilitator, for instance in co-design workshops where participants may align to the existing assets and build new service scenarios; or co-design activities where design prototypes are used to envision and discuss new possible solutions.

From this short review the authors learnt: the relevance of identifying promising practices as a starting point for affecting wider systems; the important of designing for the co-creation of value, recognising the potential conflicts between the original values behind these initiatives and the new contexts and communities where they should develop or expand to; and the potential of a design-led process to increase the accessibility and attractiveness of the solutions and the collaboration and consensus building across diverse social actors.

In the following paragraphs, after an introduction of the Italian and Brescia (a small city in the East of Lombardy region) contexts, we present and discuss the Recovery CO–LAB project where promising co-produced practices were identified and analysed as the starting point for their development and replication in the organisation.

Recovery CO-LAB: framing the context

While *recovery* and co-production are embedded concepts in the international mental health arena, in the Italian context - where government documents and a recent proposal for a new Mental Health Law¹ introduced *them* as a mandatory orientation - their declination in routine activities of mental health services still lacks behind.

Nonetheless, some good practices are still running across the nation informed by Basaglia's flagship experiences such as those of Trieste, Trento and Modena (see for example the national meeting for patients, families and carers "*Le Parole Ritrovate*" in Trento). Besides these major initiatives, many promising projects occur but hardly reach the attention of a wide audience.

In the Brescia area in particular, *recovery* and co-production began to be on the agenda of local mental health services about ten years ago when public and third sector services agreed to test a tool for the promotion of person-centred care - the so-called Mental Health Recovery Star - introducing concepts such as peer-support and negotiation between users and services.

However, a sort of cultural divide about *recovery* and co-production still characterizes and separates front-line staff members from middle-managers and directional board. With this in mind, the UOP23 of Spedali Civili di Brescia became interested in service design as an alternative methodology to enhance their ability to change.

The Recovery CO–LAB project

The UOP23 (Operational Psychiatric Unit n. 23) is part of the Mental Health Department of *Azienda Socio-Sanitaria Territoriale Spedali Civili*, a health organisation that operates under a regional framework assuring continuity of care from acute settings to ambulatory care through rehabilitative interventions. UOP23 is composed by: an acute inpatient unit, two community mental healthcare centres covering about 220.000 inhabitants in the area of Brescia, a day-centre and two rehabilitative residential units with different levels of care. The multidisciplinary team of UOP23 is staffed with psychiatrists, psychologists, nurses and social workers.

Recovery CO–LAB is a one-year experimental project developed by the Departments of Design and Management Engineering of Politecnico di Milano in collaboration with the UOP23. The project explored the application of design approaches and tools to foster co-production in *recovery* oriented experimental practices across UOP23 services. The process had been involving a heterogeneous group of actors including patients, family members, doctors, caregivers and local actors for a total of 59 people.

¹ The mentioned governative documents are "*Ministero della Salute. Linee di indirizzo per la salute mentale*" (2008). And the law proposal refers to "*Proposta di legge 2233 di Casati et al. del 2014, Camera dei Deputati*".

The project was structured in two design and learning cycles of 10 weeks conducted within two very diverse contexts (see Figure 1). The first cycle focused on the community mental healthcare centre, the day-centre and the rehabilitative residential unit in Brescia, while the second cycle on the inpatient unit and the community mental health centre in the Montichiari hospital.

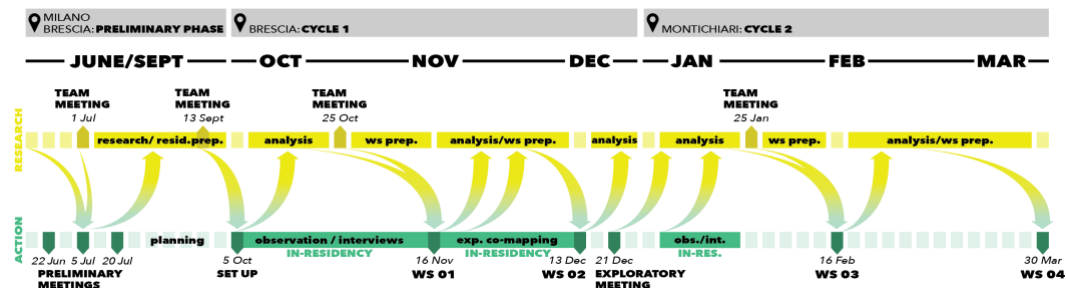


Figure 1 - The Recovery CO-LAB process.

Moreover, inspired by the artist-in-residence programs, the project funded a 2-day-a-week presence of a designer-in-residence in the UOP23 premises. Thanks to this residency the design team was able to informally talk with people, directly observe activities and key events, exchange information with key actors, and agree on the project development on the spot. Also, a temporary innovation lab - a physical corner located at the community mental health centre in Brescia - was introduced to support the contextual research.

Recognition and observation of promising practices

In agreement with the process of design for social innovation the project started with the identification of some promising practices, that were informally infusing co-production principles within the organisation and that through design interventions had the chance to gain more relevance in the Mental Health Department.

Definition of common values

In parallel to the identification of promising practices, the research team started to investigate the UOP23 context in order to individuate the values recognised by contextual actors - including patients, their families and professionals - as facilitating co-production.

The identified values, shared with participants and used as common language for co-design activities, consisted of:

- Equality: perceiving other actors as capable, allowed to act and respectable;
- Responsibility: everyone is empowered to accomplish activities;
- Informality/Flexibility: there is no fixed roles and spaces for each specific activity;
- Negotiation: everyone feels qualified to act and to negotiate his/her own role.

Keeping these values as a point of reference, co-produced practices were analysed considering both the experiences of people involved (activities and spaces where these take place) and organisational aspects (roles and rules). Reflecting on co-production values helped the design team to map the state of the art of promising practices and then to identify critical points and opportunity areas that became input for co-design workshops.

What emerged from the preliminary analysis was also how values were not perceived by all the contextual actors in the same way - both on individual and service level, because there were very diverse levels of awareness or constraints around co-production. These different levels of readiness constituted another starting point for the design intervention.

Supporting co-produced practice with design interventions

As mentioned before, the design cycles were conducted in two very diverse contexts in terms of organisational readiness to co-production and they were structured around 4 co-design workshops.

The first workshop focused on the personal medical record prototyped for the UOP23 residential services and the second on the community mental health centre welcoming desk. In the second cycle, given the complexity of the inpatient ward in Montichiari the team had to slightly reframe the research with the aim of investigating the context and try to co-define some opportunity areas for the improvement of the inward experience.

The design interventions aimed to foster the following changes:

1. Rethinking the concept of a personal medical record into a personal journal able to support the overall *recovery* journey;
2. Fostering the shift from the community mental health centre welcoming desk to an accompanying service across the entire patient journey across services;
3. Re-thinking the in-ward activities to open-up opportunities for co-production in a high-risk environment.

1. From personal medical record to a personal recovery journal

The personal medical record prototyped and co-produced by caregivers and patients of the UOP23 residential services in Brescia, is a paper repository for patients to collect all the fundamental information about their illness and symptoms as well as notes and tips for rehabilitation. It was chosen as a clear example of a co-produced tool, whose development was still in progress and for this reason had the potential to be improved.

The design team used data collected during the field work to create 3 patient journeys and scenarios as participatory material for the first workshop, which involved 15 participants - including patients, their families and professionals. Co-design tools such as persona profiles, customer journey maps, value and inspirational cards and a service offering map (see Figure 2) were proposed to re-think the personal medical record.

From the co-design session emerged some new ideas, such as a “role play” table game in which the patient-player can go through the challenges of an ideal rehabilitation journey; or an online and offline “multi-level activation platform” providing relevant information, self-help tools and peer-to-peer exchange channels that could be activated in agreement with doctors and with different levels of visibility.

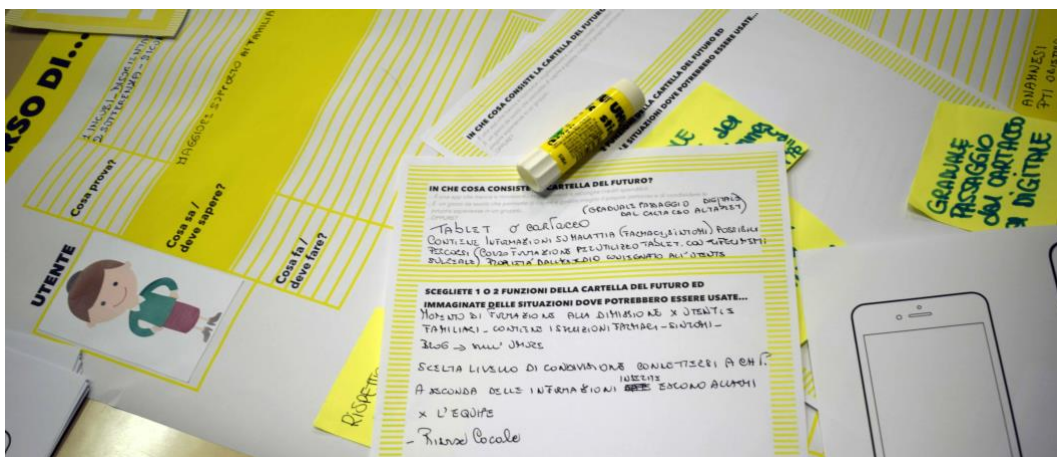


Figure 2 - Workshop 1: co-design tools.

In preparation for the second workshop the design team trained expert patients to interview other patients using a simplified customer journey map. The collected stories allowed to identify key-common stages of a *recovery* journey that were used in the second workshop as a tool for participants to align their knowledge.

2. From the welcoming desk to an accompanying service

The welcoming desk is a service co-produced and co-delivered by some healthcare professionals and expert patients in the community mental healthcare centre in Brescia. It involves expert patients on a daily basis welcoming and helping to orient new patients across the UOP23 services.

The second workshop aimed at evolving the experience of the welcoming desk toward an accompanying service, meaning a service able to support patients in the different stages of their *recovery* journeys. 16 people participated to the session, divided into 3 groups. Tools used in this session consisted of a synthetic description of the key steps of the *recovery* journey as a trigger for the discussion, inspirational case studies (see Figure 3) and role cards to imagine new functions and their impact on the roles of people involved.

Ideas and discussions emerged from the session focused on combating stigma and aspects related to the support needed during the latest stages of the patients' journey, when they try to go back to their social life and their work activities. For instance, a group envisioned a safe space with very practical job facilities (carpentry, kitchen, etc.) where patients - supported by experts - could experiment with job skills.



Figure 3 - Workshop 2: inspirational case studies.

3. Opening up space for co-production within a high risk environment

Aware of the complexity of the Montichiari context, the second design cycle started with an exploratory meeting with representatives from Montichiari acute inpatient unit and community mental health centre.

As mentioned before, the meeting revealed limited familiarity with the concept of co-production as well as difficulties to imagine how co-production could be implemented in a ward working in an ongoing emergency situation and with patients in a state of acute conditions.

At the end of the field work stakeholders agreed to focus on implementing the daily in-ward stay, reflecting in particular on activities and spaces. Thus, workshops 3 and 4 focused on this topic and involved respectively 15 and 17 participants, also including local stakeholders (a librarian and an art therapist). Similarly, to previous sessions, some tools were used to help participants in using creativity and aligning very diverse perspectives on existing services. These consisted of inspirational case studies, quotes from UK literature and field research insights cards (see Figure 4).

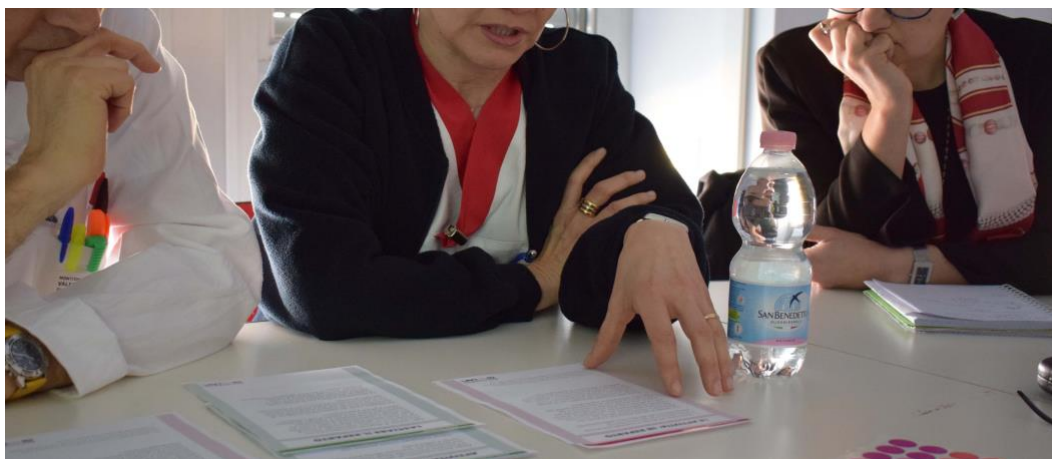


Figure 4 – Workshop 3: inspirational case studies, cases from literature and research cards.

The groups came out with new rehabilitative and social activities –such as walking sessions, art, book reading, in-ward music sessions, etc.– and explored the possibility of strengthening the bond with existing services available on their territory. Workshop 4 aimed specifically at turning these ideas into concrete solutions to be actually implemented by the ward, like an in/out ward information kit, or developing the role of expert patients as support for in-ward stay and the exit phase.

Discussion

This paper has used the analogy between the concept of promising cases in social innovation with the work done to increase co-production initiatives in mental healthcare. Together with the importance of building up on already known experiences, similarity was found in the importance of working on co-production values to make them more recognisable, shared and practicable, even where there was no original awareness of the term and its implications. Furthermore, the design team used design tools to help translating these abstract terms and values into ideas and potential activities, all built around a deeper understanding of the *recovery* journey.

Building up on already known experiences

Working on promising practices was useful as people already owned these initiatives and could reflect on possible improvements starting from very personal experiences. Choosing the welcoming desk as design focus of the second workshop, for example, allowed to ask expert patients working at the desk to collaborate in the design research in collecting other patients' stories favouring a higher level of participation and involvement, not always easy with this kind of population.

Different awareness on co-production

The level of awareness on *recovery* and co-production was very diverse for people involved in the process and often very subjective. This implicates different levels of readiness even among services of the same organization. Because of this the design team had to adopt different context-based strategies: if workshop 1 and 2 could work on improving and expanding existing practices across the system, the second cycle needed to first align the participants on recognisable values. For this reason all workshop participants were asked to review *recovery* and co-production starting from literature quotes, case studies and insights from the field research. Emerging from this activity was a negotiated space for

experimentation in the form of possible inward activities for patients or the need for improving the entrance and exit of patients as part of their overall *recovery* journey.

Making values and concepts tangible

Identifying shared values as objectives to be achieved and guidelines to be followed acquires a fundamental role in establishing a common language and aligning participants' expectations. Fundamental vehicles for engagement was the sharing of patients' *recovery* experiences and the use of co-design tools as a way to translate abstract concepts and values into ideas for practical activities: e.g. the co-created patient profiles, the *recovery* journey map alternating the patient and professionals' views on the service provision, the value cards providing hints for the re-thinking of services or the inspiring cases cards providing tangible examples.

Responding to the needs of the whole *recovery* journey

Through the co-design process the design team aimed to support all the stakeholders in envisioning how these values could respond to the need of the *recovery* journey that, with its iterative and recursive nature, required a holistic vision of the current mental healthcare system. Analysing very diverse stories and the existing gaps between service providers, helped participants to look outside their own services and teams and consider other internal and external resources as new assets to guarantee continuity of support along the *recovery* process. As an example during the workshop 3 participants envisioned the possibility for inward patients and caregivers to attend rehabilitation courses provided by the mental healthcare community centre, anticipating the beginning of the *recovery* process and gaining fundamental knowledge for when they would exit the hospital.

These valuable insights do not diminish the extreme difficulty of engaging and motivating people participation and engagement. The project confirmed the strong need for very motivated actors which are keen to invest personal extra effort and are willing to take positive risk. Also, given the vulnerability and diverse conditions of patients, a significant effort was made to make sure that user knowledge was considered and fostered as a crucial resource.

Conclusions

This paper has taken inspiration from studies on design for social innovation where designers work to recognise, develop and empower promising practices so that they can become self-standing social enterprises and have an important impact on society.

As discussed in the previous section we found a strong similarity with this process even if working just at the early stages of the process. What was inevitably different instead was the constraints given by a highly institutionalised context as the mental healthcare system where these promising practices should grow and develop. In this context increasing awareness and exploring opportunities for *recovery* and co-production are a fundamental first step to find, negotiate and create the actual space for experimentation and change. In the authors opinion, thinking of dedicated co-design tools for this stage could be particularly relevant.

Finally, empowering people involved in service co-production and creating a safe space for starting a new dialogue on co-production are both very important aspects that need to be simultaneously considered and nurtured in designing a strategy toward a lasting systemic change. It is only after having built some evidence on co-production values and having negotiated this experimentation space that the design intervention could start working on the "enabling solutions" (Jégou & Manzini, 2008) that can favour the growth of *recovery* oriented and co-produced mental healthcare services, as it is for social innovation initiatives.

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