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MANAGEMENT ENGINEERING – SUSTAINABLE OPERATIONS AND SOCIAL INNOVATION

CO-PRODUCTION IN MENTAL HEALTH: HOW TO MAKE IT WORK?

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ABSTRACT

Nowadays the delivery of services for mental health is shifting toward a model that implies a deeper inclusion of the users and their families, both in the design and in the production of services (i.e. co-production and recovery). This approach is expected to be more effective with respect to normal rehabilitation processes, as it leverages on the abilities of the patients and their social environments; as such, patients are more involved and sustained in undertaking actions with enduring positive effects. However, this shift toward participatory and co-produced services, entails a radical change in organizations, roles and relationships. How and if departments of mental health in Italy are putting this change into practice is still an open question. This work aims to provide an initial investigation on how recovery models and co-production are currently delivered within the mental health system, by providing evidence emerging from a case study in the Milan Area. The cases helped to detect some of the challenges that organizations face when applying the recovery model.

SOMMARIO

Negli ultimi tempi i servizi di sanità mentale si stanno spostando verso un modello che mira sempre più a coinvolgere l'utente e i suoi famigliari sia nel design che nella produzione del servizio (es. coproduzione e recovery). Questo approccio si prospetta più efficace degli attuali processi riabilitativi, poiché fa leva sulle capacità e la rete sociale del paziente, così da coinvolgerlo e supportarlo nelle sue azioni per generare effetti positivi. Questo cambio di rotta implica un cambiamento radicale nelle organizzazioni, nei ruoli e nelle relazioni. Come e se i dipartimenti di sanità mentale in Italia stiano mettendo in pratica questo approccio, è ancora un quesito aperto. Il lavoro mira a dare una prima indagine su come i modelli di recovey e coproduzione siano implementati nel sistema di salute mentale, basandosi su ciò che è emerso dal caso studio dell'area di Milano. I casi hanno permesso di evidenziare alcune sfide che le organizzazioni devono affrontare quando applicano il modello di recovery.

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A mia madre, la mia forza.
A mia sorella, il mio orgoglio.
A Lucia, la mia luce.

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INTRODUCTION

Context

Nowadays the concept of mental health and mental illness is changing, there is the will to overcome the stigma around this issue. Against this background, from health professionals is emerged the need for an approach oriented to recovery and collaboration with patient (Holsenbeck, in Mulligan, 2003) that could change the burden created from mental illness because it is an approach that aim to involve the person, to create a strong relationship. In fact, the issue is people's minds, so the person benefits from being involved, knowing what is the mental illness he/she is living to heal. In some organisations, there is the will to introduce the co-production in the therapies to involve the patient in the process building a therapy customised for the user. In the analysed area, there are some example of co-production approaches used in mental health, they are cases used to understand how the co-production can be applied in actual organisational context.

Research objectives

The research aims to understand through the literature and through the experience of one case study how organisations put in practice the concept of recovery and the co-production. The analysis is focused on three organisations in the Milan area. With the case the objective is to find out if the critical points highlighted by the published literature are managed and how. The case studies can also identify what are the limits and the possible barriers that do not allow the complete implementation of the coproduction approach.

Thesis outline

The thesis starts with the literature review, which provides a summary of information, examples and models related to the coproduction in the health care services and in the mental health services. Moreover, the review helps to detect the critical areas for implementation. After the delineation of these areas, the interviews realised in the Milan area give the actual situation related to real examples of the application of coproduction

approach. The results coming from interviews are discussed and compared with the literature findings to give a picture of the real open points in the issue. The results proposed three main areas that influence in a critical way the application of the coproduction approach: Recognition, Resources and Methodology.

Chapter 1

CO-PRODUCTION, LITERATURE REVIEW

Objective and methodology of literature review

The objective of the literature review is finding a link between coproduction and mental health through examples of existing models that can both give a demonstration of best practices and put in evidence the critical points that have not been explored so far. From this review, it emerges a "customized" definition of coproduction applied to the field of general health care and mental care, highlighting the importance of the practical experimentation of this new approach. Thanks to the literature review it will be possible to explore the advantages and limits of the coproduction approach: a useful starting point for the research work.

The review is led to find not clear points and possible implementation area, so the papers are explicitly pro-coproduction in order to find models, examples or experimentation of this approach.

The outcomes of the review are: a common definition for coproduction in health care and mental health; critic points, limits, potentialities and models of the coproduction approach in the mental health services.

Due to the novelty of this issue, the sample taken in consideration is composed by all the papers where pertinent information about the coproduction in the health care and mental health services are present.

The methodology used for the research review is described by schemas in the figures 2.1, 2.2 and 2.3. In the first step, the focus was on the correlation between the words "coproduction" and "health care" and, secondly, between "coproduction" and "mental health". The search engines used are: Scopus, Webofknowledge and PubMed.

After the selection of papers there was an analysis of the abstracts. The abstract and the text of each paper was analysed considering the pertinence of the issue and the pertinence about the objective elements: models, experimentations, limits, critical points. The research

produced also duplicates that was removed: 33 about the first combination of keywords and 7 about the second combination from WebofKnowledge, 5 about the first combination of keywords from Pubmed.

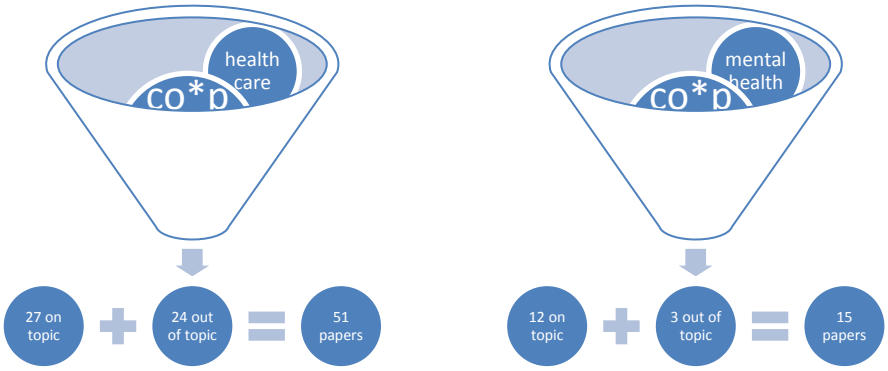

Figure 1.1 Results of Scopus

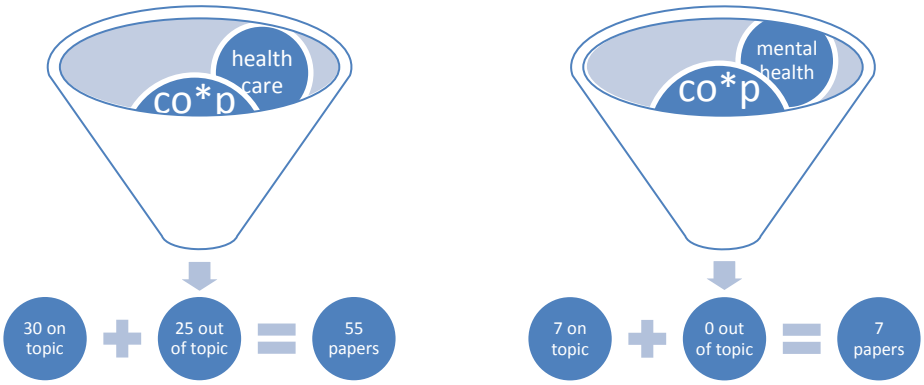

Figure 1.2 Results of Webofknowledge

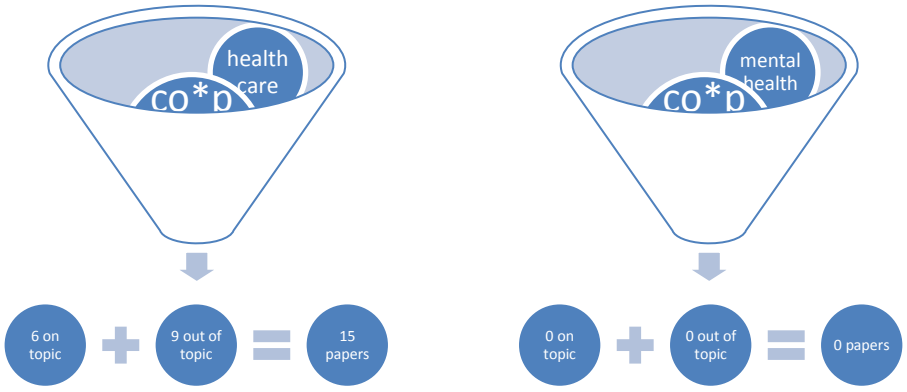

Figure 1.3 Results of Pubmed

Mental illness (disorder)

In order to give a definition of mental disorder it is necessary to cite the Diagnostic and Statistical Manual of Mental Disorders (DSM) that, in its last version (DSM V), it proposes this definition.

> *"A behavioural or psychological syndrome or pattern that occurs in an individual that has, as consequence, clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning), and it reflects an underlying psychobiological dysfunction. Mental disorder must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals). It is not solely a result of social deviance or conflicts with society. Mental disorder must be validated diagnostically using one or more sets of diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment), and it must have clinical utility (for example, contributes to better conceptualization of diagnoses, or to better assessment and treatment)."*

This is a clinical definition that try to put in evidence what is a mental disorder and what is not. The definition argues that the mental disorder is related on behaviour and it causes dysfunctions. Not all the behavioural instabilities can be defined as mental disorder, and every mental disorder can be validated through diagnostic instruments (validators).

"A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others. . . and daily functioning" (National Alliance on Mental Illness 2014).

This is a more generic definition that states clearly how much the mental disorder affects everyday life. In 1990, mental and behavioural disorders represented 11% of the total worldwide disease burden, expressed in terms of disability-adjusted life years (DALYs) (Hosman et al. 2005). This percentage is predicted to increase to 15% by 2020 (Hosman et al. 2005). The effects that this kind of illness can have on people is the main reason why mental health is becoming very important nowadays (Hosman et al. 2005). There is also an economical reason that presses for paying more attention to the mental disorder, in fact mental health problems result also in a variety of other costs to the society (World Health Organisation 2003 & Kickbusch 2003).

Mental disorder was stigmatised in the past with the tendency to conceptualise "mental patients" as an undifferentiated group of victims, however this stigma restricts the potential of sociological (Mulvany, J. 2000).

Moreover, mental disorder was seen as something that could happen only to a specific kind of people: actually, it is generated by a lot of factors: mental disorder is about mental disorders, symptoms and problems. Mental disorders are defined in the current diagnostic classifications mainly by the existence of symptoms. Mental symptoms and problems can exist even without meeting the criteria for clinical disorders. These subclinical conditions are often a consequence of a persistent or temporary distress, and they can be a marked burden to individuals, families and societies (Lavikainen et al., 2001).

What is co-production

Co-production is a term that has seen different interpretations according to the time and the context. The first one to introduce this term was Ostrom in 1973, who focused on the fact that citizens should be involved in public services (Batalden et al.2015). Other definitions linked the term to: developing skills and abilities to work together for the joint provision of public services (Ottmann, et al. 2011), creating a network that delivers public services with reciprocal relationships (Ledger & Slade 2015), improving the quality of the service

through sharing the power of professionals with citizens (Kidd et al. 2015; Slay and Stephens 2013 p. 3), and creating a constructive customer participation in service creation and delivery (Zainuddin et al. 2011).

According to the elements found in the different interpretations of co-production, a definition can be summarised as follow:

> "Co-production is the involvement of the customer, that is recognised as an active part of the process in designing and delivering a public service. The active involvement implies the presence of interaction activities among the customer and the other stakeholders of the process, with a power sharing that permits to reach an innovative and useful result."

This definition wants to underline the fact that, to realise co-production, it must be given to the customer more than the simple attention, but he/she must have the power to act on the process like a company worker. However, co-production is not so simple to realise, in fact in some companies the co-production is be a "controlled" phenomenon where the customer participation is monitored with parameters defined by the service provider (Ostrom et al. 2010).

What is co-production in health care

Focusing on the health care field, co-production takes a more outlined form. From the literature, the term and the ideology of co-production principally focuses on the aspect of building relationships with patients (Sabadosa & Batalden 2016); they, in fact, can build a network with all the actors involved in the health care service like professionals, care givers and nurses (Batalden et al. 2015). The high-quality interactions, derived from the collaboration of stakeholders (Murray Cramm & Nieboer 2014), can create an ecosystem (Honka et al. 2011) that grants the active participation in the process activities (Ottmann et al. 2011), since patients are viewed as partners of doctors (Honka et al. 2011).

The coproduction, concerning the health care system, is not seen in the same way everywhere. In fact, it is an issue approached in different ways, or not approached, according to the context determined by the country (Lichon et al. 2016) or the education level of the

patient (Murray Cramm & Nieboer 2014). For this reason, it is good to summarise also a definition for the co-production about the health care system as follow:

"In the health care system, co-production is the creation of a network among the stakeholders involved in the health care service, where the actors have the same importance and their roles are recognised and accepted. The actors establish a stable and productive trust relationship in order to create an ecosystem that produces value."

This definition stresses that the actors' position must be at the same level. The patient position was not even considered in the classic paternalistic clinician-patient approach (Lichon et al. 2016) and, nowadays, some clinicians find it difficult to involve the patient due to different reasons: lack in knowledge, instruction level, feeling in danger for their professional position.

This literature review shows that the relationship between co-production and health care is an unclear issue that becomes even more complicated if the field is mental health. In fact, the patient uses the health care system to benefit from the knowledge of the health care professionals and the health care resources, so someone could ask "why does the patient have to participate in the production of the therapy/service, if he/she already delegates the clinician to solve his/her problem?". The answer could be seen from two different points of view: patient/caregiver direction and health care professional direction.

- **Health care professional**

  From this point of view, the situation is that some doctors do not give value to the interaction with the patient and the network around him/her (family members and care givers). Who works in the mental health care is unwilling to trust of the patient's preferences about the treatment (Hansen et al. 2004). Some professionals underestimate the value of patient/family involvement, as they consider it a waste of time, so they focus on the treatment without giving worth to the relationship with the patient (Bradley 2015). Professionals use to have a paternalistic behaviour,

assigning to the patient a passive role as the receiver of the treatment (Wagner EH. 1996).

This situation clashes with the studies that encourage the involvement of the patient and his/her network. In fact, the collaboration between professionals and patients influences the attitudes of health professionals (recovery orientation, attention to patient opinion, faith in the therapy) towards people with mental disorder positively (Babu et al. 2008). The importance of such a relationship is demonstrated by the inclusion of the co-production approach in the education of professionals, nurses and care workers. The 75% of undergraduate nursing and postgraduate mental health nursing programs include consumer participation in some capacity (Happell et al., 2015). The inclusion of the patient can give access to some information that could not be available otherwise, which could help to develop the therapy (Solomon et al. 2012). For example, it is demonstrated that including cancer patients in the cancer care education for students could improve their confidence, since they may influence the creation of negative attitudes among the students (Komprood, 2013). The realm to involve the patient, by the professional's point of view, means informing the patient through the evidence-based medicine and activating him/her through recognising his/her role in managing the disorder: this can contribute to the recovery of the patient because it means giving to him/her the possibility to better understand his/her condition (Murray Cramm et al. 2014).

- **Patient/caregiver**

The patient and his/her family may be seen as a resource of the health care process. Firstly, patient's experience could give important information that can improve the outcome of the therapy (Batalden et al. 2016). Secondly, the family members, called "informal carers", spend approximately more than three times the average time spent by the mental health nurse in taking care of the patient (Bradley 2015). The involvement of the informal carers has been recognised as a fundamental element of the mental health service provision (Bradley 2015). Another important datum that

underlines the worth of the family members as resource is an economic datum, in fact in UK it was estimated that patients' families save £87 billion per year (Bradley 2015), so the involvement of the patient and the network around him/her is a source of value both in practical and economic point of view.

The situation regarding the patient involvement is characterised in some contexts by the lack in the possibility, for the patient, to have an opinion level equal to that of health professionals. This leads the patient and the family members to feel a sense of inferiority when they talk with professionals and, as a consequence, the level of cooperation between the two parties, patient and health professional, is low and users find it difficult to access to health services (Bradley 2015). The difficulty of the patients to be listen is characterised by fact that the network, patients and their families, is not recognised in the policies and in the academic context (Wharne 2015). On the other hand, with respect to the marginalization of the patient from the decisional process, there are examples of a change in the role of the patient, from a passive receiver to a proactive partner and "coproducer" of health care (Honka et al. 2011). In fact, there are recent and diffused models of care delivery that aim at developing in a good way the involvement of the patient. For example, the Chronic Care Model (CCM) is structured to promote a more complete understanding of patients' lives and preferences, the customization of high quality care, and the empowerment of patients as proactive participants who take responsibility in their care delivery (Murray Cramm et al. 2014). Summarising, the patient involvement is still not recognised everywhere and it depends more on the ethical thinking than on policies or good practices.

Co-production in mental health

As mentioned previously, talking about co-production in mental health is complicated. The National Practice Standards of the Mental Health Work-force published in 2002 (Commonwealth of Australia, 2002) articulated the clear goal of the actively involvement of patients in the education of health professionals. In Australia, for example, this kind of

approach was not even embedded in the nurse education at the undergraduate level (Deakin University Human Services, 1999; McCann et al., 2009), so promoting a co-production approach with people that were not even prepared could be very difficult. During time, the situation in Australia moved towards the increasing in patient involvement in nurse education (Happell, Platania-Phung et al., 2015; McCann et al., 2009; Mental Health Nurse Education Taskforce, 2008) and now health professionals express the need of an approach that promotes recovery and willingness to collaborate (Holsenbeck, in Mulligan, 2003). The future step is developing a strategy in order to promote the patient involvement at a more autonomous level (Byrne, Happell, Platania-Phung,Harris, & Bradshaw, 2014; Happell & Roper, 2009). From this example, it emerges that both patients and nurses find the collaboration productive and so they form a network of relationships that is a positive and protective factor for mental health against the onset or recurrence of mental ill-health (Hosman et al. 2005). This network creates the opportunity for the patients to increase their access to the resources, giving them knowledge from other experiences and being supported by relevant and appropriate materials (best practices), instead of trying to work around health professionals' literature (Happell et al. 2015).

Well-supported coproduction in mental health has the potential to bring together expertise by experience with conventional academic and clinical expertise (Gillard et al 2010). This assumption indicates that, in order to be effective, coproduction must not only be the simple involvement of the patient but it must be supported. Co-production is not possible unless all parties have the freedom to enter into it by choice with an equal ability to promote their understandings (Wharne 2015). Coproduction will not work if people cannot enter into it freely or openly express their understandings. Negotiation in reaching mutually agreed decisions is very difficult when someone is "backed into a corner", or "having to follow procedures". Coproduction must be something that people "want to do", not an imposed regulating system, or an uninformed dismantling of professional understandings (Wharne 2015).

Mental health

In the past 20 years, the interest in promoting mental health has grown (World Health Organization 1981, 2002), because its importance is grown too due to the increasing of cases of mental disorder and the perception of mental health as an integral part of health (World Health Organization 2001). In fact, from the World Health Organization 2001b, p.1 definition of health: "… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", it also emerges that mental health is not only the absence of mental disorder and mental health is connected with physical health and behaviour. Another important element that increases the attention for the mental health is the prevision, made by the World Health Organization and the World Bank, that indicates that by the year 2020 depression will constitute the second largest cause of disease burden worldwide (Murray & Lopez, 1996). The global burden of mental ill-health is well beyond the treatment capacities of the developed and developing countries, and the social and economic costs associated with this growing burden will not be reduced by the treatment of mental disorders alone (World Health Organization, 2001c).

For what concerns mental health in specific, World Health Organization 2001b, p.1 provides the following definition: "… a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". From this definition, it emerges that mental, social and behavioural health problems may interact to intensify each other's effects on behaviour and well-being and, as a consequence, they can affect the society (World Health Organization 2005). In this terms, mental health implies fitness rather than freedom from illness (World Health Organization 2005).

A positive mental health can be described as a resource. It is essential to the subjective wellbeing and to our ability to perceive, comprehend and interpret our surroundings, to adapt to them or to change them if necessary, and to communicate with each other and have successful social interactions. Healthy human abilities and functions enable us to experience life as meaningful, helping us to be, among other things, creative and productive members of the society (Lavikainen et al., 2001).

The mental health is determined by a lot of factors that could be grouped in some areas: *individual factors and experiences, social support and other social interactions, societal structures and resources, and cultural values* (Lahtinen et al., 1999). Considering the individual, the value of mental health is realized by positive feelings and different individual skills and capacities that can be seen as components or consequences of good mental health (Korkeila, 2000).

In conclusion, nowadays mental health is having a growing importance because of the effect it has on the society and the burden it implies when it is ignored. Mental health is influenced by several factors and it touches in a very important way the health of the people.

Recovery

The term recovery groups more issues than the only elimination of symptoms of the illness. Recovery definitions include individual aspects like the achievement of living a meaningful and productive life, community aspects that can increase health and social citizenship (Krupa & Clark 2009) as the definition provided by Provencher H. 2002: "Personal recovery has been defined as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness". Recovery goes over the cure and puts at the centre the patient and his life. With this approach, the illness is seen as a condition of the life path of the patient that could be temporary or permanent and the patient has to learn how to live in harmony with this condition. Recovery does not include only symptoms or cure but it touches the life of the patient in a very personal way; it has been called a 'transformation ideology' for mental health care, in particular meaning a shift from paternalistic patterns of care to more inclusive ones which value people's autonomy (Le Boutillier et al 2011).

With this meaning of recovery, the recovery-oriented practices and measures are different from the clinic ones. In fact, in a recovery path, a key pillar is promoting and facilitating participation (Le Boutillier et al. 2011). For the measure, there are frameworks that fix some standards in the quality of the recovery, for example *Pillars of Recovery Service Audit Tool* (PoRSAT) identifies six pillars of service development: Leadership, Person centred and

empowering care, Hope inspiring relationships, Access and inclusion, Education, and Research / Evaluation (Higgins A. 2008); the *Practice Guidelines for Recovery-Oriented Behavioural Health Care* covers eight domains: primacy of participation; promoting access and engagement; ensuring continuity of care; employing strengths-based assessment; offering individualized recovery planning; functioning as a recovery guide; community mapping, development and inclusion; and identifying and addressing barriers to recovery (Tondora J et al. 2006 and Davidson L et al. 2009). The *Recovery Promotion Fidelity Scale*, instead, assesses organization performance in six domains: Participation and acceptance; Self-determination and peer support; Collaboration; Quality improvement; Staff development; and Miscellaneous.

Levels of co-production

Co-production is not an approach that consider only one factor. In fact, co-production could be applied in different stages of the service development, or it could differ according to the responsibility given to the customer. This assumption means that it is useful analysing what could be the levels of coproduction.

In the literature, we can find some classifications of coproduction in the health care services according to the contexts analysed; here below It is reported the different interpretations of levels of coproduction.

Levels of co-production as intervention areas

This classification could be used in policies development because it can give a clear overview to make a policy complete under all aspects, following a coproduction approach (Corburn et al. 2014). The areas mentioned in this classification are Governance & Leadership, Economic, Development & Education, Full Service & Safe Communities, Environmental Health & Justice, Quality & Accessible Health Homes and Social Services. Corburn et al. 2014 reported a practical example of coproduction approach with respect to these intervention areas: the case of the city of Richmond. In particular, the *Governance and Leadership* intervention area focused on institutionalizing

health equity awareness and practices within all functions of city management including the city's budget. The *Economic Development and Education* section targeted city investment in the following way: existing workforce development initiatives, traditionally underrepresented people of colour and women owned local businesses, neighbourhood-based childcare, new health service job training programs, and a partnership with the school district to implement a full-service community school program. The *Full Service and Safe Communities* intervention area focused on neighbourhood-scale programmatic interventions that are known to reduce "toxic stressors" and support healthy choices, including promoting healthy food store development through land-use zoning and enhancing the city's financial investments in and commitment to restorative justice, community based violence reduction, and prisoner re-entry programs. The *Residential and Built Environment* intervention area focused on directing city resources toward revitalizing foreclosed and substandard housing, expanding lead paint abatement, improving street lighting, developing a homelessness prevention and emergency shelter program, and engineering "road diets" that make streets safer by narrowing vehicles lanes and widening pedestrian and bicycle zones. The *Environmental Health and Justice* section included investing in climate change adaptation in vulnerable neighbourhoods, a comprehensive asthma reduction program, community-based air monitoring around the Chevron oil refinery, rerouting truck routes away from residential areas, and hazardous waste and brownfield site remediation. The *Quality and Accessible Health Homes and Social Services* intervention area emphasized how the city could increase access to health care due to opportunities available with implementation of safety programs and expand a place-based community health workers (CHWs) program that offered both employment opportunities and health promotion services to low-income residents and people of colour.

Levels of co-production as results of mix of variables

The analysis of the co-production approach in two dimensions, Frequency of co-production and Scope of co-production, produces three areas: Regular – Restricted, Intermittent – Intermediate, Irregular – Expansive. These areas give information about how the lifestyle and the behaviour of the patient change according to the level (Spanjol et al. 2015). *Regular – Restricted coproduction* represents elemental and narrowly circumscribed behaviours, which occur daily at regular intervals and are marked by a concise behavioural scope. It consists of setting cues that help initiate as well as complete the specific, daily actions of medication taking (Spanjol et al. 2015). *Intermittent – Intermediate coproduction* encompasses periodic behaviours, occurring at longer time intervals (such as weekly or monthly) and not always regularly. Intermittent-intermediate coproduction is marked by a wider scope, as it encompasses a set of related behaviours that are aimed at facilitating implementation of regular-restricted coproduction (e.g., through weekly refilling of pillboxes and other refill-related actions) (Spanjol et al. 2015). *Irregular – Expansive coproduction* reflects those behaviours that allow individuals to adapt to external and predominantly unexpected disturbances to their adherence efforts by modifying regular-restricted and intermittent-intermediate coproduction behaviours (Spanjol et al. 2015).

Levels of co-production as involvement forms

The principle of this classification is reciprocity of the service, with a continuous interaction between the service provider and the user. The classification describes the approach of the user and his/her interaction in the service (Dent & Pahor 2015). The involvement forms can be: *Consumerist form* where the patient (both individuals and groups) is transmuted from "consumer" navigating a market (albeit of a peculiar kind) to "citizen" with certain rights to engage dialogically in decision-making processes (Hirschman, 1970); *Deliberative form* is the building of democratic forums (Dryzack, 2000; Newman, 2001) where patients can express their opinions about the treatment moving from a traditional professional decision making, done by professionals, to an active

community participation (Dent & Pahor 2015); *Participative form* is a step forward of the deliberative form because in this case the patient is at the same level of the professionals: his/her is not just a simple opinion, but the patient actively participates in the development of the therapy (Dent & Pahor 2015).

Levels of co-production as participation modes

It describes the relationships of the users and the public agents in the public service delivery (Whitaker 1980). The citizen could interface himself/herself with the public agent as: *requesting assistance form public agent, providing assistance to public agents, interacting with public agents*.

Levels of co-production as objective setting

The areas are divided according to the objectives set with the user (Pestoff & Brandsen 2007) so we have: *co-production, co-management and co-governance*

Levels of co-production as process phases

The following areas are divided according to what phase the user wants to participate in (van Eijk & Steen 2014). The concept of co-production is relevant not only to the service delivery phase, but also to refer to service users being part of service planning, delivery, monitoring and/or evaluation (Bovaird and Löffler 2012). Bovaird and Löffler (2012) summarize a range of service activities that emphasize different elements of co-production, such as *co-planning*, *co-design* of services, *co-prioritization*, *co-financing*, and *co-delivery*. From this classification, it emerges that the customer can have a different role, like a worker in the company could have, according to the phase where he/she decides to participate.

Limits/Barriers

The fact that the coproduction approach in the mental health and in the health care is new means that there are some limits and not clear points that could mitigate the effectiveness

of the coproduction approach, if they are not examined and structured. From the literature review emerged that there are some areas not well structured. Here there is the classification of these uncertain points that could constitute a limit in the development of the coproduction approach among the health care system.

Scalability

This area includes some critical points like the education of health care workers (physicians, nurses, etc.), which was experimented with success but it was only a case limited to one hospital, so it does not constitute an empirical evidence (Edwards et al. 2016). The studies have not identified in a definitive way what are the characteristics and competences that have effect on the interaction between professionals and patients (Murray Cramm et al. 2014) that could enable the creation of a value chain (Murray Cramm et al. 2016), nor the key activities that the user does as active resource of the process (McColl-Kennedy et al. 2012) and the motivation that push the user to take part in a coproduction process (C. J. A. van Eijk et al. 2014). Summarising, the big problem related to the scalability of the approach is the fact that all the examples and experimentations are local programs that can only give information about a limited context. As a result, it is not possible to create a general model that can describe how the value is distributed.

Health Outreach System

There is not a clear clinical evidence on the fact that the methods based on coproduction approach work. This implies that there is a problem in the measurement and organisations cannot accept the risks related to the application of this kind of methods (Honka et al. 2011).

Support technology

The technology is a key element to enable a coproduction approach, in fact it supports the interface between the health care system and the patient, helping the patient with the autonomous activities expected in the therapy. Unfortunately, the

examples of support technology lack in full success and there are still problems related with lack in best practices, experimentations limited in specific contexts, managing timing of giving drugs and in the supply channel (Honka et al. 2011). These uncertainties bring to a lack in clinical evidence on the success of the network enabled by the technology support, so nobody wants to take the risks connected with the development of a coproduction approach (Anita Honka et al. 2011).

Design

This area refers to the uncertainties related to the future evolution of the organisation when it will adopt the coproduction approach. The doubt expressed in more articles is about how the organisation can adapt itself to the principles of the coproduction. The application of a coproduction approach touches all the areas of the organisation and its correct functioning depends on the complete embedding in everyday activities and thinking. Another critical point is the acceptance of this approach on the client side, because the application of the coproduction approach in the organisation does not imply that customers want to join in it. Many articles highlight the uncertainty in encouraging the co-design of the service. The reason is that the user does not feel confident in giving his/her opinion, overall in health care and mental health issues. The last problem that literature identifies for this area is the construction of a measurable model to track the performance, which is the basis of the design phase of a service. This issue is connected with the problems of the local context, that seem to be the only arena where the models cited by literature work.

Policy Support

From more articles emerges that there is not a universal policy that regulates the coproduction approach in the health care system in general and, as consequence, it is not clear how the new system could be financed, so even the possible cost efficiencies coming from the coproduction have not a specific treatment.

Performance

The performance measurement presents many problems in different issues. Firstly, it is not clear what are the good indicators to measure the effects related to the introduction of coproduction approach, because the answer rate of surveys is under the 50%, which is not a significant percentage (Marston et al. 2016). Secondly, it is difficult to convert into economic value the coproduction activities, because they are part of bigger and more complex groups of activities (Marston et al. 2016). These problems mitigate the construction of a general model because, without measures, it is unclear if the change in the organisation is good or bad, so the limit related to the scalability and performance must be overcome together, in order to have a clear vision of the model of coproduction and of its results.

Network

In order to adopt a coproduction approach, it is necessary to create a network of different stakeholders. They are not at the same level and they have different levels of information according to their role. The literature review highlights, in several articles, that the asymmetries in skill, information, power etc. between the stakeholders could mitigate both the quality and the continuity of relations among the stakeholders in the network, because who has less power or knowledge, for example, could feel uncomfortable since his/her opinion does not count as that one of a more powerful or informed stakeholder. This issue represents a limit in the development of a coproduction approach. The critical point in this area is the fact that there is not a defined strategy nor an organisational policy that gives a method to manage the asymmetries present in the network, so the management of this issue depends a lot on the ethic of the organisation.

Research question

The literature highlighted many critical points, such as how the coproduction could be seen as a scalable approach, the conditions that favourite the coproduction for both health professionals and patients, and how the organisation will evolve using this type of approach.

For this reason, the thesis will try to answer to this research question: *"How the coproduction can be applied in the mental health services, and what are its effects? What are the limits detected from who try to apply this approach?"*.

To answer to this question, this thesis work will consider the Co.Re. project as a case study, so that we will be able to understand if and how these critical points are managed.

Chapter 2

METHODOLOGY

According to the research question formulated it was decided select some cases of practical implementation of the coproduction in order to investigate about what are the changes that the coproduction bring in the organization, the perception of these changes among the actors of the service and the results achieved with the application of the coproduction in the activities.

Fields of application

The Italian regulation for the mental health contemplate different organization methods according to the region. In region Lombardia the mental health system is organized in: 28 departments for the public mental health, each one divided in operative units (64 in Lombardia region) and among these units there are the structures that deliver the mental health service.

The structures contemplated from regional program are divided in different kind of services where activities, time of permanence and frequency of utilisation are different.

CENTRI PSICOSOCIALI

This kind of structures are focused on psycho-clinic and psychotherapy activities. The activities realised and coordinated are: the ambulatorial activities of psychiatric theme, so session with the clinician where there could be a check on the situation the prescription of drugs etc., psychotherapeutic intervention that could be individual or group intervention, activities applied to the family, rehabilitation activities and resocialisation, home based business, crisis intervention. In this structure the clinician can formalise therapeutic-rehabilitative programs for the single patient. There can be the interaction with the other structures of the operative unit and with the others social agencies on the territory. These structures have a major accessibility and they follow not intensive treatment pattern in general.

CENTRI DIURNI

This kind of structure is focused on the rehabilitation activities and on the resocialisation ones. This structure adopts a semi residential regime, so the user can stay in the structure for at least 8 hours per day, 5 day per week. In the structure are realised: therapeutic-rehabilitative programs, resocialisation activities, so recover of personal and social abilities and integration with the resources of the community on the territory. There is an intensive treatment pattern. The intervention most frequently delivered are: resocialization groups, groups for the recovery of the base abilities and social abilities, groups of expressive activities, individual interventions on the base abilities, social abilities and resocialisation abilities, group of corporal activities. The users of the structure suffer of a significant disability from the psychosocial point of view.

SERVIZI PSICHIATRICI DI DIAGNOSI E CURA

The mission of this structure is the cure of the treble psychiatric diseases not manageable at territorial level. The work is focused on nursing personal and clinician. The function of the structure is: hospitalization and obligatory sanitary treatment. The treatment pattern is generally not intensive

CENTRI RESIDENZIALI PER LE TERAPIE PSICHIATRICHE

This structure adopts the principle of therapeutic community and it has a semi residential regime and they are finalized to residential treatments. The activities done are: temporary therapeutic-rehabilitative programs that require the temporary residentially of the patient in an assisted structure for 24 hours, rehabilitative and resocialization activities done by groups of resocialization groups focused on the recovery of the base activities and social activities. The workforce is composed for the major part of nurses.

COMUNITA' PROTETTE

This structure realizes rehabilitative and resocialization programs in general for patients with serious chronic mental diseases. This kind of structure operates with the condition of

protected residence, so, the community offer a 24h assistance service and partial, so there are projects of long term hospital stay. In the structure works mainly nurses and educators and, with less prevalence, psychologists and clinicians. The structure treats users with chronic pathologies.

Case studies

The case studies refer to the analysis of three real contexts in the area of Milan. These structures developed some coproduced activities and they are trying to integrate the coproduction approach in their organizations. The investigation follows these steps:

•Interview through a survey with open question structured in two parts, the first one related one the service in general focusing the attention on what is coproduction, what are the examples of coproduced activities and which effects the coproduction generates in the organization.

•Analysis of the interviews with the correlation of data according to the critic points identified in the literature review.

Cps1 & Cps2

Cps is a public structure so the following information is adopted for Cps1 and Cps2, since there are not particular features that differentiate these two structures from the general pattern.

The structure is a centre of first level in the organization of the psychiatric assistance, as descripted by the DDG n. 7/17513 of the 17/5/2004 and "progetti obiettivo nazionali". The purpose of the structure is the evaluation, consultancy, taking into care and taking charge for the mental diseases, programming and coordinating the interventions, ambulatorial and domiciliary activities following the principles of the therapeutic and assistance community and the intervention integrations.

The cps is located in an area where there is a high index of unemployment, poverty and foreign population.

The cure path offered by the cps is characterized by a first phase of hospitality and evaluation, after there is the definition of the cure process. The activities done in the process are:

•Taking in charge: is the answer of the service to the users that have complex needs that require a complex and integrated program of intervention

•Taking into care: this activity is addressed to who has not the necessity of a complex and multi professional treatment. The user can require the supply of services from all the operators.

The tool used for the cure process is the "piano trattamento individuale (PTI)" that is stored in the medical record and it is continuously updated according to the clinic process and it is renewed within a year form the last drawing up. The PTI is signed by the case manager, a figure that is the referent of the project and he/she assumes the specific function of monitoring the actuation of the project and he/she fosters the integration valences.
The role of the psychiatrist in the structure is the evaluation, diagnosis and drug treatment for the users. The figure can be related, collaborate and consulting with more entities and services. The psychiatrist can make emergency interventions on the territory. He/she programs and manages the therapeutic-rehabilitative projects on the users collaborating with the other figures of the structure, does medical-legal evaluations for the tribunal (ordinary and minors), makes interventions on the relatives, participates to the management of the "servizio psichiatrico di diagnosi e cura", participates to training and projects work integrations with the help of "Associazione Nazionale Lotta all'Aids".

The role of the psychologist is to do the first session with the user, making psychological consultancy, psychotherapy, support psychotherapy, psycho-educative interventions, psycho-diagnostic evaluation activities and tutoring activities.
The role of the nurse in the structure is the hospitality of the user (new or old) with the evaluation of demand, psycho-educative support, information to the users, management of social-sanitary documentation, hospitality, sorting and registration on the internal protocol

of reporting coming from the institutions, tutoring of the trainee nurses and calls management.

Cooperative

The structure projects and manages innovative social interventions, hospitality services and cure services addressed to people affected by mental diseases and disabilities, young and adults with difficulties like drug addiction, alcohol addiction, foreign people victims of human trade. The intervention is based on projects into communities and networks, listening space, presence in schools, teams of operators "on the street" for what concern the prevention of youth problems, damage reduction and prevention of sexual diseases.

The structure developed meaningful partnerships with local institutions and hospital agencies and it realized several initiatives with the European co-financing. Actually, the cooperative is present in 7 medical organizations (ASL) and 5 provinces.

Chapter 3

RESULTS

This section groups the answers of the actors interviewed in the Milan area. The results include the experiences and the opinions of the different groups analysed for each structure: operators, users and family members. Only the cooperative had not the availability to find family members for the interview. The results are divided according to the structure and the typology of actor interviewed.

Case description

In every structure was conducted some interviews based on a semi-structured questionnaire with open questions divided in two part: one related on the coproduction in general and on the experience of coproduction; the other one related on one coproduce activity in particular.

Results

Cps1

- **Operators**

  The operators talked about coproduction as thinking the activities and projects defined with the users and the family members. The coproduced activities described by the operators in the cps1 are the group "Tre Tra Pari" and the training courses realised with users and family members. The Tre Tra Pari's objective is to realise activities in order to improve the service. The operators decide to dedicate a specific space to take the decisions related to the Tre Tra Pari activities. The outcome of the group is the work done in the hospitality space of the cps where, actually, there is a hospitality service given by the family members and the space was made more hospital by the users. This work received also an achievement

about the quality improvement: the relatives are happy to have this recognised space into the structure and they feel more welcomed.

The training courses were based on the UK recovery college model and it is structured with 10 meetings where the lessons are given by the users and family members.

The operators learnt about the coproduction and the recovery through training, participating in the network about the recovery coordinated by the doc. Lucchi and literature papers about the recovery in England. They stimulated also their user to became expert users, they have the will to continue in the coproduction direction because after the hospitality space they want to implement a wellness program for the users.

The operators tell about the idea to spread coproduction culture among the other operators in order to be nearer to the users' needs and to have a professional enrichment, because they notice differences at a clinical level in the therapy process in both cases, when the user feels good and when the user feels bad. In their opinion there are operators that could continue to use the old work procedures blocking the change, because they fear about unbalance between hospitality and security given by the coproduction.

In their structure the coproduction is in an initial phase: there are few people that can apply this approach and the operators do the activities as an initiative allowed by the person in charge. They believe that the institutions could help to make possible the application of the coproduction approach by creating regulation policies that will include the payment of the user, but the difficulty related to have remunerated expert users in the service because is to find a way to financing it.

- **Users**

Users agree to the fact that the coproduction is to do things together to reach a common goal. In their opinion is important to mediate, find a common line and have different points of view in order to find a collective solution. The user3 thinks

that the change is also a question of culture because before the approach was that the user underwent the therapy and he/she was not part of the cure process. The user2 participates to the training course done by the cps1, he participated also to conventions as spokesman and he is part of the group Tre Tra Pari. The other users participate in the group "Tre Tra Pari" and the user3 is also vice-president of the association "rete utenti Lombardia".

The users are all motivated to pursue the coproduction by the fact to use their competences to help the others, it increases their self-esteem and allow them to contribute to the quality of the cure and life. They can represent the users' perspective in the group "Tre Tra Pari" and, according to user2, they can give an experiential knowledge that, joined with the professional knowledge of the operators, it can produce better results.

User1 think that some operators could not understand the need of changing. User2 affirm that one big problem is the stigma among people, most of all the operators that has to be eliminated. User3 says that everything must be done without information asymmetries.

The user1 think that the improvement represented by the hospitality space managed by the family members is good, in her opinion the user that enter for the first time in the cps feels more comfortable. The user3 thought that the group "Tre Tra Pari" could reach more goals like social inclusion for the user and helping in auto determination and emancipation from the service.

The user2 and the user3 were involved in the results measurement, the user2 participated in the presentation of a measurement tool, the "target", in a convention and he take part to the presentation of the recovery star. The user3 was involved in the developing of the Co.Re. tool about the definition of measurement areas.

With the engagement in the coproduction context users learnt new skills and competences as user1 that learnt to found associations and she thinks that the coproduction helps the user to put out his/her competences. The user2 learnt

more about the organisation of the cps and the departments, he had difficulties to introduce himself in the new context of the recovery. The user3 learnt skills more related to personal traits like diplomacy that he sharpens with experience. They relate with new people like the user2 that at the beginning he knew only the psychiatrist and now he knows a lot of people that work in the service.

The user1 describe a change in her behaviour, before she was more shy to take out her problems but now she knows that her point of view is relevant and she shares more than before and she feels more comfortable in asking information. The user2 and the user3 want to continue the relation with the service, the user2 want to convert the activities that he does in the service in a work and the user3 want that the operators provide the resources to increase the number of expert users.

- **Family members**

The family members have different opinions about what is the coproduction. Relative1 said that coproduction is collaboration, when the other actors are interested in which is the others contribute, for relative2 coproduction is when all the opinions are listened and when the relative feels good, because the relative feels good when the user feels good. For the relative3 the coproduction is related to a permeability of the shell constituted by the role of the actor, permeability means empathy, allowing the others to enter in your shell and the ability to enter in the others shells.

Relative1 participate to hospitality service in the cps and she understands better the work of the operators now.

Relative3 was involved in the developing of Co.Re. tool, she discussed with the operators and the users the grade to give for each area of the measurement. The relative2 creates the survey "Conosciamoci Meglio" with the association Tarta Vela that identifies the user age, relation with the service, residency, work, awareness about the support administrator.

The motivations given by the family members about the engage in the coproduction are: for the relative1 the will of the user to do the activities, for the relative2 and relative3 personal motivations.

For what concern the vision about the system the relative1 affirm that there is the will to group the associations of family members in order to become a bigger entity and realise more coproduced activities. Relative2 feels good with less but well done, for example the program of wellness that the cps will realise is enough for now. The relative3 thinks that the key is the co-creation of something new like the congress of the 30 November that was the first congress in Milan where the operators and the users was relators.

The relations with operators and users changed. The relative1 noticed that, when the operators have a case difficult to manage, they rely on the group of family members present in the cps. The relative1 says that there are users and operators that talk with the family members about things that they do not have the courage to tell to the psychiatrists.

Cps 2

- **Operators**

For the operator2 the coproduction is the utilisation of the user as a resource in order to improve the service, the resource provided by the user is the experience about the mental illness. In the cps2 the coproduced activities are the photography group carried out by one operator and the hospitality service, that the operators proposed after they had seen this approach in other services in north Italy.

From the clinic point of view the operator1 affirms that, with the "utilisation" of the operator as a resource in the therapy process, the process itself could be more rapid instead of focusing only on what set in the therapeutic plan. She says that the output received by the user is totally different from that one received by the other operators. The operator2 feels that the users' quality of life is better.

The motivation that induces the operators to pursue coproduction is related to the enrichment of their work and the possibility to have a human approach. The operator1 says that this approach can help him to overturn his point of view. For the operator2 the coproduction fill a professional gap, introducing the user's experience in the process.

The operator1 thinks that the user and the operator could become too involved in the respective lives. On the other hand, the operator2 believes that only a part of the team could accept the change, in fact the operator1 affirms that some operators are hostile to the coproduction approach. Operator2 points out the fact that the new activities will have an impact on the old organisation creating difficulties, like the fear of knowing the figure of the expert user and there will be a work overload due to the adding of the coproduced actives to the ordinary workload.

The operators find difficulties in create a space designed for the coproduction because they have to fight with structural and organisational limits. They also see from the regulation point of view the limit related to the institutional structure of the health care system represented by the hospital agency that is different in context and it has difficulty to let in new approaches. The operator2 add that there are certain conditions to let in the user with the coproduced activities, like assurance, that they solved through the association, where the users belong, that pays the assurance. The operator1 also highlighted the lack in founds to allow the creation of a specific space for the coproduction.

Only the operator2 knows the recovery star as an experimental tool and its utilisation in the cps2 comes from the initiative of the operators.

The operator1 highlights the high degree of autonomy that the user has in doing the front office activity, she says that they can stay alone to do other activities without any problem. She evidences also the fact that the users appreciate the activities, for example they will participate again in the next edition of the photography group.

- **Users**

  For the user2 the coproduction is the collaboration between user and operator.
  The activities coproduced with the users are: for the user1 the hospitality and for the user2 the hospitality and the support to the trainee. The user2 highlights that he has to start from zero because the front office requires to answer the phone and he was not comfortable with this task.
  They express the will to be involved and participate in the cps activities. The user1 is motivated to participate in the service by the possibility to help the users that come to the cps with difficulties or problems that she knows and can help to manage. In her opinion an expert user can give, through his/her experience, something different than what can give an operator. The user2 is motivated by the possibility to do something concrete, and he agrees with the user1 that the good result reached giving the user experiences to help one person to solve a crisis situation.
  The user2 highlighted a problem related with the perception of his position, because he is officially an expert user only the Tuesday morning but the other user treat him like expert user even the other days. This put him to a difficult position because he is not authorised to do activities as expert user out of the official "work time".
  Both the users highlight the change in the relationship with the operators. User1 noticed that before she came to the cps only to do the session with the psychiatrist, but now she relates with the other actors in the cps. The user2 affirms that he feels comfortable to talk informally with the operators.

- **Family members**

  For family members, the coproduction is collaboration. The activities done in coproduction by the relatives are support in the accompaniment of the user in the structure and helping in the hospitality.

The motivation that motivate the family members of the cps2 to participate in the service are personal motivations related to their relatives that use the services and they are happy to help others. The relative1 see an improvement in the life of the user and both the family members notice an improvement in their relation with their relatives.

The relative1 confirm the fact that she acquired more competences with her activities in the service.

Cooperative

- **Operators**

The operators agree that the coproduction is when the operator and the user are on the same level in all the aspects, so including the retribution. They think that the coproduction must be done from the design phase to the delivery phase. The activities coproduced listed by the operators are training courses, "gruppo forum" and the activity of the web radio where the users can talk about mental health issues. The training course is addressed to the operators where, in every lesson, there is an expert user as teacher. The operator2 said that there was a dedicated investment for the operators' training about the recovery star in the cooperative.
The operator1 confirm the fact that the involvement of the user helps to be better operators and to grow. The fact that the cooperative has paid user is very important and meaningful for the projects. This motivates also the operators of the cooperative to pursue the coproduction approach. The projects of the cooperative aim to valorise what come out from the user, so the integration is thought upstream in the project. In the "gruppo forum", for example, the operator1 saw a great potential for the growth of the operators. The operator2 noticed that the users try to do their best in the activities, this new approach modify the old paradigm of the educator that put the users in a lower position. The operator1 thinks that the coproduction approach helps the operators to better understand

the needs of the users and not to focus only on big scientific studies. He sees a better quality in the cure and in the life of the user and the fact that coproduction is giving to the cooperative the opportunity to develop innovative projects and services.

The operator1 thinks that some operators could accept the new approach only formally, because coproduction means change the routines in order to include the user in the activities, so the operators fear an overload in their work. The other issue highlighted by the operator1 is the stepping back necessary to give the right space to the user in the activity or project. On this point the operator2 remembers an occasion where his presence was barely necessary and the users could do the activity with full autonomy.

The operator1 describes the Milan area, for what concern mental health service, very fragmented because there are many departments and associations but, there is a coordination between all the entities in the Milan area about the mental health.

With this evolution of the system, operator2 affirms that the responsibility of the operator increases because the operator helps the users to became more critic in their life, so the operator is observed and judged more than before. In his opinion, this new situation generates also operators that want absolutely listen the users, their needs, their opinions. It is a new model that creates expectations.

The operators agree to the necessity of a space to take decisions even if the projects activities are developed outside. The operator2 highlights that the space is very important for the atmosphere created in the group (about the 60% in his opinion). The only problem identified with the space is the location because the operator2 noticed that, according to the distance, the 10% of the presence to the group sessions of "gruppo forum" is influenced by the choice of the location.

The operator1 confirm the fact that the juridical form of the cooperative allows more flexibility respect to other organisations like an hospital agency. He highlights also that there is not an institutional recognition of the expert user and this as a consequence on the retribution that is given to the users because the cooperative

find the necessary financing. The operator2 noticed that the institutions are interested in coproduction but he believes that they will give minimum effort, so minimum resources, just to make a good impression.

About the measurement of the process the operator1 highlights the lack in tools to measure the services but he cites the Co.Re. that is a tool able to measure the service in terms of recovery and coproduction, but it is still in the experimentation phase. The other kind of measurement that he cites is that one imposed by the region if the cooperative participates to regional call. The operator1 said that for the projects developed by the cooperative there is a budget that list the expenses related to the project.

The operator2 highlights the fact that he has to interface with more actors than before, the network become more complex and every actor must be aligned.

- **Users**

For the user of the cooperative, the coproduction is a work done in synergy between users, operators and family members and it is realised in collaboration in every phase of the process. He was interested to participate in the "gruppo forum" because he saw in it a perspective of growth. He brings the experience and the contribute of the group into the other groups where he participates.

What motivates the user to pursue the approach of coproduction is the recognition of his skills by the others and the contribution that he can give to change the paradigm related to the mental health services. In his opinion the person that is affected by the mental illness must not be identified as the mental illness.

The user makes the example of the Trento as mental health service that succeeded in the user integration in the last 16 years with a rationalisation of the expenses, less hospitalisations and less entrees in communities. Trento cps produces also cost efficiencies reinvested in prevention.

He thinks that if the problem is faced well, the relapses will reduce in time and intensity. About relapses he thinks that could be a mitigating factor in

coproduction activities, because the person could go over his/her limits, so the user should level the commitment according to their energies.

At institutional level, he thinks that the actual associations are fragmented and they develop redundant activities, but their merger could increase the effects of the activities and the project developed. The user see also that the institutions have to recognise the figure of expert user and provide training courses about recovery, he makes the example of English mental health system where the expert users integrated in the service are between the 45% and 50%. In his opinion, the operators have to provide the resources in order to allow the user to participate in the service and the users have to overcome the inadequacy feeling, because with the coproduction can emerge potentialities.

Chapter 5

DISCUSSION

In this section, there is the confrontation of the results with the critical points found in the literature. Some results confirm what described in the literature review but, with the analysis of the case studies, it seems that some points are manged. Furthermore, the results suggest what could be the base to develop a coproduction approach.

Scalability

Organisations analysed made an investment in the operators training about the recovery approach. This point it is important because the operators training is coproduced with the users of the service that are the trainers. Users are trained too. The aim of the training is to teach the inclusion of the user in the process of recovery and to stimulate operators to replicate coproduced activities in the other structures. The only point that is still not clear is the inclusion of family members in the training process, in fact they have to get informed by their self about the issue. However, there are also examples of inclusion in the training process: in the cps 1 there was implemented a training course where the users or the family members can contribute to the lesson.

Another key point is the relationship between the user and the operator that can bring to a mutual advantage in terms of knowledge. According to an operator of the Cps2, to make this it is necessary the acceptance of the user by the operator that can help he/she to be open toward the user, improving the professional relationship. For one operator of cooperative the relationship generated can help the operators to growth.

The behaviour noticed from users and operators is different. Users want to be accepted from the operators. This can generate more points of view that can bring to a better and collective solution, according to one user of cps 1. On the other hand, operators are divided in those who agree with the coproduction approach and make a fair relationship with the users, those who disagree and they do not recognize the user's experience. There is also who agrees only in the appearance without believing in the approach.

The motivation that bring actors to pursue this kind of approach are very different. Operators see an improvement in their job and in the results generated by coproduced projects, they have a better perception of the user's needs, and they see the potential behind the coproduced activities, even if someone tends to use the paternalistic approach. One operator of the Cps1 said that she does not believe that the actual psychiatry is appropriate for the times that we are living. Users have personal enrichment with an improvement of their self-esteem and they are conscious of the effects that the coproduced activities have outside like helping other users with their experience or contribute to eliminate the stigma of the mental illness at a public level. The user of the cooperative that is very proud to give a contribution in fighting the stigma around the mental illness. Family members are moved by personal feelings and by the possibility to give their contribution.

The value generated by the coproduction approach is the innovation brought in the activities and the projects. The operators of Cps2 feel that the user can fill the gap in the professional knowledge and they agree with family members and users that this approach bring to a better quality of life. The operators of the cooperative believe the activities, like their "Gruppo Forum", can be projected upstream with the users. The generation of value is most of all the outcome of the coproduced activities, for example the Cps1 received some acknowledgements for the realisation of a more hospitable waiting room with the space reserved to the family members to help users and the book sharing service. According to one user of Cps1 the users can give their experiential knowledge, combined with the professional knowledge of operators, it can produce great results.

There is the intention of spread the activities motivated by the will of the user to show their value outside. One operator of the Cps1 said that there is the will of the organisations of Milan to create an urban work table about the externalisation of the mental illness issue. According to the user of the cooperative, he wants to bring the experience and the contribution of the "Gruppo Forum" into the other context where he participates. The operators of the Cps2 noticed that the users want to bring outside what they learnt and felt in the coproduced activities.

The coproduction in Milan is still in an initial phase, according to the operators of Cps1, there are only some users that have the competences to do it for now, even if there is the intention to increase the quantity of expert users. An example of enlargement of the contribution of the users and family members is the increase of the areas where there are associations of users and family members. This enlargement is also fed by the curiosity of some citizens that encourage the users to show the world of mental illness, according to the user of Cooperative. The perspectives for the users in this new context are the formal integration, so a regulation of the role and a retribution as well as a public recognition from the citizens in order to fit the stigma that the mental illness carries with itself.

Health Outreach System

The operators see, at a clinical level, the improving user's life quality and the reduction of relapse. The changing is noticed even from the operators' front. According to one operator of Cps1 there is a different collaboration at therapeutic level in both cases when the user feels good and, most of all, when the user feels bad and. In her opinion, the relationship is more strong, more productive. One operator of Cooperative said that is different to have a user when policies and projects about mental health are discussed. The operators see different results coming from the users in respect to their colleagues. In Milan, the objective measure of the clinical evidence in the effects given by the coproduction approach is still in the initial phase, so the only evaluations are subjective. There is an example of complete integration of the user in the mental health service in Trento where, the users are included in the process of cure for sixteen years and there is the effective improving of the service and cost efficiencies. The family members also perceive the changing in the relationship with their parents.

The risks identified by the actors in the interviews are related on the homogeneity in the application, so the acceptance from every actor in the organisation in order to create a real organisational culture. According to the operator of Cps1 there could be operators that want to remain with their old work methods and they could agree only formally to the project. In her opinion there is also the imbalance between hospitality and security, that is an aspect to take in consideration with the coproduction approach because the user and the operator are

more in contact than before. The relationship between operator and user with a coproduction approach can bring to misunderstandings on what are the limits between the two figures, there is also the possibility that the role of the expert user, the user that give his/her contribution in the process, is seen like a personal quality and not like a professional role, for example another user can ask help to an expert user but he/she is not in his/her "work time" so there is not the authorisation to intervene. This can cause confusion on both parts about the behaviour to use.

The actors noticed that the coproduction helps to generate value in both ways practical and emotional. This is due to the involvement of different figures. According to the operators of Cps1 the family members manage in a different way the hospitality space in the cps and it helps the user to feel good when he/she enters for the first time in the structure. The family members of Cps1 believe that they can bring out the users' needs. Another point is the capacity of the operators to let the users developing the activities, as said by the operator of the Cooperative, in order to make something beautiful that can't be created in other ways. There is also the introduction of a new point of view in the context, the user one, that can see people and situations in function of their past experience and act with different results, as said by a user of Cps2.

Design of Organisation

The coproduction will bring changing in the organisations and, for the interviewed, the evolution of the system must have a direction toward the recognition of the expert user as a professional figure inasmuch a trained person that could give an experiential knowledge and can put more empathy in the approach with the other users. According to the family members of Cps1 the associations, that are fragmented in this moment, should cooperate together to reach the common objective of 360° coproduction approach that will be solid, homogeneous and it will generate more critic users and they will give more value to the activities and projects. From the user perspective, the system should reach the gradual emancipation of the user, allowing to live a life without the service, as said by a user of Cps1. According to the user of Cooperative the institutional system has to recognise the figure of

expert user and the operators have to accept the presence of this kind of user in the service in order to give the right resources and help the user to feel adequate to be involved.

From the users, there is the will to replicate the activities and to create something new. For example, in the Cps1, after the hospitality space, there will be the initiative about health and wellness and, in the Cps2, there will be another edition of a photography group, managed by a user. This situation increases the involvement and the achievement of common objective and, according to one operator of Cooperative, this generates a different kind of educator, that want absolutely listen and stimulate the user.

For the users and the operators there is the need to have a space where to do the coproduced activities, even if these activities are developed on the territory, a place where take decisions.

The limits individuated by the operators in the developing of the activities are related to two areas: the physical place where the activity takes place as said by the operator of Cooperative, more specifically the distance that the user has to travel in order to arrive to the designed place, it can influence until the 10% of the participation of the users. The other area, according to the operators of Cps2, is the workload of the operators that have to do the coproduced activities with the other ordinary activities, so for them these activities are extraordinary to the service. One user of Cps1 noticed a conceptual limit related to the real effect bring by the actual coproduced activity of the "gruppo TreTraPari" that, in his opinion, should create something like shared cure processes, activity aimed to the user's benefit and user emancipation.

Policy Support

At the institutional level, the system seems to have many gaps. At the moment, the coproduction is managed according to the freedom given by the district without any defined structure, according to the operators of Cps1, in fact they would have a more structured involvement of the user with formal training and recognition from the institutions. The cooperatives have more flexibility connected to their juridical form, in fact the cooperative gave a retribution through financing. The problem with the financing is connected to the lack in the regulation of the expert user that cannot have a recognised retribution without a

juridical recognition from the institutions. The operator of Cps1 said that, actually there is a bargaining for the financing related to users' retribution.

There is the example of cps of Trento that was able to have cost efficiencies from the application of the coproduction approach. The saved costs were reinvested in the service and in the prevention measures like users cage where there are trained users that are able to intervene according to specific problems or the "decompression rooms" where people can stay to calm their selves and let the malaise pass.

Performance

The measurement of the recovery approach is well defined for what concern the individual person, in fact there is the recovery star that measure the effects of the coproduction and recovery approach on the users that evaluates him/her self with this tool. For the organisation, there is a tool, the Co.Re., that evaluate the effects on the organisation in terms of coproduction and recovery approach. Another form of measurement is that one imposed from the region, for example the "Forum" project is a regional formative project and the Cooperative has to make a relation evaluating ten indicators decided from the institution.

The involvement in the measurement sees that all the actors (family members, operators, users) giving their contribution to the creation of the tools for the measurement. The family members of Cps1 agree to say that the recovery star and the Co.Re. are tools created for the stakeholders.

One way to see the economic significance of the coproduction approach can be the budget where, for example in the cooperative, the expert user retribution figure like a cost voice in the budget. Another way could be the cost saving generated by the involvement of the user.

According to the operators of the cooperative the user can give a different contribution in the process, he/she can bring more value under the human aspect through the empathy that they have.

Network

All the actors of the interviews have noticed the need to learn new skills, because they do different activities or through training, autonomous documentation or experience. Some

actors, most of all users, noticed that they can reuse some competences with the possibility to create something real, that have an effect. The necessity to learn new competences is the natural consequence of the adaptation to the new kind of relationships generated by the coproduction approach, so all the actors have to know more about the service, the other actors and the responsibilities related to their role.

The coproduction produced a sense of opening among the users and family members that have the will to contribute and collaborate, but there are operators that want to control the situation until the non-acceptance of the new context.

According to the operators of cooperative, with the mutual relationship between operator and user there is the possibility to generate a productive exchange that can create a complete knowledge composed by professionality and experience.

The involvement in the project of different entities and actors brings an enrichment of the process. The activities and the initiatives have more attention to the outside. According to operators of Cps1, there could be the occasion to be stimulated from the outside and start more initiatives, more original, something that can enrich their work. According to the opinion of one operator of Cps2, there could be also organisations that are afraid to coproduce activities due to the possible overload of resources.

The relationships created with the coproduction approach generates, according to the users, a more equal vision in respect to the old perception of the patient. Form the operators side, one operator of the Cps1 thinks that the culture of coproduction is something that must be built, most of all for who work in this field for many years.

The users' and family members' vision of the network created by the coproduction is an environment where the information is shared and all the stakeholders are aligned, but at practical level they see some limits like bureaucracy (ex. privacy law) and some barriers put by some operators, so they have a necessity to be informed and aligned with the other figures. From operators, there are also example of information sharing with family members when there is a case that the operators cannot handle by themselves. A good evidence of the will of users and family members is the fact that they create associations to aware the institutions of their positions and their rights. There is a total change in the perspective. One

user of Cps1 affirms that she feels more confident in express her problems and her ideas because she knows that her point of view is relevant to the others. The family members of cps1 are more aware about the operators' work, so they better understand problems and situations in the structures. In their opinion, even the operators have a different perception of the family members that actively participate in the structure. One operator of the Cooperative notices the difference in the context because he participates to projects with expert users that are at his same level as organisers. The operators of Cps2 notice a more spontaneous and well defined interaction with users.

The situation generated by the coproduction is equality in the relationship among actors. One user of Cps1 feels more equal with this approach she is able to relate herself with others and she feels to be part of the organisation.

The operators noticed a difference in the density of the network with the coproduction, because there are more actors involved in the process, the decisions are taken together. The operator of Cooperative said that he has to interface himself with more actors, so he has to update and align himself with every actor in the process and it is more complicate with coproduction, he has to spread his attention. There are also differences in communication and in the division of the workload, because the operators can give a certain degree of autonomy to the user, that can do the activity alone and allow the operator to do other activities.

The users and the operators confirm cases of high degree in continuity of relationships. There are users and operators that want to reproduce the coproduced activities and want to work in the service. An example is one user in the Cps1 that want to do his activity in the service as work. Another signal of will to continue this kind of relationship is the request form users and operators of the necessary resources to pursue coproduction approach, like what said by one user of Cps1 that think that is difficult for a user to participate if the operators does not help the user to recognise his/her resources and potentialities. Other examples that demonstrate the will of continuity are Cooperative with its training course coproduced renewed for the second year and the photography course implemented in the Cps2 that is at the second edition too.

All the actors noticed cases where even in a relationship of coproduction there are differences in power. Family members of Cps1 report that there are users and operators that feel fear about the power position of the psychiatrist as a figure, in fact there is not any regulation regarding the position of the psychiatrist in the coproduction approach. The level of freedom in the activities is something purely accorded with the concession of the psychiatrist. In the opinion of one operator of Cps1 the user must be oversaw and the intervention must be accorded with the micro team of cure, on the other hand the training issue is more flexible and the user has a total freedom in the development of this activity. On the user side, there is more awareness on the therapy and, as said from one user of Cps1, they do not accept decisions take on them without their opinion. According to one family member of the cps1, family members have a little more authoritativeness than before.

Results report that, actually, there is a common conceptual schema about the concepts to teach to introduce the coproduction in the cure process, so there is a clearer structure in explaining the approach, for example defining principles, phases etc. All the people interviewed that have followed a training course, they learn about the recovery process that include the coproduction of the therapy between user and operator. The recovery concept gives a methodology in order to include the user in the therapy process, so it is a homogeneous approach about what are the concepts to teach. The only unsolved issue is to make the training as something systematic, at the moment, who follow a recovery courses decides it by own initiative or by proposal.

There are not specified activities that the user can do, the activities developed take place according to the context, user's abilities and preferences. From this point of view there are big potentialities on what could be the implementable projects and activities to coproduce.

There is an effective evidence on the effects related to the coproduction on the clinical point of view but also on the results reached by the coproduced activities. The critical point remains the consistency of these effects that are measured only with the perception of who live the situation. It makes the measurement something subjective embedded in the context where the activity is developed.

The interviewers noticed specific risks regarding: partial acceptance, rule the professional relationship between operator and user, the regulation of the role of expert user that has to be explained and structured like any other professional role in the service.

In order to develop an effective coproduced system, the organisations and institutions have to recognise the figure of expert user and to give the resources necessary to activate this role. The working example of coproduced system that one of Trento, demonstrate the possibility to have a structured and measurable model. The organisation has to create a real culture of coproduction, so who works in the organisation has to accept the new roles and the introduction of the user. Another point to take in consideration for the design of a coproduced service is to find the "space" for coproduction, as physical space and, most of all, as time space, at the moment the operators do the coproduce activities as extraordinary activities.

Focusing on the institutions, it emerges the lack in a specific policy in the Lombardia region that regulate the figure of the expert user. Actually, the issue is in the negotiation phase with the health care departments. The only way to overlap the legislative gap is the juridical form of the organisation, in fact the cooperatives has more freedom to ask financing and to do activities in respect to the cps. As consequence of the institutional gap, there is the financing gap because, if the role is not defined by any law it will be difficult to estimate an expense for the role.

The coproduction approach creates a network with more and different actors respect to classical mental health service approach. In order to allow the complete integration of the actors, there must be the same level of information and all the actors have to learn what is necessary to contribute in the service and activities. This implies that all the actors must have the resources to be aligned and ready to give contribute. There is still the fear about the power position of the psychiatrist figure despite the user and family members feel a fairer behaviour.The results put in evidence the presence of some key aspects in developing of coproduction approach like the network formed with all the actors participating in the process, the coproduction culture that allow, most of all, operators to accept the figure of

the user as equal in the contribution about the therapy and the will to extend this approach to higher levels in order to fight the stigma related to the mental illness.

Even if there are many areas that contribute to create an integrated and complete system of coproduction, it seems that the pillars where all the other issues gravitate are: **recognition**, **methodology** and **resources**.

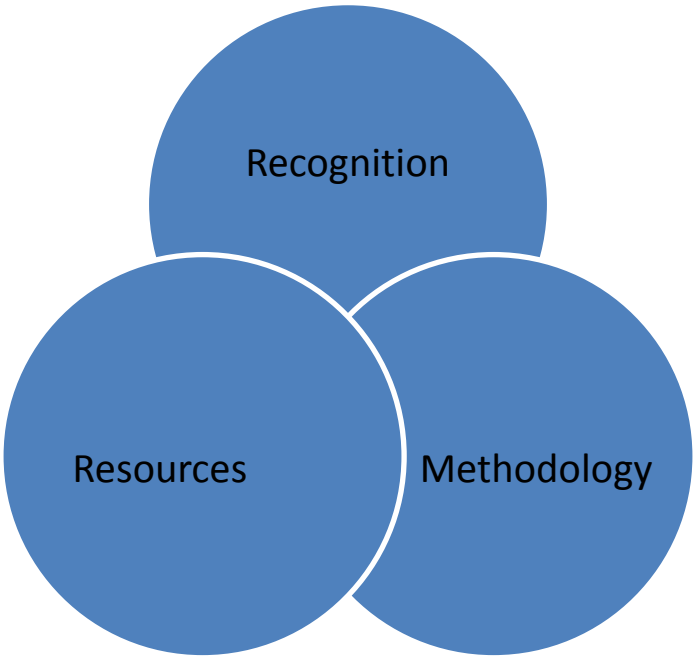

Figure 5.1

Recognition

It means the acceptance of the user as someone that can contribute to the service and to his/her own therapy. The operators have to accept the opinion of the user about the therapy and they have to trust them in the developing of activities and projects, because the contribution of the user can bring different and better results, as described in the interviews. With their recognition, even the users gain a better quality of life, because they feel treated as people with capabilities, so equal in the possibility to participate in the service's results. The recognition must come from the institutions too. The fact that there is not any policy that give a juridical structure to the figure of expert user means that, everything is done with

an expert user, so activities and projects, are limited to the degree of freedom granted by the operators that coordinate the activities and this could mitigate the results. From the interviews, it emerges that there are some examples of activities managed and coordinate by the users, but the initiative was decided with the permission of operators. From the interviews, it is noticed also that the citizens have to recognise the user of the mental health service because there is still the stigma related to the mental illness. The ideal result of the first pillar is to create a common culture about the user of the mental health service that will delete the stigma related to the figure and will change the perspective of all the actors already working in the mental health field.

Resources

Good intentions are not enough to realise a real and productive approach based on coproduction. On the operators' side, there must be a total availability to share the information related to the user's therapy and all the information that can help every actor in the network to give his/her contribution. Giving resources is also made possible to users and family members to participate in the service, so it means give trust and teach, if necessary, to the actors what they need to contribute in the service. The user from his/her side have to put his/her effort in the activities, overcoming the feeling of not adequacy related to the position of mental health service user.

The role of the institutions is to give policies and financing to allow the departments to apply the coproduction approach. From the interviews, it emerges that some points to regulate at institutional level. The figure of the expert user: responsibilities, duties, autonomy. Recognising to the operators the hours dedicated to the coproduced activities. Providing financing to pay the expert users.

Methodology

There is a clear need to systematize the approach of coproduction. The case studies exanimated demonstrate that there is the will to learn about the new approach form all actors. Until the coproduction remains something done by personal initiative and there is not any structured process that introduce and guide to coproduction, all the activities and

the projects will remain limited to the little contexts where they are developed. The lack in methodology is a bridle to the scalability of this approach. A structured methodology implies a process replicable, measurable and even improvable in order to be applied in different contexts and there will be more actors that could contribute to improvement of the approach.

Summarising, the coproduction approach in the mental health services has the potential to make a great change in the mental health world. We are talking about the radical change in the actual perspective about the user. The user will become more like a colleague for the operators and no more the patient to cure. The all social context around the user will change with the definitive elimination of the stigma related to the mental illness.

To do this the three pillars cited could be taken in consideration. The recognition is the base to do everything related to coproduction, because if a person does not believe in something he/she cannot improve anything. From the recognition pillar starts process of coproduction developing, because it is the fundamental factor to create a coproduction culture among operators, institutions and society. The coproduction approach needs resources to be implemented; therefore, every organisation and institution have to invest resources on it in order to see real results. Last but not the least, the methodology put a solid structure to replicate coproduction and to give confidence to the organisation that will have a guide to implement and measure this new process.

Chapter 6

CONCLUSION

The work focused on potential challenges and barriers against the implementation of co-production in mental health services. The first step was to learn about the state of art from the literature review of papers with the objective to find models, examples and possible organisational structures that confirm the integration of the coproduction approach in the health care services and mental health services. The research was done using research engines for scientific paper, and the results discovered in the literature highlighted some critical points that are still not managed. Given the gaps derived from the literature review, the intention was to find a confirm or a way to manage these critical points developing a list of questions grouped in a survey in order to make interviews in the mental health services. The interviews were done in the Milan area and the actors was interviewed separately or together according to the availability of the respondents. Unfortunately, the quantity of interviews does not represent meaningful data to make strong assumptions but what emerged from the actors interviewed open the perspective on what could be some basic pillars to set the coproduction.

Future Steps

According to the three pillar, further research could be done to find a way to introduce, develop and consolidate a coproduction culture in the organisations. The future research can also find methods to reinvest the resources generated by the coproduction approach, such as cost efficiencies. For the methodology, some actors cited the example of Trento that could give some points to modelling a structured coproduction approach in order to replicate and measure it in other contexts.

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