

# redesigning psychiatry

a strategic repertoire to stimulate  
transition in the mental healthcare sector

/ master thesis

Sophie Holierhoek

April 2020



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## / colophon

### Master thesis

Redesigning Psychiatry: A strategic repertoire to stimulate transition in the mental healthcare sector

April 2020

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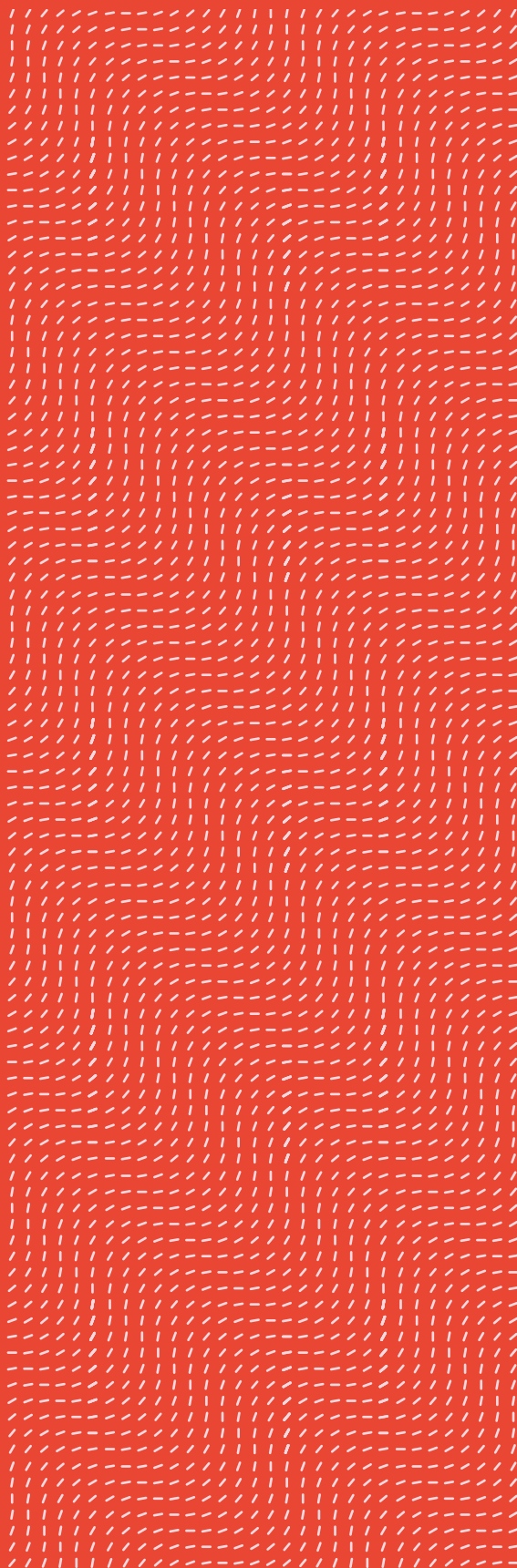
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# transition

/træn'ziʃ.ən/

*noun*

The process or period of changing from one state or condition to another.

/ hi!

# preface

Here it is, my final thesis for the Master Strategic Product Design, marking the closure of a happy time at IDE. This project has been performed for Redesigning Psychiatry and has ironically taught me a lot about my own 'psychiatry' as well.

Matthijs, Rebecca and David, I would like to thank all of you for your support throughout this project, and for giving me the time that I needed to complete the project. Rebecca, thank you for the numerous sessions providing me with your academic perspective on just about anything. Matthijs, thank you for always helping me see the bigger picture and for being my abstract sparring partner. David, thank you for your passion for mental health and unyielding enthusiasm about the project.

To my friends, thanks for your love and support. Stijn, you've helped me take back my project, and for that I'm endlessly thankful. Also, to the peeps at Groen, thank you for your (very) intensive love for strategic thinking. You've reminded me that I love what I do. Jord, your energy never ceases to give me energy, and I hope to enjoy that for a very long time to come. Marte, thanks for your much-needed advice and your even more needed humour. Sander, Suzanne, Josien, Veerle, Yara, thank you for your indulgence of my graduation mood swings and for supporting me in eating away my emotions (I'm looking at you Joos).

And finally, mam, pap, Dave, Hannah, thank you for your love and your unbroken belief in me.

That brings me to the ending of this preface, and to the beginning of this report. I hope you enjoy the read, I know I enjoyed the writing ;)

A handwritten signature in blue ink, reading "Polierhoek". The signature is stylized with a large, sweeping initial 'P' and a long, horizontal flourish underneath.

/ in short

# executive summary



The mental healthcare system in the Netherlands is in dire need of an update. With 90,000 people on the waiting list, an urgent shortage in staff, regular occurrence of ‘incorrect’ diagnoses, and a persistent stigma on mental health, this was exactly what was on Redesigning Psychiatry’s mind (Redesigning Psychiatry, 2020). Steering clear of the problems of today and rather focusing on a desired future, they crafted a vision for mental healthcare in 2030. The purpose of this project is to support Redesigning Psychiatry in their efforts to move towards the mental healthcare system they envisioned.

By gaining understanding of how societies and their functional systems transition, a theoretic framework depicting societal change will be developed. This newfound knowledge is enriched by studying ways to influence transitions. In parallel, a context study will be performed, to understand how change happens in the mental healthcare sector, and how people working in the sector perceive change. The theoretic framework will be used to structure and understand the findings from this context study, providing insight into what is influencing the system in moving towards its desired goal. The aspects influencing change (and transition) are boiled down to four primary themes, that describe enablers next to blockers:

- The challenges of addressing system lock-ins;
- The inertia of mental healthcare organisations and their inexperience with innovation;
- The balance between intuitive and scientifically funded change;
- The effect of growing public interest on the system.

Making use of the newly gained understanding of transitions and ways to influence them, a strategic repertoire is created to address each of the challenges. Furthermore, the most relevant challenge for this project—the challenge of organisational inertia—is addressed in a more specific strategy. The strategy outlines a way to structure innovation in mental healthcare organisations as a means to increase the organisation’s capability to address systemic problems, and thus its readiness for transitions. Redesigning Psychiatry’s role in this is as a facilitator of design processes and knowledge exchange. The results of this project have been evaluated with experts, which enabled a further detailing of the proposed strategies.

/ in this report

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/ chapter 1

# establishing the project

12 / project introduction

14 / project approach



## establishing the project / 1.1

# project introduction

This graduation project will be performed for Redesigning Psychiatry, a knowledge and innovation hub involving several large (public) mental healthcare institutions, designers and philosophers. The organisation has the aim to radically reform the Dutch mental healthcare system.

In the first two years of its existence, Redesigning Psychiatry (RP) has focused its attention on creating a vision on the role of mental care in both our society as a whole and in people's daily lives. It can be seen as a reaction to a scenario of our world in 2030, which is based on thorough research. In this vision, the mental healthcare sector is taken from its silo, and given a role in multiple layers of society. This includes a radical new way of looking at mental disorders; one does not have a 'condition', but an undesired behaviour pattern, that can present itself in various forms (Redesigning Psychiatry, 2016).

The 'new' mental healthcare system is envisioned to be interwoven within society, and as such, it proposes an almost completely new system. The roles of current players in the system change, or might even be eliminated. Moving towards such a system requires major changes.

Transitions such as this one are not unique in these transitional times. They have been subject to academic attention in all kinds of fields already, including the design field. An upcoming methodology is 'transition design' (Irwin, Kossof, Tonkinwise, & Scupelli, 2015); arguably a manifestation of the expanding movement the design discipline has made in the past years (Buchanan, 1992; Sanders & Stappers, 2014). Transition design takes on a holistic perspective and applies "an understanding of the interconnectedness of social, economic, political and natural systems to address problems at all levels of the spatiotemporal scale" (Irwin et al., 2015, p. 1).

At this time, there are little (known) examples of transition design in practice—as the methodology is still quite young—which complicates the evaluation and optimisation of the approach. PhD projects are being carried out at Carnegie Mellon University to this effect, but these have not yet been completed. This brings a joint opportunity. Redesigning Psychiatry is having trouble putting their vision into practice, as the complexity of the case is withholding them from finding suitable steps to take. Their case could function as an 'in-practice' example, of which the results can be used to expand academic knowledge on transition design. Hence, in this project the existing body of knowledge on transitions, design, and change in general will be applied to the challenge RP is facing.

## establishing the project / 1.2

# project approach

### 1.2.1 Project goal and scope

With their vision, Redesigning Psychiatry is searching for ways to start moving towards a desirable future, which has proven to be difficult. The current mental healthcare system is ridden with bureaucratic rules and agreements. A system transition is complex on its own, but in these conditions, it becomes even more of a challenge. This project is an extensive exploratory research into the nature of system transitions and how they can be catalysed. This knowledge will be used to understand the transition that RP is facing, and to create informed guidance in the transition to a new system.

Both the current system and the system envisioned by RP are transitive to such a degree, that approaching the problem from a reductionist point of view is highly discouraged in transition design literature as well as system's innovation literature (Ackoff, 1999). Therefore, this project aims to take on a holistic perspective, by looking at the way change currently manifests itself in the mental healthcare sector, and linking this to existing knowledge on system transitions. In this way, the project takes a more general approach that RP might be able to use in different kinds of situations, and on different points in the ongoing transition. Therefore, the project goal can be narrowed to the following statement:

Supporting Redesigning Psychiatry in moving towards the envisioned system, by creating a theoretic framework and corresponding actions for stimulating transition in Dutch mental healthcare.

### 1.2.2 Project approach

The assignment of this project will be to deliver a strategy that guides Redesigning Psychiatry in stimulating a transition, stemming from a theoretic framework. Considering the uniqueness of the transition the mental healthcare system is facing, the knowledge needed to create the framework needs to come from other sources next to transition design. For that reason, the creation of the framework is done in two



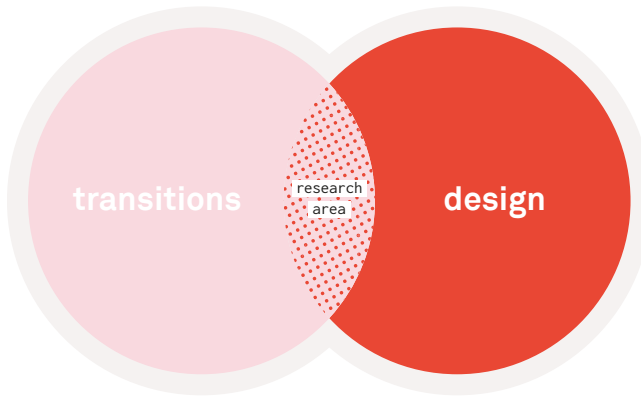


Figure 1: Academic research area

complementary activities, that will be performed simultaneously. On the one hand, a theoretic framework will be created, describing how change in society happens, and how it can be influenced. On the other, knowledge from this specific context will help in adapting the framework, making it applicable to the context Redesigning Psychiatry is working in. The insights derived from this are the starting point for an array of strategies. After this, the framework and corresponding strategies will be validated by collaboration with experts and the Redesigning Psychiatry core team.

### 1.2.3 Research plan

#### Academic research

At this point, transition design has not yet matured into a complete methodology. As such, a large part of the project will focus on the theoretical exploration of adjacent approaches, knowledge domains and theories of change (figure 1). The aim is to understand socio-economic and socio-technical transitions from different perspectives and on different scales (micro, meso, macro), and to understand what the role of design(ers) could be in guiding these transitions. The knowledge drawn from this will be used to bridge gaps in the methodology, and to tailor the methodology to this particular project context.

### Contextual research

Transitions occur on different levels in society. For example in one person (individually), within an organisation or community, or in society as a whole. In this project, the subject of change and transition will be studied on all three levels, because it will allow an understanding of the interaction between them. To this end, a system analysis will be combined with insights from user research. Whereas design traditionally has a primary focus on the 'individual' level, the focus of this project is mostly on the organisational and societal levels, while maintaining an adequate understanding of the individual level.

> An extensive research plan can be found in Appendix 1

### W Project phases

Broadly speaking, the project consists of three phases, loosely based on the double diamond: 1) Discover, 2) Define & Develop, and 3) Deliver (figure 2). Define and develop have been combined, as the development of strategies will simultaneously be a moment to reflect on the framework.

**Discover:** This phase encompasses academic and practical research. Academic research has the aim to understand socio-economic and socio-technical transitions, to understand what the role of design could be in guiding these transitions, and to understand how people become motivated to change. The practical investigation has the aim to get a (visual) overview of the current system structure and understand the phenomenon of change within this particular context. The weight of the project lies in this phase.

**Define & develop:** The conclusions from the academic and practical research will be boiled down to a transition framework for Redesigning Psychiatry. The framework is used as a tool for context analysis, resulting in a contextualised framework that will be used as the foundation for the development of strategies that can guide RP.

**Deliver:** The framework and corresponding strategies will be evaluated, of which some results will be used to detail the strategy.

> See figure 3 for detailed overview of the project phases (next page)

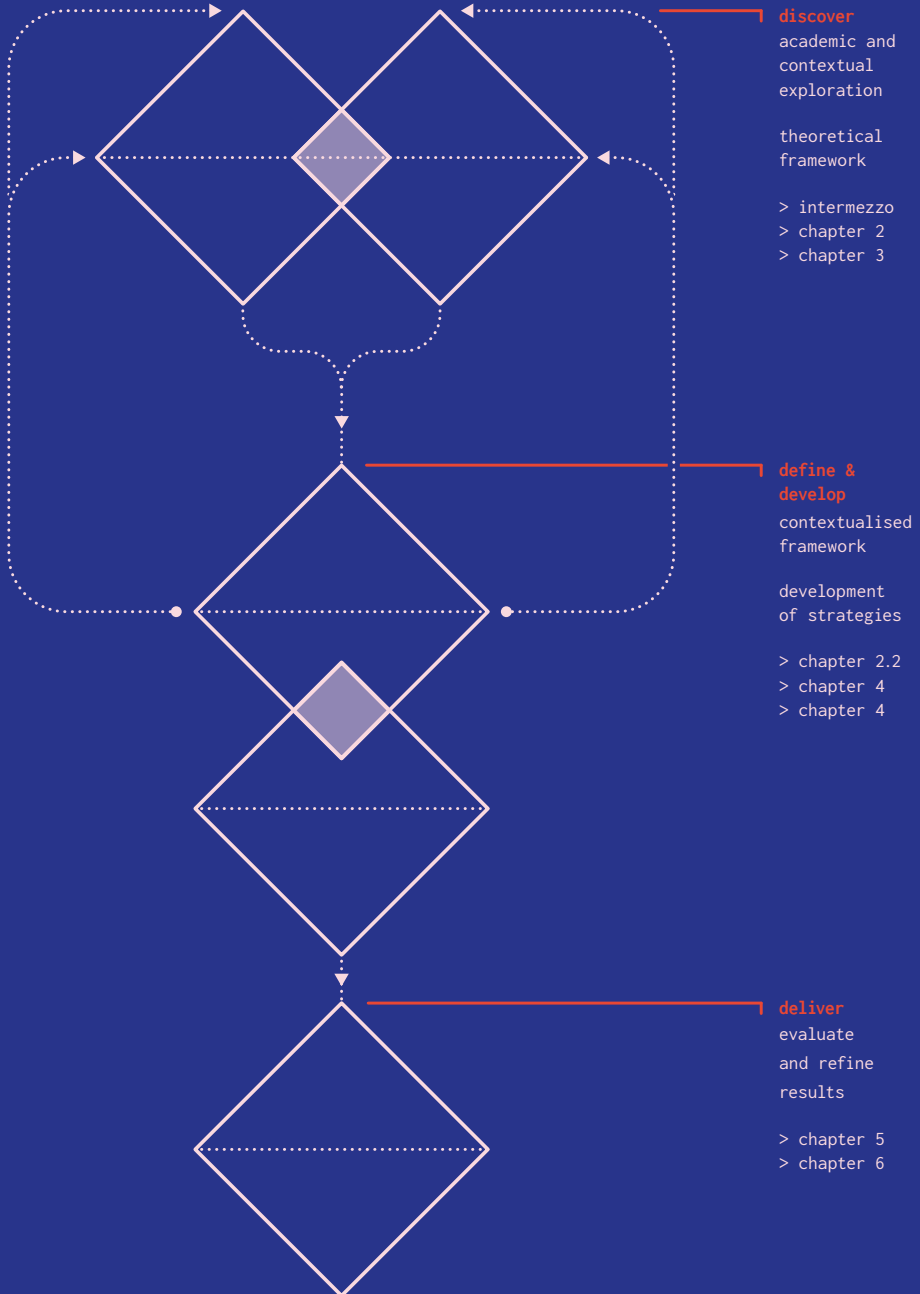


Figure 2: Project phases

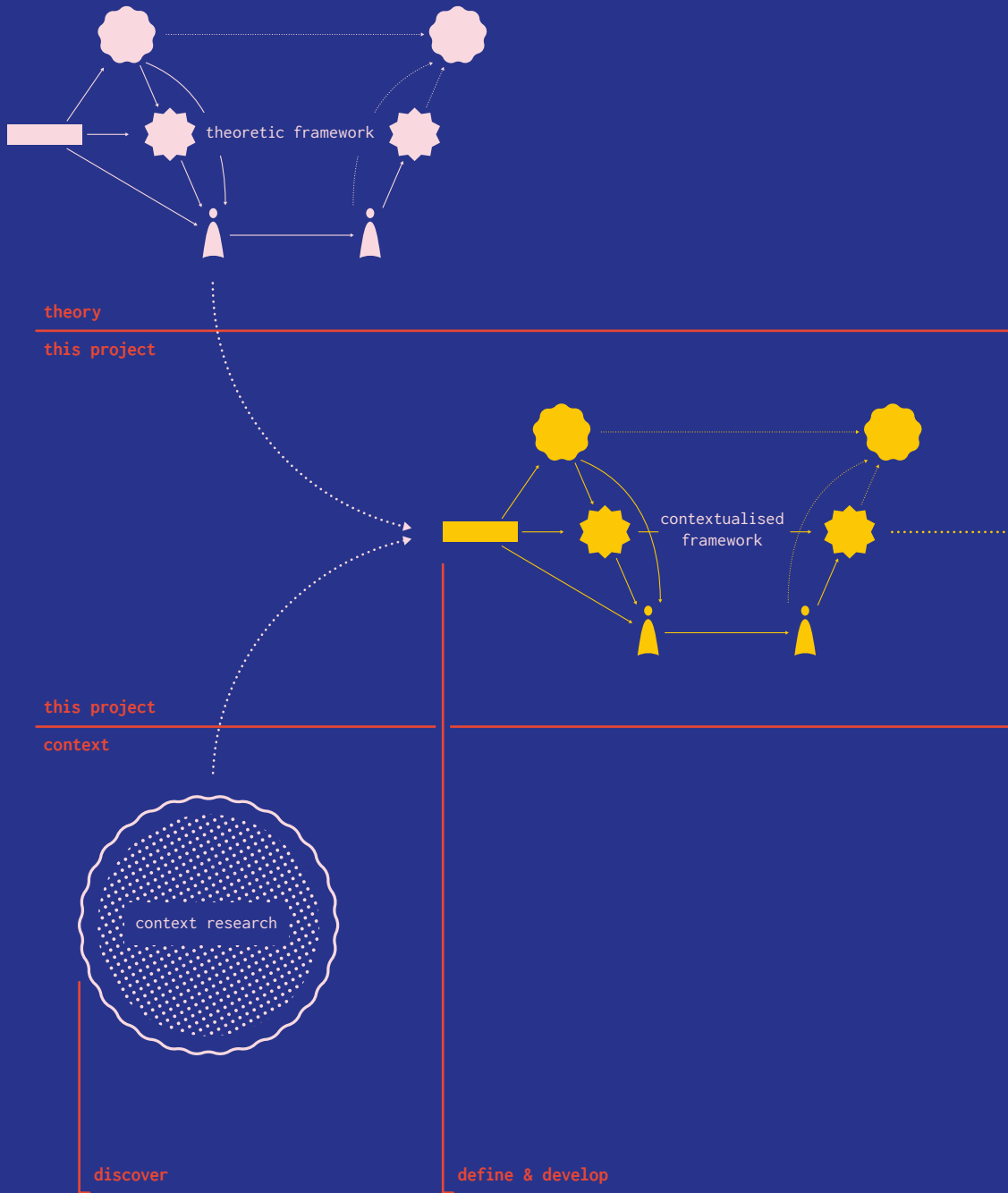
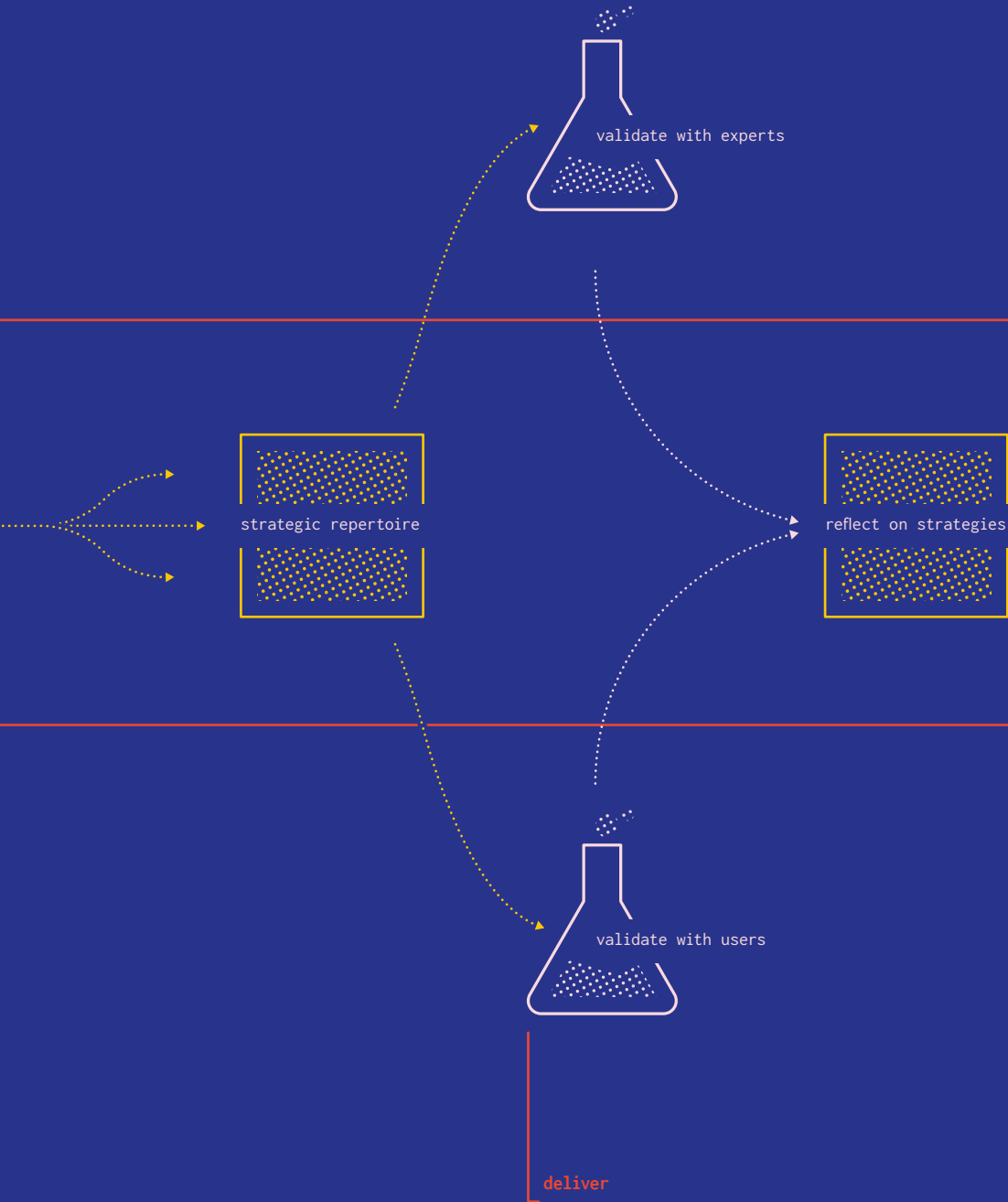


Figure 3: Detailed overview of project phases



/ intermezzo

# the redesigning psychiatry vision

a short intermezzo to understand  
the vision redesigning psychiatry  
aims to transition towards



/ intermezzo

## the redesigning psychiatry vision

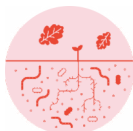
Redesigning Psychiatry is working towards the mental well-being of future generations, but what does that entail? In this intermezzo, we will look at the RP philosophy and summarise how it is different from the current mental healthcare system.

The RP vision is remarkably ambitious; it aims to break through the healthcare sector silos and look at the role of mental care in multiple layers of society. The vision describes a network of care and support, that invests in both mental healthcare, and in the ability of people to cope with their problems independently. With this comes a radical new way of looking at mental disorders. One does not have a 'condition', but an undesired behaviour pattern, that can be present in many various forms. These behaviour patterns are explained by a combination of psychological, biological and social factors that interact through time. Consequently, this asks for an integral approach and more collaboration between different areas of expertise, whilst paying attention to people's life paths. A realisation of this vision would affect the sector in multiple ways. First of all, it would entail a paradigm shift, affecting people's mental models of mental illnesses and the management thereof. Secondly, it would mean a huge change is necessary on the system level. The changes the vision implies on a system and paradigm level are summarized in eight 'flip-thinking' steps (Redesigning Psychiatry, 2019):



### From things to patterns

Personality and mental issues are not just things in someone's head. They are patterns, that can be recognised in all kinds of complex interactions.



### From reductionism to ecology

In ecology, patterns can be in equilibrium. By describing equilibria in the human domain, reductionism can be left behind, and neurology, individual, or social structures can be incorporated.





#### From condition to 'pihip'

A 'pihip' is a self-sustaining interaction pattern, that a client can get stuck in and might need help getting out of. This term would replace terms like 'illness' or 'condition'.



#### From treatment to helping

Instead of treating mental illness, the aim is to disrupt a pattern to establish more favourable patterns, based on neurobiological, psychologic and/or social aspects.



#### From wanting to stories

In the current system, clients are expected to know what they want. People tell stories to give meaning to their behaviour, which can be used to figure out what they need.



#### From societal norm to resilient diversity

Being mentally healthy is still seen as non-divergent from the standard. RP advocates for acceptance of difference; for (mental) resilience while maintaining social diversity.



#### From sector to network

Instead of receiving help when 'sick', and not receiving any when 'healthy', RP wants to offer a network that is active in all aspects of society.



#### From agreement to trust

The current mental healthcare system, is paralytically bureaucratic, without delivering more trustworthy care. For that reason, RP envisions a network based on trust, in which each party needs to give good reasons for that trust.

### New responsibilities of the network

Based on the vision and the 'flip thinking' steps, Redesigning Psychiatry has envisioned what a mental healthcare network might look like in 2030. Broadly speaking, it would have three functions (figure 4, next page) (Redesigning Psychiatry, 2018).

### Develop capabilities

This part of the network is dedicated to developing the cognitive, social and emotional capabilities that someone might need to support themselves, to be able to reach out for help when needed and to help others in need. Building this capacity increases the resilience of society as a whole. The development of these capabilities would preferably already start during childhood.

### Support transitions

The second part of the network is about supporting people during vulnerable moments like life-alternating transitions (e.g. having children, graduating, retirement). Important here is that the support of these moments is approached with an optimistic mindset, whilst making early signalisation and referral possible as well.

### Break through patterns

Lastly, the network has a responsibility to help people break through self-sustaining interaction patterns. People with severe (mental) complaints are stuck in patterns that do not go away on their own, or that keep coming back. In these cases, a network of care and support is needed to break through these patterns.

### Takeaways for this project

- > Some of the changes proposed in this chapter require a radical system change, like losing the divide between 'sick' and 'healthy'.
- > The transition to the system that RP envisions would not only entail a systemic shift, but it also requires a complete paradigm shift, as it radically rethinks the way mental health is viewed in society. This complicates the project; systemic shifts and paradigm shifts require different approaches, but cannot be addressed in solitude, as the subjects are heavily interrelated.
- > Regarding the ambitiousness and the interrelatedness of the challenges outlined in this chapter, focusing on just one part of the challenge is hardly possible. One challenge on its own is too big for a 100-day project, and the challenges are hard to separate. Therefore, equipping RP with the knowledge and capability to address these challenges themselves seems like a more logical step.

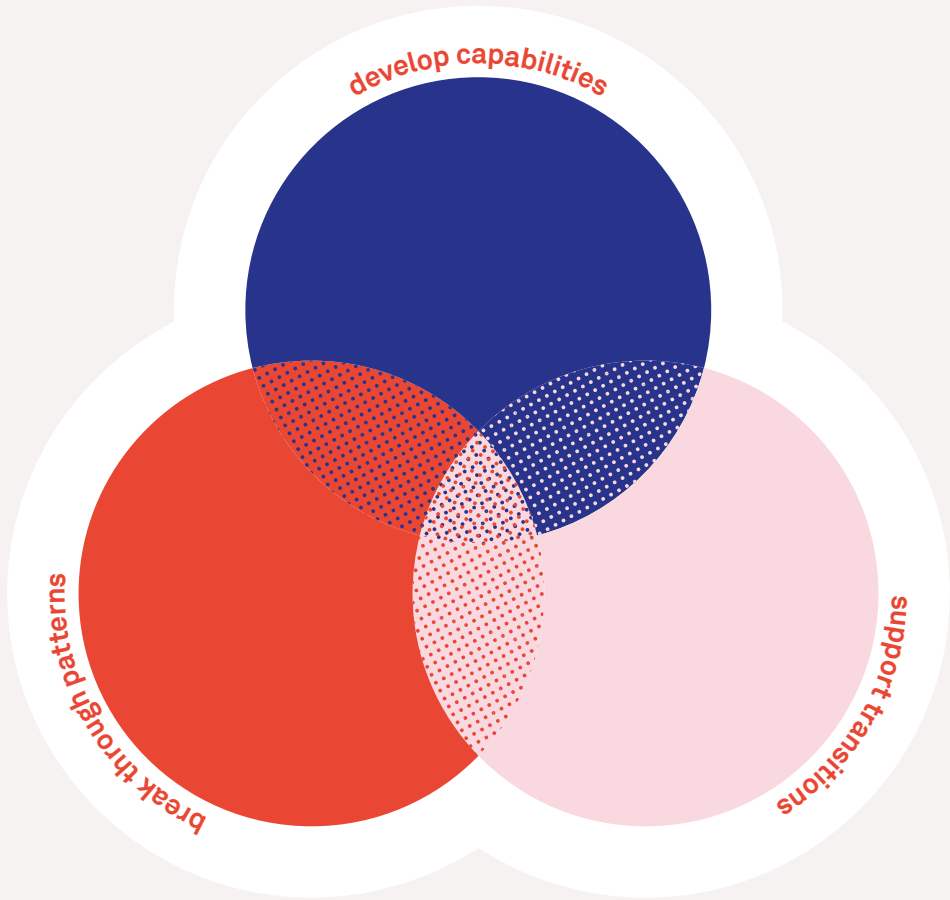


Figure 4: New responsibilities of the network (Redesigning Psychiatry, 2018, p. 47)

/ chapter 2

# literature review

30 / finding fundamentals: dynamics  
of a society in transition

40 / instruments: strategies for  
change in complex systems

52 / a theoretical framework for  
societal change



## literature review / 2.1

# finding fundamentals: dynamics of a society in transition

When searching for ways to set a transition into motion, it is fundamental to understand how change happens within society. What patterns does it follow, and what could be factors that slow down a society? Or, on the other hand, what are factors that make a society speed up?

The phenomenon of societal change can be viewed from multiple perspectives. In this project, it will be viewed from two. A perspective derived from literature on socio-technical transitions, which we will call the 'system perspective'; and a perspective derived from sociological theories, called the 'human perspective'. These two perspectives are inextricably linked, because organisations and society change and adapt interdependently. As such, both are important for understanding how a society goes through a transition.

In a first comparison it can be seen that both perspectives make a distinction between different levels of society (i.e. macro, meso and micro-level). The definition of what these levels entail does differ between perspectives (GeeIs, 2002; Van Tubergen, 2020):

	'System'	'Human'
<b>Macro</b>	Landscape	Society
<b>Meso</b>	Regime	Community
<b>Micro</b>	Niche	Individual

### 2.1.1 System perspective

The 'system perspective' as described in this paragraph mainly stems from the fundamental principles of an approach called *transition management*. A practical tool developed around the start of the millennium to support the Dutch government in managing the energy transition (Rotmans, Kemp, & Van Asselt, 2001), which has since then matured in one of the go-to approaches and sources of knowledge for socio-technical transitions<sup>1</sup>.

<sup>1</sup> More on this approach can be found in paragraph 2.2.1

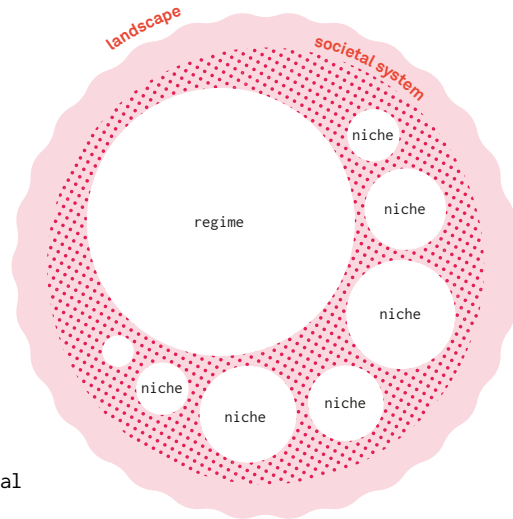


Figure 5: A 2D-representation of a societal system and its multiple levels

Within this perspective, a transition is defined as “a gradual process of societal change in which society or an important subsystem of society structurally changes” (Rotmans, et al., 2000, p. 19). For clarification: a society or subsystem can be seen as a *societal system*, a part of society that fulfils a specific function. In the case of this project, the mental healthcare sector is such a system. Structural change can be interpreted as a change in system structure, culture and/or practice (Rotmans, 2005; Loorbach, 2007).

#### Multi-level perspective on the societal system

As described earlier, transition management literature divides societal system into three levels: Regime, niche and landscape (figure 5).

- 1 The **regime** is the dominant functioning of the societal system and can be seen as a network of infrastructure, technology, culture, policy, and practices. In the mental healthcare sector, the use of DSM-classifications, the agreements between health insurers and MHCIs, and MHCIs in general are all part of the regime.
- 2 A **niche** is best described as a functioning in the societal system that is different or new to the regime, and serves a smaller part of society. In the energy system, an example of a niche is solar or hydrogen power. Within the mental healthcare sector, identifying

niches is more complex. Redesigning Psychiatry can be seen as a niche, as can spirituality and religion.

- 3 **Landscape** can be seen as the context in which the societal system is situated. Other societal systems are part of the landscape, as are trends, governmental regulation and global events. The societal system is influenced by the landscape, but it is also possible that it happens the other way around.
- \* **Niche-regime** a niche that has grown to be competitive with the regime, or that can co-exist with the regime. Examples are public transport and bikes in the Netherlands (GeeIs, 2002).

### A societal system in transition

As discussed above, you can speak of a transition when a societal system and its regime have structurally changed in terms of culture, practice and structure. According to transition management literature, this change process happens by the rise of technological niches (figure 6). This process resembles natural evolution; as technological niches mature, they adapt to user preferences, technology limitations, etc. As time passes, elements of niches might be combined, resulting in new socio-technical configurations. These in turn might influence the regime, and the regime changes structurally (Kemp & Van den Bosch, 2006). The change process just described can generally be divided into three phases (figure 7).

- > Predevelopment; in which niches are maturing and the landscape is changing.
- > Acceleration; in which matured niches ‘break through’ and have a lasting impact on the regime; the regime changes.
- > Stabilisation; in which a new balance is found (Frantzeskaki & de Haan, 2009).

Transitions take a long time to go through these phases, at least one generation (i.e. 25 years) (GeeIs, 2005).

Taking a closer look at this change process, there are three different conditions in the societal system that might ignite or influence change (Frantzeskaki & de Haan, 2009).



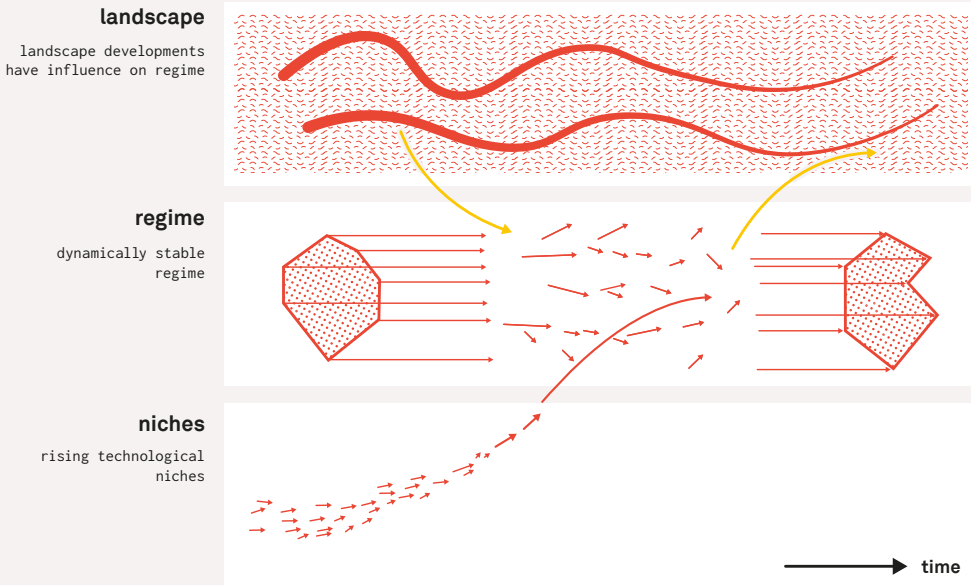


Figure 6: Dynamics of structural change in a societal system (Geels, 2002, p. 110)

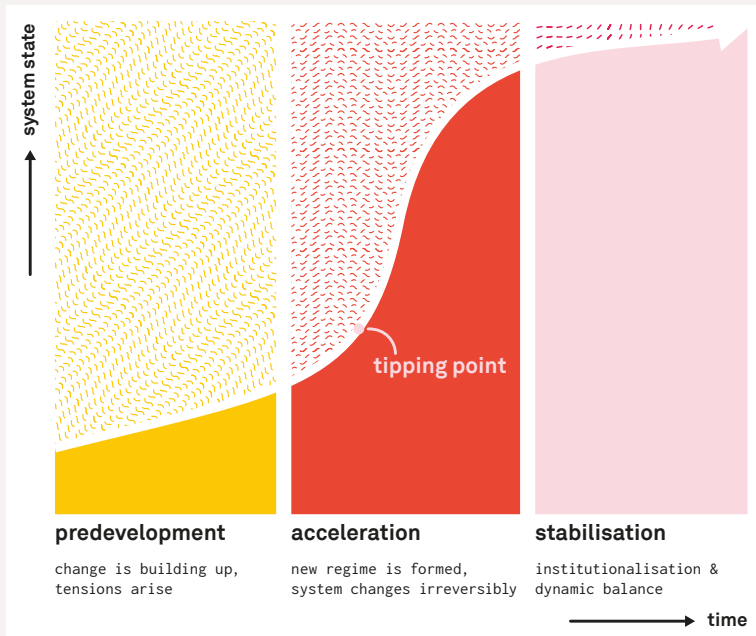


Figure 7: Different phases in the transitional process (Frantzeskaki & de Haan, 2009, p. 595)

**Tension** occurs when the landscape and the regime start to 'grow apart'. Certain events in the landscape might cause it to shift, whilst the regime remains the same (**figure 8**), for example the continued use of fossil fuels, while the support of fossil fuels in the landscape is declining.

A regime is under **stress** (**figure 9**) when internal aspects of the regime don't match. An example of this can be found in the healthcare field itself: the Dutch healthcare system is built on free market principles, but healthcare is perceived as a basic right (**example taken from Frantzeskaki & De Haan, 2009**).

You can speak of **pressure** in the societal system when growing niches are present in the system, that come to point of being competitive with the regime. Pressure can be a result of tension and stress in the system, as the deficiencies of the regime leave room for other niches to become competitive and gain societal support (**figure 10**). An example is the rise in popularity of meat substitutes, pressuring the regime of meat production and consumption.

Depending on the severity of these conditions, the regime might incorporate or adapt towards better fitting niches, resulting in structural change. Another possibility is that a niche-regime autonomously expands and becomes the new regime.

### Limitations of the organisational perspective

This perspective gives a clear view of how socio-technical systems go through a transition. It has a strong focus on the rise and fall of technologies, and the assumption seems to be that human behaviour and culture follow suit. Within a *socio-technical* system, this might be a safe assumption. However, this project concerns the transition of a *socio-economic* system, and has one of the primary goals to change human behaviour and culture. As such, the same assumption can't be made (**Kemp, 2019**). This is enforced by the notion that the neglect of human factors is an important cause of system failure (**Norman & Stappers, 2015**). In a system whose main function revolves around human well-being, the human aspect of a societal system cannot be left out. For this, the sociological field might provide guidance.

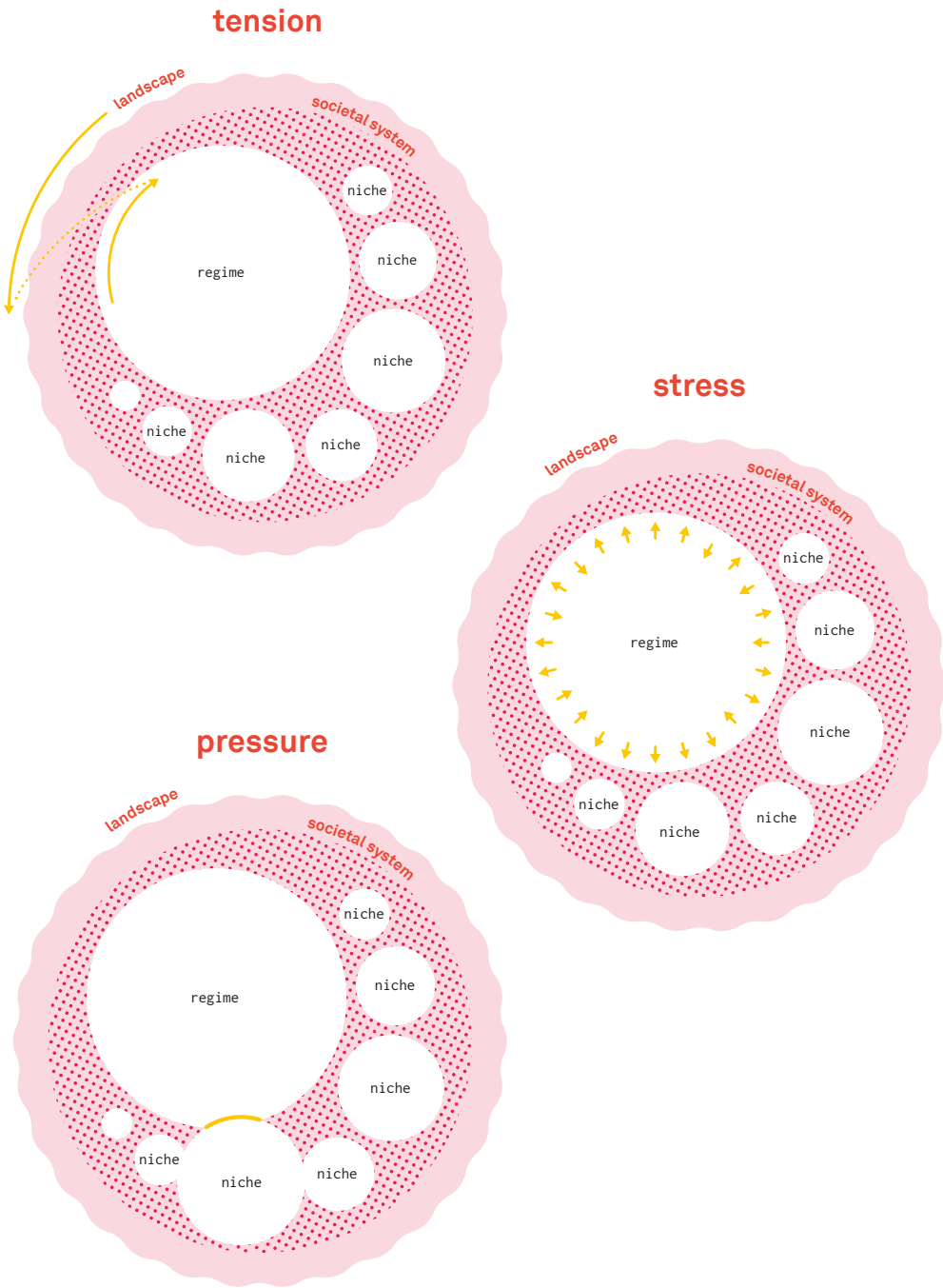


Figure 8-10: Tension, stress and pressure in a societal system

### 2.1.2 Societal change from a human perspective

Traditionally, sociology is the scientific field that studies society, social relationships, culture, societal change, and how all these elements are related. For this project, we will look at the knowledge body concerning the relation between societal conditions and individual actions, and the methods that are used to explain these interrelations.

Similar to transition management, sociology divides society into three different levels. The **macro-level** entails society, nations or economies, whereas the **meso-level** comprises of smaller networks of people, for example communities, organisations or ethnic groups. When looking at the **micro-level**, individuals or small groups of people (2-5 people) are studied (Course Hero, 2020).

#### A model to explain micro-macro relations

Sociological analysis mainly focuses on the interconnections between different scale levels; how are individuals influenced by events on the macro-level; how do social ties among people affect groups; and what is the impact of individual behaviour on higher scale-levels? In order to explain how macro-conditions can lead to individual behaviour, Van Tubergen (2020) proposes a model that makes a distinction between the context in which individuals are embedded, and the rationale behind an individual's behaviour given that context (figure 11). The model is a reaction to Weber's (1978) call for *Verstehen*: understanding the human behaviour that lies between macro-conditions and micro-outcomes. In this model, all the factors that lie outside the individual, are considered macro.

#### Individual context: Logic of the situation

The logic of the situation describes an individual's macro-conditions (i.e. their social context), and how this influences the individual's situation (i.e. micro-condition). Factors that influence the forming of micro-conditions are for example one's opportunities, the available information, certain biases or a mental model the individual might have.

#### Individual rationale: Logic of the action

The logic of the action further specifies the individual's micro-condition by describing the opportunities, choices, beliefs and preferences that

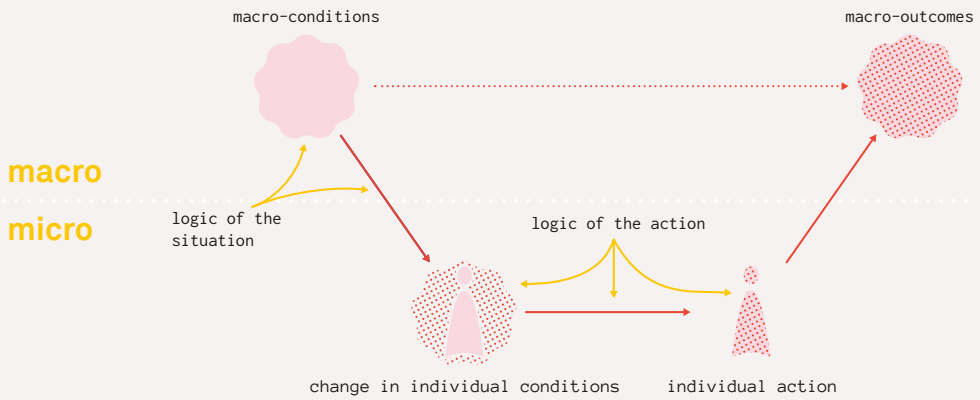


Figure 11: Model to portray macro-micro relations (Van Tubergen, 2020)

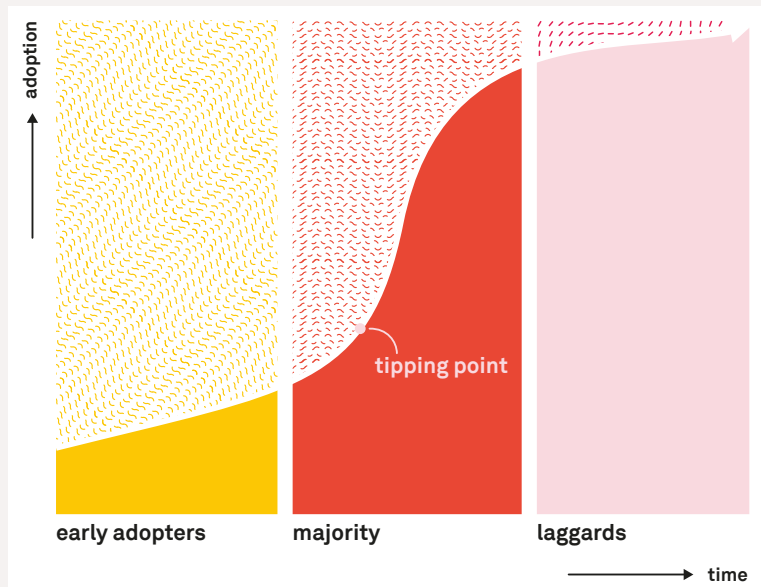


Figure 12: S-curve of adoption within society (Rogers, 1962; Van Tubergen, 2020)

an individual has. Subsequently, the logic of the action describes an individual's behaviour based on these specific micro-conditions. Is this for example rational, emotional or impulsive behaviour?

### Assumptions about the logic of the situation and action

On its own, this model does not help a lot in understanding macro-micro relations, as discovering each individual's opportunities, preferences and mental model would be quite labour-intensive. Also, incorporating each individual's behaviour in the model, would make the model endlessly complex. For this reason, sociologists generally work with a set of assumptions for the logic of the situation and logic of the action, referred to as a *micro-model*. Such micro-models try to find the optimal balance between abstraction and reality, and differ among different phenomena<sup>2</sup>. Broadly speaking, the assumptions take into account the following circumstances:

- People might not always have complete information, and might believe things even though they aren't true;
- The social group an individual belongs to, has a large influence on the opportunities and beliefs an individual might have;
- Next to have personal desires, individuals might also have desires concerning peers;
- An individual does not only have material goals, also emotional goals

### Impact of individual behaviour on the macro-level

Now that we have established how macro-conditions can result in micro-outcomes, it is important to know how these micro-outcomes affect the macro-level, as transitions are effectively macro-outcomes of micro-decisions (Schelling, 1978).

When possible, sociology assumes a model of *social independency*, in which people act independently from each other, and macro-outcomes can simply be aggregated. When dealing with *social dependency*, this is not possible anymore (Van Tubergen, 2020). In this case, change takes the form of an S-curve (figure 12), as individuals subsequently influence each other to adopt certain behaviour. When dealing with social dependency, macro-outcomes can (broadly) be predicted by using

<sup>2</sup> This does not differ much from the design perspective, in which things tools like personas also sketch a 'typical person', representative of a larger group (but not the entire society)

computational models, in which assumptions are made about human behaviour in certain contexts. For example, in agent-based models the actions of individuals (i.e. agents) are explicitly considered in interaction with each other. In these models, assumptions are often made about the threshold individuals might have to portray certain behaviour. Causal relations are considered here: the negative or positive effect of certain macro-conditions on the individual's behaviour, and the degree to which these macro-conditions need to be manifested before the threshold is reached and an individual portrays said behaviour (Bonabeau, 2002). Another example is that of game theory; mathematical models of situations of conflict or cooperation (Myerson, 1991), in which an element of strategy is added to explain (rational) human behaviour.

### Limitations of the human perspective

Unsurprisingly for an academic field of which the main activity is to study and understand macro-micro relations, this perspective is rather analytic. For this project, the perspective helps in structuring findings, but it is not actionable; it does not provide handles to bring about change. Additionally, predicting macro-outcomes through mathematical modelling is quite labour intensive. For scientific analysis, this is less of a problem, but this is too labour intensive for practical application.

The model depicting micro-macro movements is (understandably) very simple, and might not truly help in planning outcomes. However, this does make the complexity of societal change quite clear; when the intricacies of personal psychology are taken into account, the model becomes too complex to use. This also points out why it might be a mistake to leave out the human perspective; it might be possible that the situation is simplified to such a degree, that it does not represent reality properly anymore.

### 2.1.3 In summary

- > The system perspective portrays the dynamics of falling regimes and rising niches quite nicely, but misses the human perspective; people need to change as well.
- > The human perspective takes into account an individual's position within societal change, but lacks insight into the role of organisations and systems within changing a society

## literature review / 2.2

# instruments: strategies for change in complex systems

In this chapter, we will discuss the different kinds of (theoretical) instruments for transitional change or complexity in general. Partly, these instruments stem from the design field, but we will also look at strategies from adjacent fields.

Kemp & Loorbach (2003) argue that transitions cannot be controlled. In line with this statement, it is important to note is that none of the instruments for transitional change have the ability to *control* transitional change. Rather, they provide ways to influence, steer or modulate the transition, or even just facilitate the right conditions for change. All instruments operate and focus on a multitude of scale-levels, switching between levels or operating in one level while maintaining an understanding of the other levels.

### 2.2.1 Transition management

As mentioned in paragraph 2.1.1, the transition management methodology has been developed for the Dutch government, in order to stimulate the (socio-technical) energy transition to cleaner energy sources (Rotmans et al., 2000). The method is built on the principles of change discussed in that same paragraph; the rise of niches that are better suited to landscape conditions, and how these niches change the regime in one way or another. Kemp & Rotmans (2009, p. 309) summarise transition management in five essential principles:

- 1 “Long-term thinking as the basis for short-term policy;
- 2 Thinking in terms of multiple domains, actors and levels;
- 3 Keeping options open;
- 4 Learning as an important aim for policy;
- 5 Orienting policy towards system innovation besides improvement.”



Stemming from the principle that transitions cannot be controlled, only influenced, transition management takes an approach of “goal-oriented modulation” (Kemp & Loorbach, 2003, p. 10). Rather than planning the entire ‘route’ to reach a transition goal, the idea is to work with the dynamics that are already at play. The determination of short-term goals to achieve long-term change can be done by a combination of back casting and forecasting (Kemp, Rotmans, & Loorbach, 2007). Long-term goals inform these short-term strategies and are in turn adapted as short-term activities are carried out and learned from (figure 13).

Aligned with ‘the dynamics that are at play’, transition management preaches the consideration of the interplay of domains, actors, and levels. For domains, this means to coordinate policies from different domains that might affect one another. For actors, this means taking into account the different actors at play and incorporating their interests. For levels, this means linking top-down policies with bottom-up initiatives (Kemp & Loorbach, 2003; Loorbach & Van Raak, 2006).

Similar to the idea of *never keeping all your eggs in one basket*, the principle of keeping your options open means to explore multiple transition simultaneously, as to prevent being stuck with solutions that turn out to be less optimal for reaching the long-term goal (Kemp & Loorbach, 2003; Kemp, Rotmans, & Loorbach, 2007).

### Transition experiments

Part of the transition management approach are transition experiments. These so-called transition experiments have the goal to explore possibilities in practice, that have a considerable potential contribution to the transition process. As transitions span across multiple domains,

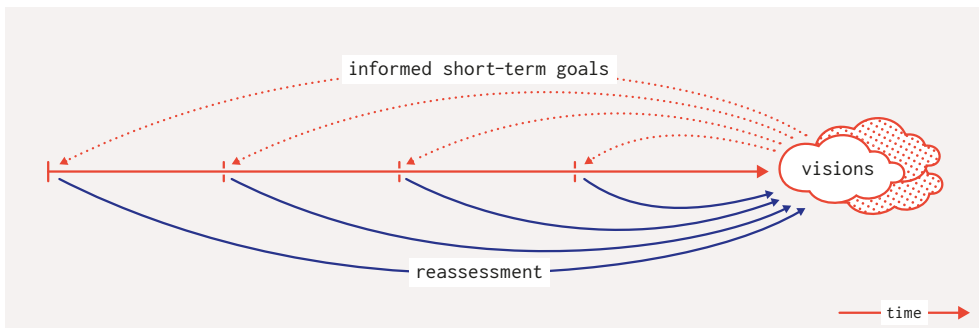


Figure 13: Long-term thinking with short-term goals (Kemp & Loorbach, 2003, p. 11)

so can transition experiments. Next to having the goal to learn and explore, transition experiments can have the parallel goal to change society through a multitude of experiments (Kemp & Van den Bosch, 2006). With each experiment, support for a certain innovation can be increased, as can the network of actors around the innovation (Kemp & Loorbach, 2006)

### 2.2.2 Transition design: an emerging methodology

Being introduced first in 2015, transition design is a fairly young method, that is still in its research phase. In this paragraph, the discipline as it is right now is laid out, including aspects that are still ambiguous.

#### Premise

Transition design (Irwin et al., 2015) is built around the premise that there is a need for “societal transitions to more sustainable futures” (ibid., p. 1). It proposes that design should play a central role in supporting these transitions. To do this, it takes knowledge from other fields about transitions and change in complex systems – such as the transition management field – and combines it with aspects (and strengths) of design.

#### The transition design framework

The transition design methodology is built around four main areas of knowledge, united in the “transition design framework” (figure 14). These four areas co-evolve, and are as follows:

#### Visions for transition

In the previous paragraph, we have established the need for future visions as a tool for setting short-term goals. Transition takes this same principle; it identifies the need for iterative and “error-friendly” visioning, and the use of the vision as informing and assessment tool for present-day interventions. The tools and methods of design can be used to create compelling visions.

#### Theories of change

The world is full of theories of how change happens in society, in nature, in organisations, within one person, etc. Transition design argues that each course of action features a conscious or unconscious theory of

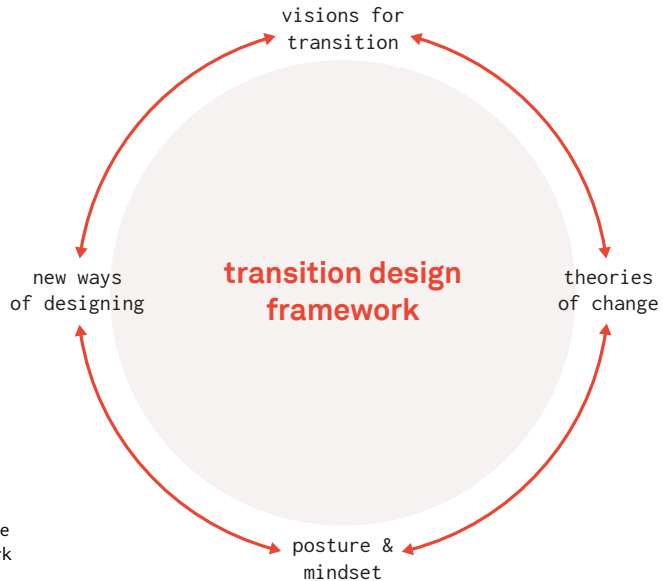


Figure 14: Four areas of knowledge in the transition design framework (Irwin, et al., 2015, p. 7)

change, and that these conventional and intuitive ideas of change are what lie at the root of wicked problems, as change in complex systems manifests in counter intuitive ways. Therefore, they advocate for the accompaniment of a ‘theory of change’ to each vision for transition.

#### Posture & Mindset

A designer’s mindset and position in the world heavily influence what is identified as a problem, how it is framed, and how it is solved. Yet this often goes unnoticed and unacknowledged. Transition design seeks for awareness of this in the design process.

#### New ways of designing

As transition design is a new field of design that is inherently more complex than the traditional design practice, its skillset needs to be expanded as well. Transition design proposes an expansion in the following aspects:

- > Development of powerful narratives of visions
- > Amplify and connect grassroots efforts
- > Transdisciplinary teams to develop place-based solutions

Additionally, a single design can be seen as a single step towards the vision, in which the system can be changed through multiple interventions over time. Maintaining an overview of the cumulative result of these interventions, is crucial (Price, De Lille, & Bergema, 2019).

### Emerging aspects of the approach

Three years after its original conception, the aspects of the transition design approach have started taking shape (Irwin, 2018, p. 969):

- 1 “Visualize and ‘map’ complex problems and their interconnections and interdependencies;
- 2 Situate them within large, spatio-temporal contexts;
- 3 Identify and bridge stakeholder conflicts and leverage alignments;
- 4 Facilitate stakeholders in the co-creation of visions of desirable futures;
- 5 Identify leverage points in the large problem system in which to situate design interventions.”

### 2.2.3 Transformative social innovation

Social innovation is known in the design field as bottom-up initiatives with innovation goals assumed beneficial to society. Social initiatives (SI) often operate across regimes (Haxeltine, et al., 2017), and this in combination with their large number, makes that they have the potential to have transformative impact. Haxeltine et al. (2017) have built a theoretic framework for transformative social innovation (TSI), that outlines the workings of TSI-processes – how they come to have transformative impact – and how SI-networks become (dis)empowered. For the sake of this project, this can be useful because it can provide insight in ways to empower and connect social initiatives in order to have social impact. In this case, Redesigning Psychiatry itself could be considered a social initiative, as well as like-minded initiatives that fall in the category of ‘grass-roots efforts’ (see paragraph 2.2.2) and that have the potential to become partners.

The framework identifies four main clusters of TSI relations, that address different levels of TSI (figure 16). Three of those are relevant to this project, as they address initiative empowerment, resulting in transformative impact and institutionalisation.

### Relations within SI initiatives

When looking inside SI-initiatives, it is of primary importance to maintain high motivation within members. This can be achieved through having collective successes, having a strong collective identity, and empowering members. Members can be empowered by addressing three basic psychological needs: autonomy, a sense of belonging and a perception of effectiveness.

### Network formation processes;

A Social Innovation initiative's potential for transformative impact is largely decided by the initiative's ability to form networks with other SI initiatives and become collectively empowered. Factors playing a role in this are for example the stability of the SI's operating field; the presence of transnational networks that can provide funding, legitimacy, collective identity, knowledge sharing; and the presence of SI communication elements like narratives and metaphors.

### Institutionalisation processes;

In order to become successful, initiatives need to have an 'institutional home' in their transition to an institutional existence. This is a balancing act, as aligning with the institutional home too much can cause the loss of new, transformational values. Furthermore, in order to become institutionalised, SI initiatives generally have an array of strategies to adapt to changing circumstances.

The creation of a *hype* or *movement* is in one way empowering, but the rapid upscaling can also cause mistranslation and fragmentation, as a result disempowering the SI initiative (Haxeltine, et al., 2017).

### 2.2.4 Design as a method to resolve wicked policy problems

In the past years, the design discipline has gradually evolved from the design of products and services, to the 'design' of strategy, culture and organisations (Sharma & Poole, 2009; Muratovski, 2015; Buchanan, 2015). With that, it has ventured into the area of complex social problems, otherwise called *wicked problems*. Wicked problems are defined as "a class of social system problems which are ill formulated, where the information is confusing, and where there are many clients and decision makers with conflicting values" (West Churchman, 1967, pp. B-141).

When dealing with a transition with this magnitude—the transition to a new mental healthcare system—in which both a paradigm and its corresponding system need to change, the challenge can definitely be described as a wicked problem. Hence, it can be interesting to see what the role of design is in these kinds of problems.

In a comparison of design problems and wicked problems, Buchanan (1992), states that the two are similar. He continues to point out that wicked problems are characterised by an ambiguity of conditions, to which linear approaches are rarely effective, as these are built on the promise of certainty. The traditional design process, too, is based on an indication of certainty, rendering it unsuitable to address wicked problems (Norman & Stappers, 2015; Sanders & Stappers, 2008). However, the discipline as it is evolving does have some beneficial characteristics. In a comparative case study between two governmental design labs, Holierhoek & Price (2019) identify four characteristics of design that are beneficial to tackle complex issues:

- > An iterative approach;
- > creating empathy;
- > co-creating with stakeholders;
- > continuous consultation.

Furthermore, Holierhoek & Price identify the need to pair a complex problem with a holistic set of solutions. In line with this, Norman (2014) outlines the necessity to address complex problems with a multi-disciplinary team, in which the design discipline and the user are represented, next to other relevant disciplines. Holierhoek & Price offer a slightly different approach: the design activity is not primarily performed by designers in these cases. They are for example executed by multidisciplinary teams of experts and/or by people with know-how of the sector, *guided* by designers. This can also be found in aligned approaches such as *transdisciplinary innovation*, that have been described as useful in addressing wicked problems and transitions (Irwin et al., 2015; McPhee, Bliemel & Van der Bijl-Brouwer, 2018).

Finally, it must be noted that the design discipline is not (yet) fully equipped to solve wicked problems. The design repertoire needs to be

expanded in order to be able to address the continuity, multifacetedness, and longevity of wicked challenges (Holierhoek & Price, 2019). A good example of an effort to this end is the Transition Design method mentioned several times earlier in this report.

### 2.2.5 Design for Behaviour Change

Design for Behaviour Change, or behavioural design, is a subject that has been much discussed and researched in the design discipline, as its premise seems to become more popular. The subject aims to change undesired behaviour into desired behaviour (i.e. target behaviour) through design interventions (Cash, Hartlev, & Durazo, 2017). This can be achieved through multiple ways, ranging from small interventions, to entire products or services dedicated to change of the behaviour.

One of the more influential models for behaviour change is the Fogg Behavior Model (Fogg, 2009). In it, behaviour change is dedicated to three factors: motivation, ability, and prompts. In this list, motivation entails the user's willingness to portray the targeted behaviour, ability the difficulty of the targeted behaviour, and prompts entail effective stimulation to portray the behaviour. Fogg argues that only if all these factors are present, behaviour change is possible. However, the factors do not always have to be present to the same degree for the target behaviour to happen; a phenomenon that Fogg labels the 'behaviour activation threshold' or 'action line'. The prompts needed for these different ratios of motivation and ability differ as well. When motivation is high, but the task is quite difficult, the prompt needs to be facilitating. When motivation is low, but the task very easy, the prompt needs to spark. Finally, when both motivation and ability are high, the prompt just needs to be a signal, reminding the user of the target behaviour (Fogg, Prompts, 2020). Fogg's perspective shows overlap with the dimensions of behaviour change summarised by Daae & Boks (2014). They map the dimensions influencing behaviour on a matrix with scales of obtrusiveness and control. Obtrusiveness can be compared with the kind of prompts Fogg proposes. Control adds a new perspective; the amount of control the user has over the portrayal of target behaviour.

The above-described perspectives on behaviour change are quite one-dimensional, in the way that they aim to achieve minor behaviour

changes, and mostly involves behaviour in interaction with an artefact. However, the changes required in this transition are not 'minor', as it involves changes in way of working—which can be very personal in the mental healthcare sector—and even changes in mental model.

A contrasting, possibly more helpful, perspective is that of personal empowerment. The idea behind this is that people cannot be 'told' to change their behaviour, as this only causes resistance, demotivation and ultimately a loss of energy. The approach in this perspective is to determine what *drives* people and use that, preferably in collaboration with these people themselves. In this way, people are empowered and intrinsically motivated to achieve something (Van der Bijl-Brouwer, 2019). It must be noted that this approach doesn't have a target behaviour, but rather a target outcome, meaning that there is less control over *what* the new behaviour will be.

### Redesigning Psychiatry's perspective on behaviour change

Of course, as an organisation that aims to radically rethink the way human behaviour and mental health is viewed, Redesigning Psychiatry has a perspective on behaviour change as well, albeit in mental healthcare. Considering that this perspective focuses on breaking through behaviour patterns—which is exactly what this project aims to do—it can be interesting to explore this.

The RP philosophy is built on an ecological interpretation of mental health, which starts at the premise that people are in continuous interaction. Not only with their environment, but also within and between their mind, brain, and body.

Central to the ecological interpretation is the principle of equilibria. Eco-systems (in this case the human body and mind, and its environment) are in constant search for dynamic equilibria, where the goal is not necessarily returning to the old situation, but can also be adaption or transformation (Folke, et al., 2010). When an eco-system is disturbed to a degree that it can't return to the existing equilibrium, it adapts or transforms into a new equilibrium. This is called a *tipping point* (figure 15), after which the system goes through an adaptive cycle of re-orientation, growth and settling in a new equilibrium, until a new disturbance emerges (figure 16) (Redesigning Psychiatry, 2018).



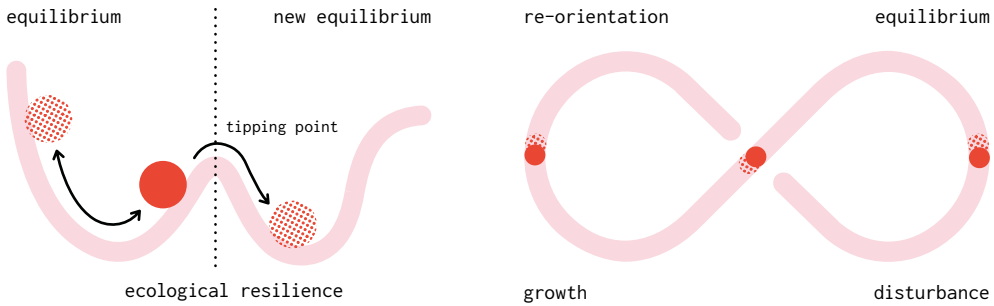


Figure 15: Ecological resilience (Redesigning Psychiatry, 2018, pp. 27)

Figure 16: The adaptive cycle (Redesigning Psychiatry, 2018, pp. 32)

From a behaviour change perspective, this means that a new equilibrium—new behaviour—can be established when the context changes, or the behaviour is disrupted, to a point that a return to the existing behaviour is not possible. As a designer, the challenge then becomes to find ways to break through the existing behaviour by changing the context or by designing (positive) disturbances.

### 2.2.6 Networked innovation

Networked innovation is an umbrella term for innovation carried out by multiple parties, from two to thirty (Bergema, 2019). The knowledge field of networked innovation can come in useful in this project, as large-scale system change inevitably involves the collaboration between system actors. The networked innovation field makes a distinction between setting up innovation projects, and orchestrating innovation projects.

#### Setting up the team

When setting up the team that is to perform the networked (i.e. collaborative) innovation project, the first thing to do is to create a shared vision or ambition that the entire team can rally behind (Berasategi, Arana, & Castellano, 2011; Bergema, 2019). The parties in a networked innovation project most likely have different interests, but this doesn't necessarily have to be a bad thing, as long as the interests are united and aligned in a shared vision (Bergema, 2019). Furthermore, it is important to create a common language. As people have different backgrounds, it is possible that the same sentence can be interpreted totally differently by different people. By having a common language, this can be avoided (Bergema, Kleinsmann, De Bont, & Valkenburg, 2011).

Additionally, it is advisable to start with small projects and low stakes to ‘test the waters’. In this way, possible challenges in the team can be detected early, the bar to join a network is lower, and comfort with unconcrete projects can be trained. More challenging or vague projects can be started once the first project is successful (Bergema, 2019).

### Orchestrating the network

Even more important than setting up the network is orchestrating it (Berasategi, Arana, & Castellano, 2011; Swan & Scarbrough, 2005). One of the key principles in fulfilling this purpose, is to establish a strong team culture and relationship. This enables a feeling of collectivity, that can make the bonds team members have with their own organisations less distinct; rather than ‘our’ organisation and ‘their’ organisation, it becomes ‘our’ team. Furthermore, it is important to keep the shared ambition sharp, as this is what unified the team in the start of the project. Both these principles are key in keeping the motivation in the team high. If the team works well on its own, there is no need to have external help. However, when the projects get to a point that external help is necessary, it might already be too late. Therefore, it is beneficial to start the project with external help, as this can reduce the chance at failure. External help often comes in the form of a neutral but up-to-date person in the team, who can help in the innovation process (Bergema, 2019).

### Design and networked innovation

When looking at the role of design and designers in networked innovation, there are certain aspects of design that are useful. Its ability to gain trust and put people at the centre; its ability to be future-focused; its ability to go outside and *talk, do*; and its ability to very rapidly make things concrete and visual is very important (ibid.).

### 2.2.7 Summary of fundamentals and instruments

In figure 17, an overview is given of the coherence of the fundamentals and instruments for societal change, and the main aspects they propose to address complexity and transition. Chapter 2.3 holds a generative conclusion in the form of a theoretical framework that combines several of the theories just discussed.

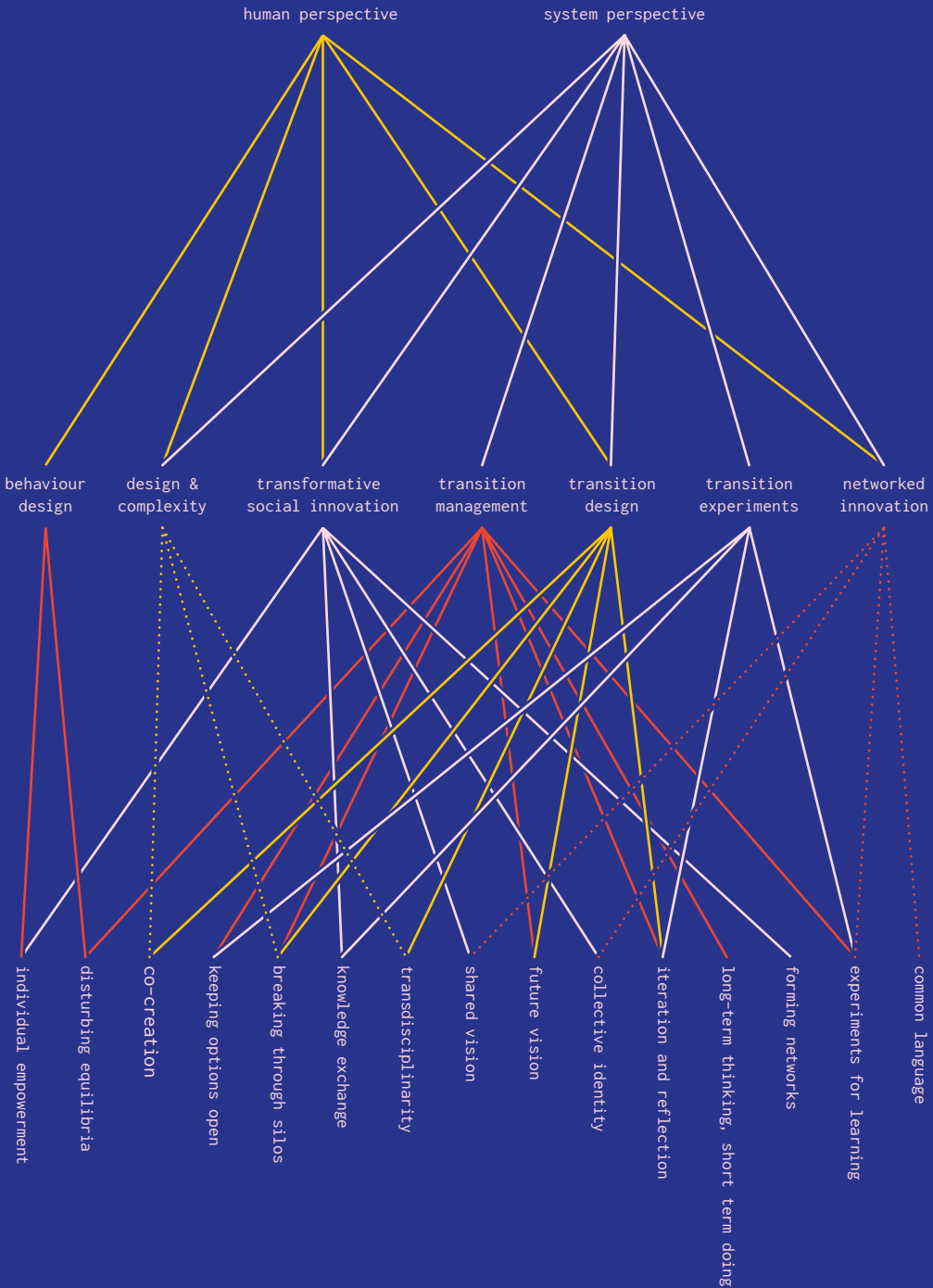


Figure 17: An overview of the fundamentals, the instruments, and the main aspects to address transitions

## literature review / 2.3

# a theoretical framework for societal change

In this chapter, a theoretical framework is proposed for societal change from a socio-economic perspective. The framework can be used to understand contextual findings and help create a strategy to stimulate the transition.

> A large version of the framework discussed in this chapter can be found in the map collection

In this framework the system and human perspective are combined into one framework. This is done because each of the perspectives' limitations can supplement one another.

The system perspective gives a good understanding of the dynamics of falling regimes and rising niches, and can support the formation of large-scale and long-term goals. At the same time, it lacks the dynamics of human behaviour that are needed for this project; there's whole group of people that can and need to be addressed personally, whose behaviour is not just a part of the landscape.

The human perspective provides this insight, but is not actionable, and cannot give guidance in reaching and deciding on long-term goals. Attention to behaviour *and* actionability happens to be found in a discipline much closer to home as well: the design discipline is very skilled in linking 'macro-conditions' to people's personal context, which makes for interesting opportunities.

Another reason to not rely solely on the system perspective, is because its corresponding approach *transition management* has been developed for governmental institutions. The government has a different set of resources, capabilities and measures at their disposal than for example Redesigning Psychiatry or mental healthcare institutions. Moreover, it has been developed with socio-technological systems in mind. As such, its principles cannot be translated one on one to this particular context.

In conclusion, the framework takes the following aspects of each perspective:

- > The human perspective's representation of cause and effect;
- > The human perspective's divide between the context people are situated in and the way they act on this context;
- > The system perspective's depiction of large-scale dynamics of change.

In the following paragraphs, the framework and its use will be explained in more detail.

### 2.3.1 Defining different levels in the framework

As both perspectives had different interpretations of what is on the macro, meso and micro scale, the framework loses these labels, and rather makes a distinction between landscape, organisation, and individual (figure 18, next page). Another reason for doing this, is that the regime and niche labels of the organisational perspective are quite abstract. For example, a regime is a network of tangible and intangible matters like infrastructure, culture and practices. This is not something that can be addressed directly. Making a distinction between landscape, organisation and individual makes the framework more actionable.

#### Landscape

The landscape layer represents the context outside the societal system. This layer is the slowest of the three. The landscape layer as defined in transition management, principally represents the general consensus of society, (inter)national events, trends, developments (paragraph 2.2.1). In this project, institutions such as the **scientific field** and the **government** can also be found in this layer. As the government is not the primary initiator in this particular transition, it can be seen as a reflection of society, thus a part of the landscape layer.

#### Organisation

The organisation layer represents any kind of organisation within the societal system. In most cases, this means **mental healthcare institutions**, but **health insurance companies** and **communities** are also part of this layer.

### Individual

In this layer, individuals operating in the mental healthcare system are represented, such as **mental healthcare professionals, general practitioners, and management personnel**. Clients are not included in this layer, as they are not the ones needing to change their daily (working) routines or mental models. Clients instead are included in the landscape layer as a part of society.

### 2.3.2 Downward movements

#### ●1, ●2 and ●3

The downward movements in the framework represent how actors in the organisational and individual layers are situated in (a momentary snapshot of) their context, and how they interpret this based on the information available, heuristics, and mental models. In the case of organisations, this concerns “shared mental models” (Kim, 1993, p. 42). There are two kinds of downward movements: active and passive.

#### Active

An expectation from an upper level to react in a certain way, for example, and organisation imposes behaviour change on an individual.

#### Passive

When an actor’s situation is the consequence of coinciding factors, but not steered directly by an upper level.

In the model, active movements are often less effective than passive movements, as these concern extrinsic triggers for change, rather than intrinsic motivation, whereas intrinsic motivation is more effective in bringing about behaviour change (Van der Bijl-Brouwer, 2019).

### 2.3.3 Movements to the right

#### ★1, ★2 and ★3

The arrows to the right in the framework represent the reaction an actor might have to their particular context. This is based on the opportunities, beliefs, preferences, and mental model of the actor. It is important to mention that human behaviour has been divided into two elements to simplify the model.

Examples of ‘organisational behaviour’ are changes in organisation structure and acquisition of technology or capabilities.

### 2.3.4 Upward movements

#### ▲1, ▲2 and ▲3

The upward pointing arrows in the framework represent the impact the reaction has on the higher level (either organisation or landscape level, or both). In theory, this could be predicted by making sociological models. In practice however, this will probably be a process of trial and error. In the upwards movements, there is also a distinction between active and passive movements.

#### Active

The actors in a lower level push for change to an upper level. For example, trade unions asking for better wages.

#### Passive

Cumulative result of behaviour of actors on a lower level.

### 2.3.5 Exerting influence

#### ◆1, ◆2 and ◆3

Lastly, the arrows in the far left represent ways to exert influence on the different levels. In this case, these could be Redesigning Psychiatry’s activities. Examples of ways to influence the landscape can be through lobby activities, gaining media attention, and activism. On the

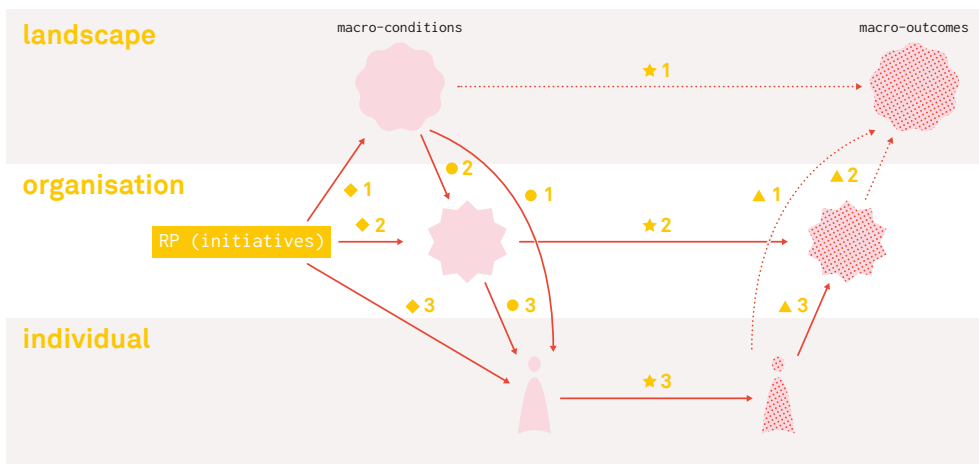


Figure 18: A theoretical framework for societal change

organisational level, ways to influence could be addressing paradigm change and difficulties in organisation change. Examples of ways to influence the individual level could be stimulating behaviour change, inspiring individuals, etc. There are two different ways to exert influence:

**Start**

Starting new paths on the map that will set change in motion.

**Catalyse**

Identifying paths of change that are already happening, and making efforts to catalyse these paths.

**2.3.6 Applications of the framework**

**Finding blockers and enablers**

When doing contextual research, the framework can be used to map blockers and enablers you might find. Are there certain things that block an actor from reacting, or that block an actor from reacting the way it wants? Those can be mapped on the framework and can provide insight in the way to address these blockers (figure 19). This application is more generative; it can inform new strategies to bring about change.

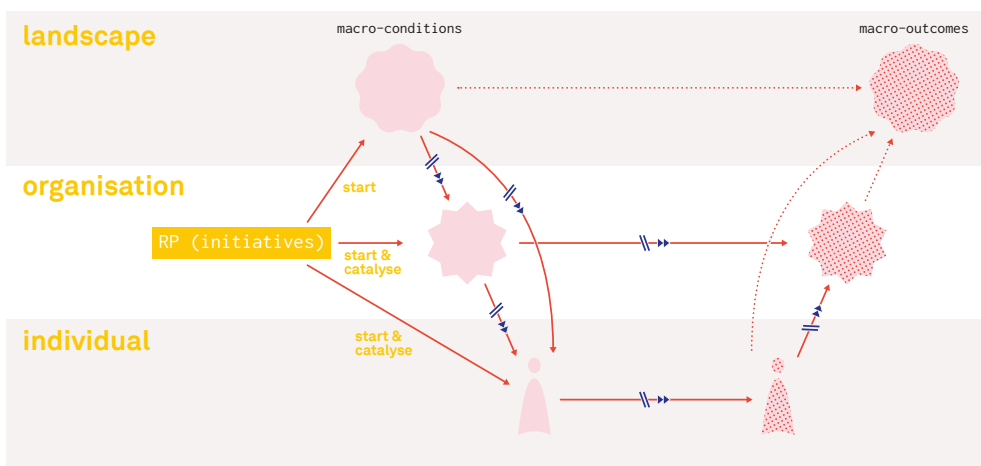


Figure 19: Blockers and enablers on the framework





/ chapter 3

# context analysis

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70 / an overview of the mental healthcare system

76 / change and innovation in the mental healthcare sector

80 / stripping and structuring insights



## context analysis / 3.1

# a closer look at redesigning psychiatry

Redesigning Psychiatry is an innovation network, in which designers, philosophers, and psychologists have worked together with mental healthcare institutions to develop a new vision for mental healthcare in 2030. The vision is based on human values, rather than economic or logistic values. Currently, the network is working on realising this vision.

### 3.1.1 Goal

Initially, Redesigning Psychiatry started with the goal to radically rethink mental healthcare in the Netherlands, putting human values on centre stage. The opportunity for this arose out of the economic and demographic challenges the sector was facing. However, rather than reacting to these challenges (that most likely are symptomatic), the objective was to take a pro-active attitude by looking beyond the current system constraints and taking a future-focused perspective (Redesigning Psychiatry, 2016).

At the moment of writing, Redesigning Psychiatry's vision is finished for the time being, and is currently in the process of being advanced within the mental healthcare sector. More specifically, within partnered mental healthcare institutions. The goal is to create movement and to break patterns within the sector, which they plan to achieve by doing the following (Redesigning Psychiatry, 2018):

- > Building collective knowledge;
- > Translating collective knowledge to experiential interventions;
- > Connecting like-minded and like-desired organisations.

### 3.1.2 Organisation structure

Redesigning Psychiatry calls itself an *innovation network*, which means that they aim to advance RP ideas through collaboration with industry partners and the gathering and sharing of knowledge. RP

has established an impressive partner network with over 10 industry partners, with whom they share long-term goals (even though short-term goals might differ across partners).

Within the innovation network, future-focused projects are carried out, with the dual goal to test concepts aligned with the vision and to move towards the vision. These activities are led and supported by a core team. The people in this team are the ones who make the strategic choices, organise meetings between partners, and try to attract new partners. A large part of this team consists of designers employed at Reframing Studio, but there are external members as well, providing for a variety of professional backgrounds and organisations (table 1, next page).

The Redesigning Psychiatry organisation follows the principles of a cooperative organisation, in which hierarchical and bureaucratic relations are instead relations of mutual trust (Redesigning Psychiatry, 2018). The team meets once every two weeks and works from remote locations in between those meetings. None of the team members hold a fulltime occupation at RP. Most of the team can spend time on RP during the workweek, others do it next to their full-time jobs. This does complicate the capacity for creative (team) work, as this can only happen during set timeframes.

### Partners

Redesigning Psychiatry has a network of eleven mental healthcare organisations throughout the Netherlands (figure 20, next page). Some of these partners are among the more innovative organisations in the Netherlands (e.g. GGZ Noord-Holland-Noord and GGZ Eindhoven), others are among the biggest and most influential organisations (e.g. Parnassia Groep and GGZ Eindhoven). Even though reasons for joining RP differ across partners, most reasons are among the lines of finding ways to change the system, from a lack of knowledge on how to. With this partner network, RP is in the unique position of being in close collaboration with the regime<sup>3</sup>, without being part of the regime.

To be part of the network, partners need to pay the RP project team a yearly subscription fee of €15,000 and appoint two ambassadors within their organisation. In return, they receive support in RP-themed

<sup>3</sup> As the regime is a constellation of (in)tangible elements, one can't interact directly with the regime. However, MHCIs are a considerable part of the regime, so it can be said that RP is in close collaboration with the regime.

Team member	Organisation	Specialty
David van den Berg	Parnassia Groep, Vrije Universiteit Amsterdam	Clinical psychologist, academic researcher
Femke de Boer	Reframing Studio	Designer
Matthijs van Dijk	Reframing Studio, TU Delft	Strategist
Kristel de Groot	Social Rebels	Project manager (with design background)
Lotte Jacobse	Reframing Studio	Designer, researcher
Nynke Tromp	TU Delft	Academic researcher, designer
Sander Voerman	Freelance	Philosopher
Beatrijs Voorneman	Reframing Studio	Designer

Table 1: The Redesigning Psychiatry core team



Figure 20: Partners of Redesigning Psychiatry

innovation projects, their employees can participate in events such as the *Summer School* and *Werkateliers* (see paragraph 3.1.3), and they have access to the knowledge generated within the network, i.e. scientific knowledge or knowledge gained in performed innovation projects.

### **Ambassadors**

As stated earlier, each partner organisation has appointed two ambassadors, who are tasked with championing the RP vision within the organisation. The way they go about this exactly differs per ambassador, but in general, it can be said that they try to initiate and support RP-themed innovation projects and to inspire and motivate co-workers. In a three-monthly meeting, the ambassadors exchange gained experiences and knowledge. Some ambassadors are more successful than others, something that can mostly be accounted to the following factors:

- > General innovation-mindedness of the organisation, ergo the receptiveness of the organisation to new ideas;
- > Influence of the ambassador within the organisation;
- > The persuasiveness of the ambassador

### **3.1.3 Activities performed to stimulate transition**

To know what Redesigning Psychiatry can do to stimulate the transition, and what capabilities they need to build, it is important to know what they are *already* doing, and how useful this is. This is outlined in **table 2**.

RP's activities have been mapped on the theoretic framework to judge their coherence and completeness (See map collection). The most important conclusions of this exploration are discussed below.

#### **Alignment between levels**

When looking at the efforts to influence actors on the individual level and the organisational level, it can be seen that these activities are not completely aligned. For example, a lot of the activities focused on individuals have the goal to motivate and call to action, but these efforts are not paralleled in the organisational level, making it harder for the newly gained motivation and action to land in the organisation.

	Rationale	Effect
<b>Projects with partners</b>	To perform projects in small settings, with the aim to start moving towards more RP-themed solutions within the mental healthcare sector, whilst also gaining new insights from these projects, that can be used to adapt the vision and future projects.	As most of these projects have not finished, the effect is still unclear. However, most of these projects have shown what the RP philosophy looks like in concrete projects and applications in practice, which can help in communication with new partners, government and individuals.
<b>Mentaal Lokaal</b> > project with partner	To implement (a version of) the Mentaal Lokaal concept in practice. This was to support a 'grassroots' project, as it was originally an initiative by a mental healthcare professional. The project aims to redesign the portal to the mental healthcare system by improving the available information on mental health.	This project has the potential to relieve pressure on MHCIs, by making people more knowledgeable in mental health, meaning they might need less professional help. The project has not been finished yet, so the actual effect has yet to be defined.
<b>Netwerkgorg</b> > project with partner	'Networked care' is a concept in mental healthcare that has the goal to create an (in) formal network around the client, to continue support when professional care is discontinued. RP is exploring this concept for Parnassia Groep.	This project is not finished yet, making its effect hard to define. However, it has the potential to relieve pressure on MHCIs, as it provides tools for the formation of personal networks that might help with mental support.
<b>Ben Helder</b> > project with partner	Designing mental support for teenagers with a low threshold, with the goals to teach teenagers to deal with setbacks and to stimulate parents or guardians to play an active role in the life of their children. By order of Lister, Brijder Jeugd and Triversum.	The proposal has been positively received, as it is currently being translated into concrete building plans. For this project goes the same as Ben Helder: The potential effect could be that of a 'best-practice' project.
<b>Landgoed Willibrordus</b> > project with partner	Developing a redesign for a long-term mental care estate, at the behest of GGZ Noord-Holland Noord. The redesign is future-focused, being based on future visions of the society of 2030, and the role of long-term mental care in this society (Redesigning Psychiatry, 2018a).	The proposal has been positively received, as it is currently being translated into concrete building plans. For this project the same applies as Ben Helder: The potential effect could be that of a 'best-practice' project.

Table 2: Overview of RP activities



	Rationale	Effect
<b>Redesigning Psychiatry</b> <b>“Beweging”</b>	<p>Creating a movement of (individual) practitioners passionate about the Redesigning Psychiatry philosophy.</p>	<p>RP events are generally well-visited, and participants leave the events inspired. However, truly creating movement has proven difficult, as people in the movement have trouble applying the RP philosophy in their daily work.</p>
<b>Werkatelier (XXL)</b> > RP “beweging”	<p>A day or half-day workshop, with the goal to inspire and educate people on the RP philosophy, and to apply their newly found knowledge on a design problem.</p>	<p>The Werkateliers are well-visited, and participants leave the events inspired. However, participants do have trouble applying the RP philosophy in their daily work, even after attending.</p>
<b>Summer school</b> > RP “beweging”	<p>An intensive two-day crash course in the RP philosophy, creating new RP experts can promote the philosophy within their professional network. Next to that, the goal is to educate them on value-driven innovation within mental healthcare, so that MHCIs can get more innovation-focused.</p>	<p>Because the summer school goes in-depth, it can move beyond just inspiring people, and give people actionable cues to start working with the philosophy.</p>
<b>Conference presentations</b> > RP “beweging”	<p>Increasing RP’s recognition within the mental healthcare sector, possibly attracting new partners and inspiring practitioners in general.</p>	<p>Reactions to these presentations are often positive, but the actual influence it has is hard to measure.</p>
<b>VPRO Tegenlicht</b>	<p>RP had the chance to be featured in a VPRO Tegenlicht episode (a Dutch documentary series). The series is quite well-watched, so the aim here is to increase recognition.</p>	<p>Since the episode aired, RP has received a lot of emails from people wanting to join the movement or people who have ideas to change the sector and are looking for a partner. In this way, it can be considered a success, as it has increased the possibilities to support grassroots efforts and create a network. However, it has not stirred a public conversation, which was hoped for.</p>
<b>Scientific research projects</b>	<p>Ensuring a strong, scientifically tested foundation for the RP philosophy, that can also inform adaptations in the vision.</p>	<p>The effect is not yet clear, as these projects are still in the beginning stage.</p>

### Efficacy of projects in the organisational level

The projects at the organisational level are mostly 'pilot-like' projects, trying to further develop RP-concepts into a proposition for the current mental healthcare system. This is not necessarily a bad thing, as it does resemble the transition experiments discussed in **paragraph 2.2.1**, and they do have the potential to be scaled up. However, the collection of projects is currently still performed in quite an 'ad hoc' manner, lacking the strategic backbone that is required to achieve lasting system change.

### Distribution over levels

When looking at the map (see **map collection**), there seems to be an even spread of activities over the different levels. Efforts on the individual level are quite saturated, so there's no need for more activities in that area. Even though there is an evenly spread, I would argue that more activities need to be targeted at the organisational and landscape layers, as these are the layers where *systemic* change takes place. For example, there are little movements to influence other players in the system, such as health insurers, schools, or government.

### 3.1.4 Entering a new phase

As the year 2019 drew to an end, the yearly subscription fee became a topic for discussion at a lot of the MHCI partners. They looked critically at what the subscription had brought them over the past year, and whether it had brought the change they had hoped to see.

In the first stages of the project (vision-forming), RP was being paid to generate knowledge on the topic, knowledge the MHCIs could benefit from to change the problems they were facing. Around the time when the project went from vision-forming to achieving the vision, the subscription fee was brought to life for financial continuity. This subscription fee was a two-end deal, partners had to invest time and attention to reach the vision as well. In most cases, on the question whether supporting RP had brought about change, this end of the deal did not seem to be considered in the answer, and a few partners decided to drop out of the subscription. However, achieving change within the organisation is not something RP can achieve alone for several reasons. Firstly, MHCIs are complex to such a degree, that it wouldn't be possible to achieve change within the organisation with a small, external, team, whose expertise does not lie

in organisation change. Secondly, the organisation itself needs to invest time and attention to the case as well, if anything will ever change.

Nonetheless, this experience did spur RP to rethink its layout and financial system. One could say that Redesigning Psychiatry is changing from a so-called start-up to a mature organisation, which comes with challenges of scaling-up and establishing as well.

### **Layout**

Ultimately, after consideration, RP's main activities remained the same. A design studio to perform projects for partners that may help in achieving the vision, as well as function as learning experiences; A knowledge network for building collective knowledge, and the RP academy for schooling people in the RP philosophy and value-driven innovation

### **Financial system**

Next to having subscription-based arrangements with the existing partners, Redesigning Psychiatry now also offers to perform loose projects or participation in educational events to non-subscribers, for a higher fee. The advantage of this system is that partners who have dropped out of subscription can still participate, but with a lower threshold. Also, it makes it easier to collaborate with non-mental healthcare partners, like schools, health insurers, and local efforts, that don't have the resources (or the will) to pay an annual subscription fee.

### 3.1.5 In summary

#### Strengths

- > Idealism; enthusing individuals
- > Holistic vision
- > Abstract thinking
- > Thinking outside of problems of the day (i.e. symptomatic problems)
- > Collaboration
- > Design projects

#### Weaknesses and challenges

- > Turning enthusiasm into activity
- > Implementation and concrete actions
- > Strategic ability
- > Organisational layout
- > Expectation management about realistic outcomes and timeframes
- > Political activities

#### Takeaways for project

- > For the most part, RP is on the right path, as they are doing well in terms of igniting individuals and performing innovation projects
- > However, challenges arise in implementation or systemic change activities. The reasons for this are the lack of a clear structure or strategic backbone. This is something my project could deliver.
- > For some of the challenges RP is facing, the power to overcome them does not lie in their hands, for example its organisational layout. For my project, this means that I have to work around these challenges, rather than address them head-on. Making use of RP's strengths, in this case, is desirable.



## context analysis / 3.2

# an overview of the mental healthcare system

For a better overview of the system, this chapter holds a system map and a short explanation of each of the actors' roles, interests and level of influence, based on the contextual research discussed in the next chapters. Page 71 in this report shows said system map, the map collection holds a bigger version of the same map.

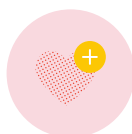


### Redesigning Psychiatry

**Role** Rethinking and reframing mental healthcare, disturbing the status quo.

**Interests** Finding ways to achieve their vision and finding ways to change the system in general.

**Influence** Has contracts with several influential GGZ institutions but is still heavily reliant on their willingness to continue the collaboration and continue to pay, as it is their primary source of income. With the right strategy, RP can be very influential.



### Mental healthcare institutions

**Role** To provide basic and specialised mental healthcare to those who need it.

**Interests** Help the client as good as possible, within a reasonable amount of resources.

**Influence** GGZ institutions have a big influence on the way clients are treated in their facilities, within the limits of organisational capability. However, it is also very dependent on health insurance companies; as payers of the care, they have a big say in price, quality, and money spent on innovation.



### Health insurance companies

**Role** Controlling the quality and effectiveness of healthcare, buying healthcare for their customers at care institutions.

**Interests** To find a good balance between quality of care and lowering the price of care, so that premiums paid by customers can be as low as possible.

**Influence** Health insurance companies are in a powerful position, as they have a strong case to negotiate prices. Nonetheless, their power is not absolute, as clients have free choice in their care provider.



### Government

**Role** Provide the system with a legal structure, control overall system performance or delegate the control of the system.

**Influence** Very large, can impose top-down system changes, even though this doesn't automatically mean that these changes will happen, or that they will happen smoothly.



### Scientific field

**Role** To study, propose and review new and existing approaches to psychology and psychiatry.

**Influence** The scientific field has a large (indirect) influence, as the standard in the system is that new approaches need to undergo extensive scientific testing before they can be used on a large scale. This slows down processes of innovation within the sector. As a result, this role is decreasing in importance as MHCIs are looking for ways to speed up innovation. (paragraph 3.3.4)

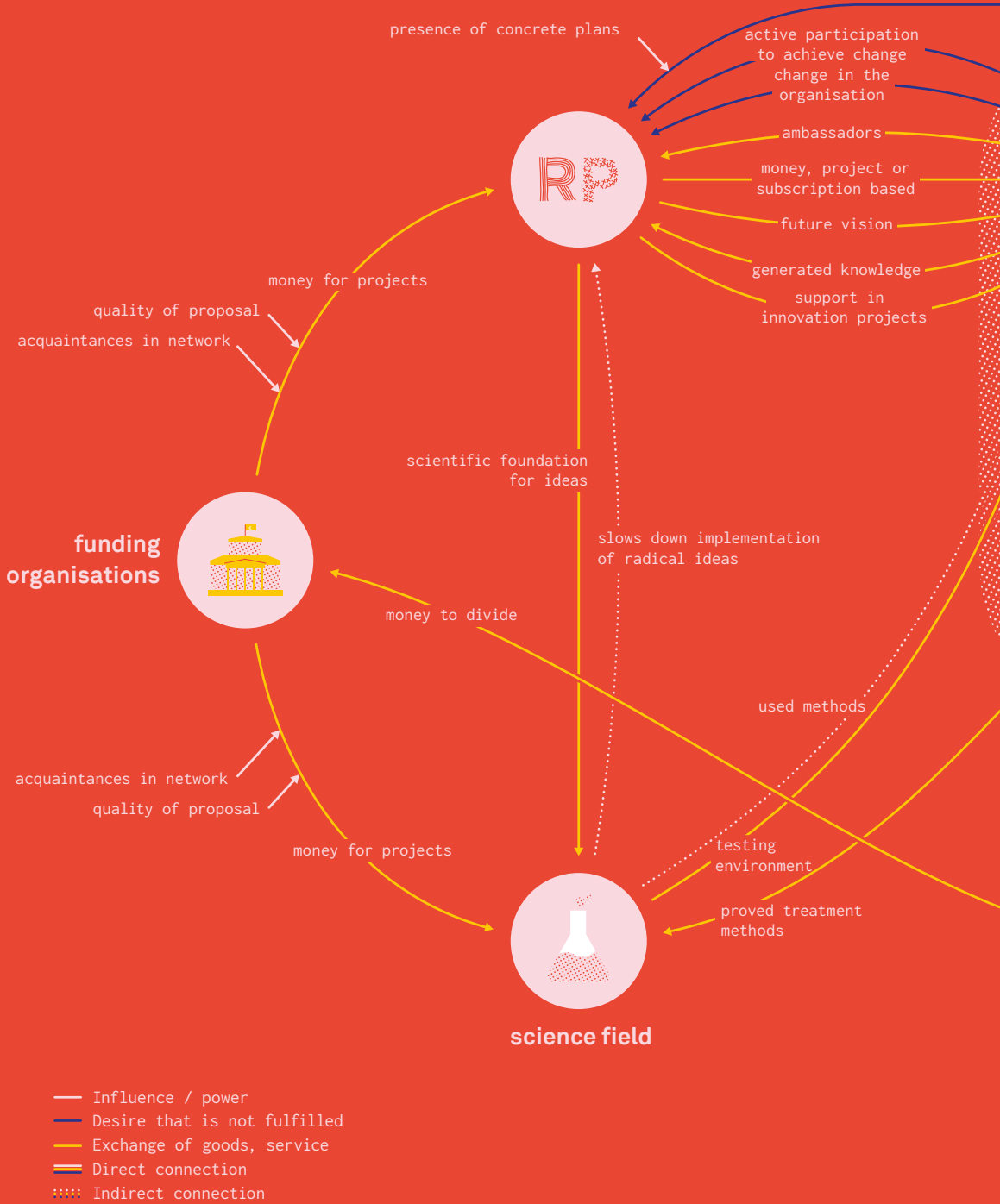
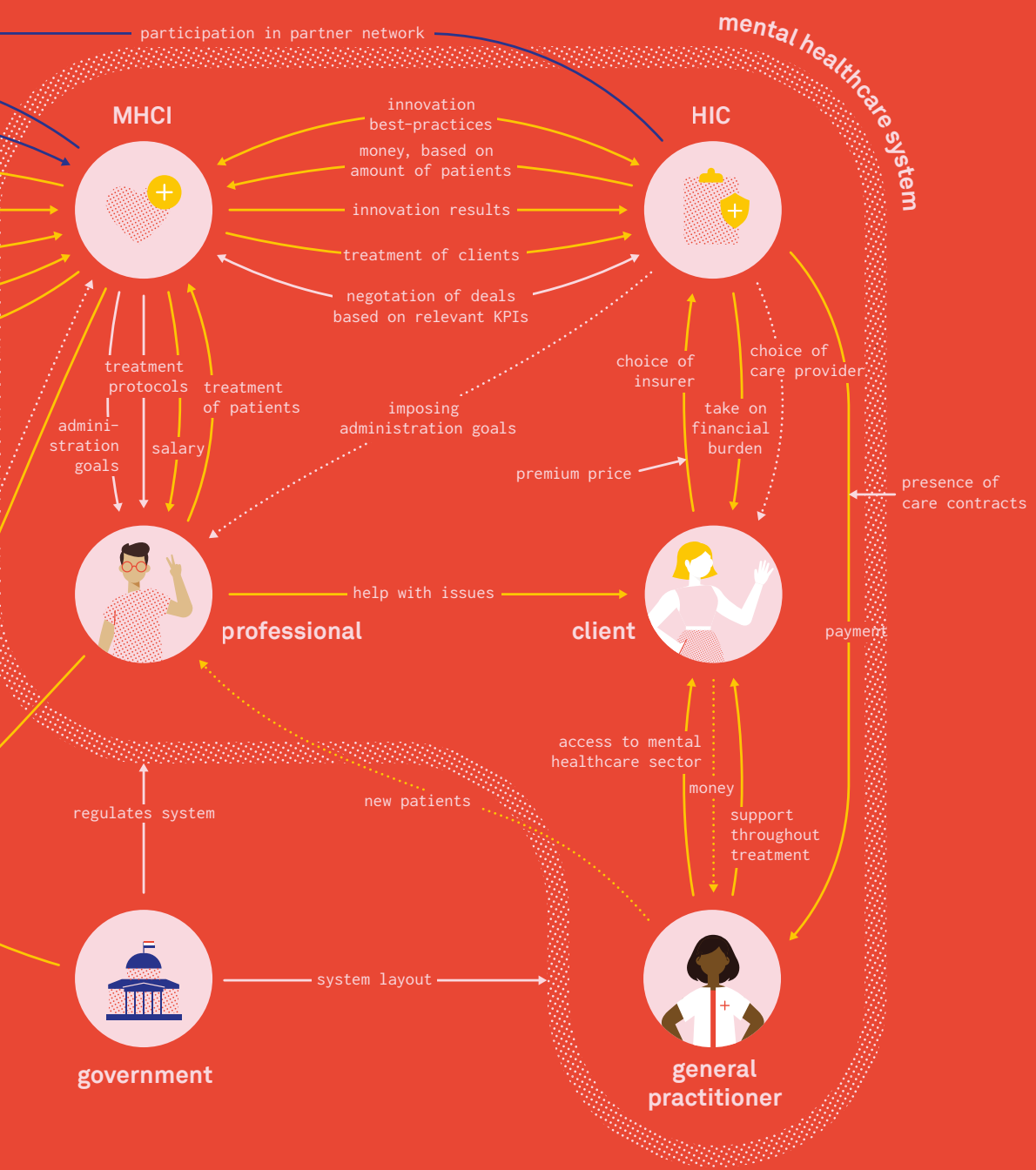


Figure 21: System map for the mental healthcare sector







### Client

**Role** Primary user of the mental healthcare system.

**Interests** To be helped properly and in a straight-forward fashion, without having to switch between caregivers.

**Influence** The power is in their number; as a group very influential, as individuals not at all.



### General practitioner

**Role** To judge clients coming in for mental care and refer them to basic or specialistic mental healthcare. Also, to treat mild cases themselves, supported by psychologists.

**Interests** Help the client as good as possible within their own capabilities, if necessary, refer the client to the right department within MHCIs.

**Influence** The power is in their number; as a group very influential, as individuals less so.



### Professional (within MHC)

**Role** To help and support clients with their mental issues, guided by their organisation's treatment protocols.

**Interests** Generally, to help clients as good as possible. Money or time are often matters that the professionals don't *want* to think about, but have to take into account because of organisation requirements.

**Influence** The power is in their number; as a group very influential, as individuals less so.

> For more elaborate statements, see appendix 4

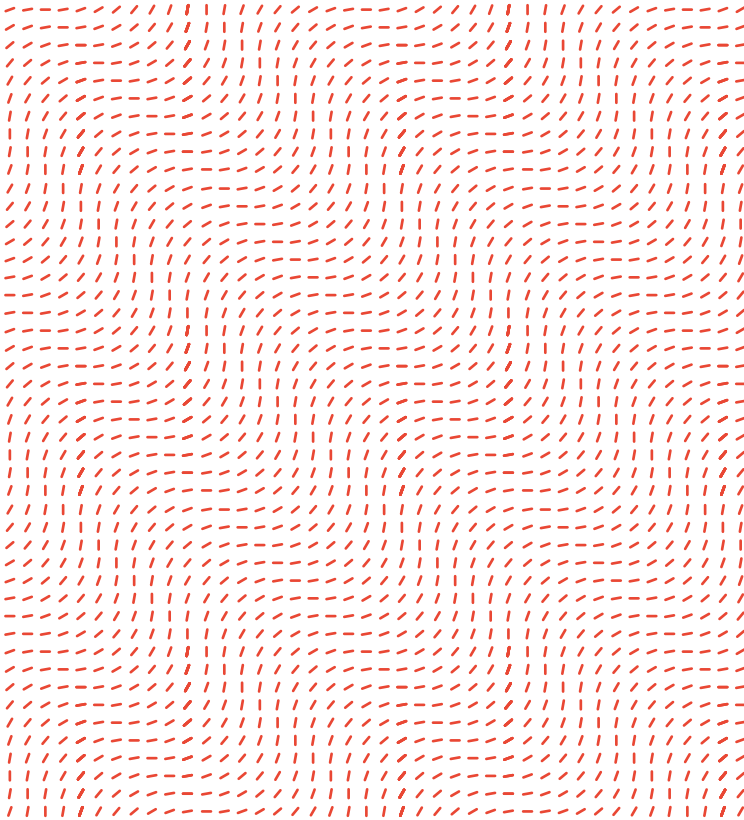


### Funding organisations

**Role** To aid and stimulate scientific and practical research through funding.

**Interests** To provide funding to (small) organisations, grassroots efforts or individual projects, based on set development goals. These goals are informed by, for example, (inter)national development goals or trend research.

**Influence** Funding organisations are quite influential, as they have a big say in which projects or initiatives can get developed, and which can't.



## context analysis / 3.3

# change and innovation in the mental healthcare sector

This chapter gives an overview of the clusters found in the context research and unites them in major themes. As a whole, the themes and clusters describe barriers or accelerators to change. A detailed study of the themes is outlined in chapter 3.4.

### 3.3.1 Challenges to change in a locked-in system

The mental healthcare system shows several system constructs that are self-sustaining, and as a result hinder change. Examples found in this research are the DSM classification system and the financial structures in the system. These blockades are caused *and* influenced by multiple nodes and relations, making cross-system collaboration very important to transcend them. However, a lot of the innovation projects within the field are stand-alone projects, happening in parallel.

#### A self-sustaining paradigm

When looking at the mental healthcare system, a lot of its components are built upon DSM-classifications. For example, it informs MHCI's organisation structure, HCIs' financial structure, etcetera. In a lot of occasions, this has the result that it is easier to keep using DSM, than it is to use an alternative. This is a self-sustaining pattern.

#### Tension between financial incentives and qualitative care

When looking at the relationship between health insurance companies, and mental healthcare institutions, some conflicting influencing factors come up. It is the HIC's responsibility to deliver care to its customers that is both qualitatively good and cost effective. These factors are conflicting, because it is very complex to measure quality of mental healthcare, and inflation combined with a lack of automation cause care prices to rise steadily.

#### Scattered innovation attempts

Throughout the entire mental healthcare sector, organisations and

individuals alike are attempting to solve (symptomatic) problems of the system by initiating innovation projects. However, it is rare that these entities find each other in their innovation efforts.

### **3.3.2 Overall inertia of mental healthcare organisations**

This theme portrays organisational inertia, and how this is manifested in the mental healthcare system. It specifically zooms in on how different scale levels play a role, both in terms of how they influence inertia, and how they are influenced by inertia.

#### **Organisational inertia**

This cluster is about how change always is a little slower within organisations, and especially within rigid organisations such as MHCIs. This is because there are a lot of people who need to go with the change, get on the same page, but also because the organisational structure and regulation can hinder the emergence of new behaviour.

#### **Personal willingness vs. personal resistance**

Within the mental healthcare sector, you can observe a spectrum of different kinds of people. On one end, there's the people who are proactive in trying to change aspects of the system they feel are not right (albeit in small-scaled efforts). On the other end, one can find the people who resist change in the system, either because they might have spent their entire career supporting opposing ideas, or because they don't trust these new propositions.

#### **The gap between organisational intent and the people on the floor**

Sometimes, the change that is needed within an organisation or within a system, is one that needs a specific kind of people, who may not always be present within the organisation. As an example, the shift to thinking about mental health in patterns, will need people who are both alpha and beta oriented, whereas most psychologists are alpha oriented. Another example is whether MHCIs have the right people in their organisation to successfully implement innovation projects.

#### **Organisational pressure undermines innovation**

MHCIs and its employees are under a lot of pressure at this moment, imposed on them by for example society, government, and health

insurance companies. When an organisation is under pressure, it is challenging to adjust to mistakes in the system, and even more complicated to find the resources and energy for innovation or lasting improvements.

### **3.3.3 The balance between scientific and intuitive efforts for change**

This theme is about the dynamics of scientific, organisational, and intuitive change movements. On the one hand, a lot of change in the mental healthcare sector is dictated by developments in the scientific field; radical ideas are evened out, and new propositions cannot be implemented until they are properly tested. On the other, several movements can be spotted in the field, in which a more intuitive decision-making process seems to take place.

#### **The delaying yet enabling influence of science**

The scientific field is on the one hand an enabler; it can make sure you can test and verify your ideas. But at the same time, radical or visionary ideas tend to be faded out when it has gone through the scientific mill, as a result, delaying opportunities for change.

#### **A step in the right direction**

Slowly and steadily, the mental healthcare sector is gaining knowledge in thinking in patterns and involving environmental factors. For example, people naturally have the tendency to talk in patterns, which might make the shift to this perspective natural.

### **3.3.4 Growing public interest in mental healthcare**

The growing interest in mental healthcare is both something that can be enabling and blocking change in the system. On the one hand, public interest may increase governmental interest in the sector, allowing for an increase in funds. On the other, a focus on incidents within institutions often reverts the organisation's mindset from innovative to controlling and regulating. Moreover, it can preserve the presence of stigmas within society.



## context analysis / 3.4

# stripping and structuring insights

Chapter 3.3 has given a short overview of the major themes influencing change in the mental healthcare sector. In this paragraph, we will take a closer look at what these themes entail, and study them from a system's perspective by laying them over the theoretical framework.

Analysing the themes with help of the theoretic framework provided a more nuanced view of what is influencing change in the mental healthcare sector. For that reason, some of the clusters discussed in the previous chapter have been split up. All of the themes and clusters have been mapped on the theoretic framework. Overall maps per theme can be found in the map collection, separate maps per cluster can be found in this chapter.

### 3.4.1 Challenges to change in a locked-in system

**Stuck between a financial reward system and an aim for qualitative care > figure 22**

In 2006, the Dutch healthcare system has been reformed to one based on market mechanism principles, in which health insurance companies (HICs) are the ones responsible for buying qualitative and well-priced care. The idea behind this is that HICs can act as intermediates because they can carry the financial burden, have buying power, and it is in their interest to have cost-effective care (Schut, 2018a). With that, they have a primary role in the healthcare system.

Because of this primary role, the expectation of both clients and government is that a HIC is in the right position to negotiate qualitative and cost-effective care, and thus, should deliver on that. This is something the health insurer still needs to grow in, in all kinds of care (Varkevisser, 2018). However, in mental healthcare, growing in this respect is more of a challenge. Up to this day, there are little measurement tools available to measure the quality of mental



healthcare, and quality indicators that *really* provide insight in the quality of care are scarce as well (Interview with director of a mental healthcare institution, 2019). Hence, improving quality of care is very challenging in mental healthcare.

“Health insurers are also looking for improvements. The costs of care are rising, so how can we put a stop to that? Of course, they need to buy good care for their clients, but they also need to make sure that the premiums don’t rise too fast” – Director of a mental healthcare organisation

Regardless of the financial pressure health insurers are under, and the difficulty of measuring qualitative care, they are open to trying to improve care. Unfortunately, this openness often disappears when the end of the year nears, and negotiations about care purchase start. At that point, targets generally revert to financial incentives, as clients choose their health insurance, there is an indirect pressure on HICs to maintain a low healthcare premium.

When looking at this phenomenon through the lens of the theoretical framework (figure 22, next page), it can be said that tension between quality and price is blocking optimal development or innovation, resulting in stunted improvement efforts.

#### A self-sustaining paradigm > figure 23

The mental healthcare system in the Netherlands is built around DSM, which divides mental health into disorders and symptoms. DSM is a theoretical psychologic concept, that people have started seeing as real (Glas, 2019; Goekoop, 2019), however, this doesn’t mean that it is.

“The reliability and validity of some DSM-categories is about as high as those of a unicorn; everyone knows what a unicorn is, but that doesn’t mean it’s real.” – Rutger Goekoop, academic expert in patterns in mental healthcare

DSM gives different collections of symptoms a specific name, but the collections that have been made are faulty. That’s why it is very difficult to give someone a ‘correct’ diagnosis, or why someone might receive

Figure 22: Money or quality?

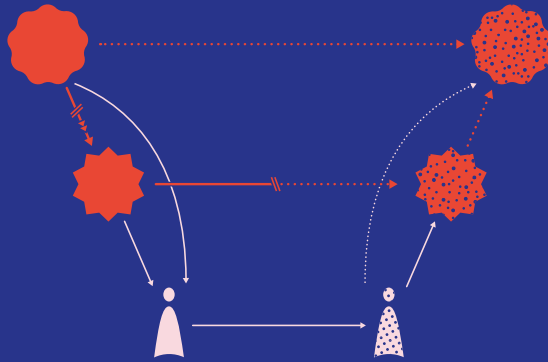


Figure 23: A self-sustaining paradigm

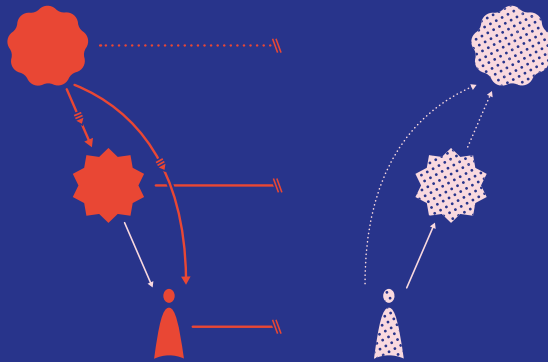
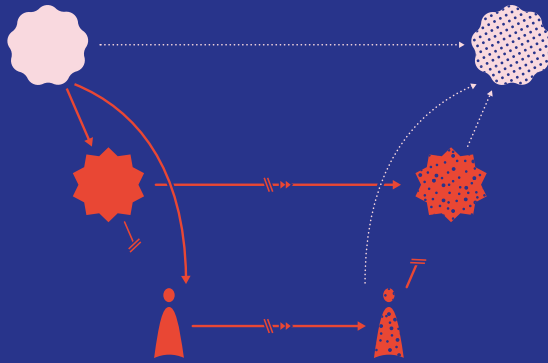


Figure 24: Absence of communication between layers



☀ Result  
☀ Suboptimal result  
⋯ Hindered / indirect movement

|| Blocker  
▶▶ Enabler  
||▶▶ Delayer / neutral

more than just one diagnosis (Goekoop, 2019). Patients often undergo multiple treatments, for different diagnoses, because each diagnosis does not completely cover the issue (Glas, 2019).

Regardless of the inaccuracy of DSM, the mental healthcare system is still built on its premise. This might be because dividing the system into DSM-categories does come with a few advantages; it enables the development of expert knowledge in both MHCIs and the scientific field. At the same time, this division blocks the holistic thinking that can enable the transcendence of DSM (Glas, 2019). Moreover, the mental medication system is built on the DSM system as well. Medication often has labels like 'antidepressant', even though they could have a lot more functions than just battling depression. This too stimulates the use of DSM over alternatives (Goekoop, 2019).

From the perspective of the framework (figure 23), the DSM paradigm is present as a blocking force in each of the layers, as the very presence of DSM in the system structures overpowers the introduction of alternative paradigms.

#### **Absence of communication between layers > figure 24**

On both the organisational level and the individual level, there is inspiration and motivation to change, ignited by, among other factors, the system conditions mentioned above. At the organisational level, this can be deduced from the numerous attempts to solve problems like large waiting lists and shortage of personnel. On the individual level, the RP philosophy is received with great enthusiasm, indicating a willingness from professionals to change their way of working, even if they don't know how to. There are even examples of individuals already trying to change their daily practice by initiating small or local innovation projects to solve the problems they are facing.

However, these different layers do not find each other in their efforts. Individuals are not taken along in organisational innovation goals, because the organisation does not know the motivation of individuals. In addition, it is hard for individual projects to find mandate within their organisations, as the innovation goals are not aligned. As a result, both efforts for change turn out less effective than they could have been.

**Absence of collaboration between organisations > figure 25**

Similar to the situation described above, motivation to address system problems can be found throughout the sector, in this case in MHCl and HICs alike.

“The HICs we are talking with are also really looking for improvement and innovation. This could be through digital solutions, but they are open to new kind of solutions as well, like the ‘mental strength in the neighbourhood’ project I was talking about earlier” – Director of a mental healthcare organisation

MHCl and HICs make deals to this end, in which it often concerns long-term plans that have the ultimate goal to decrease costs. This does come with a catch though. The way HICs fund innovation within MHCl is by letting them spend the money they save per patient, on innovation. Hence, if no money is saved, there is no money for innovation, which closer resembles an investment plan than a collaboration. During negotiations for these plans, HICs do exchange best-practices, which in itself is a good thing. Yet, the differences in context are not always taken into account, resulting in criticism instead of advice, and a lack of understanding between parties (Interview with director of a mental healthcare institution, 2019).

Concludingly, even though the parties are willing, there is still room for improvement in the collaboration between the most important players in the mental healthcare sector. Cross-system collaboration is necessary to solve system problems, but the current collaboration leads to sub-optimal results (figure 25).

**3.4.2 Overall inertia of mental healthcare organisations****Internal pressure as a barrier to institutional learning > figure 26**

When studying the conditions inside MHCl, it can be seen that there is a lot of internal pressure at both the organisational and individual level. On the organisational level, a shortage of personnel results in a shortage of patients, which in turn results in a shortage of money. Furthermore, the organisations are held up to high standards by HICs to have a sense of quality control. On top of that, most MHCl don't have an innovation structure in place (this was something RP discovered this year).

Figure 25: Absence of collaboration between organisations

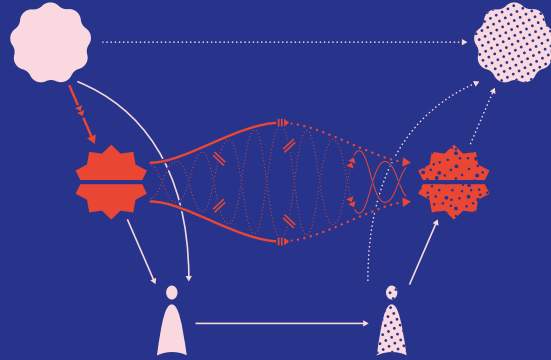


Figure 26: Internal pressure as a barrier to institutional learning

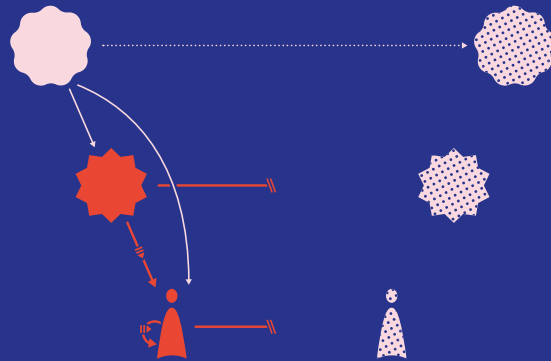
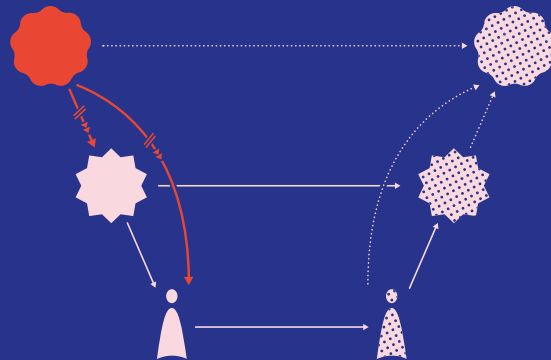


Figure 27: Increasing external pressure on MHCIs



● Result  
★ Suboptimal result  
⋯ Hindered / indirect movement

// Blocker  
▶▶ Enabler  
▶▶▶ Delayer / neutral

“If we don’t meet the [health insurers’] requirements, we [the MHCI] just don’t get paid.” – Psychologist

On the individual level professionals experience constant pressure, which is caused partly by the organisational pressure experienced above, and partly by internal and external high standards (figure 26)(end-user research, see appendix 4).

[About wanting to change anything in daily work] “I’m not sure if I would do anything differently, but I would like to take the pressure away. Now, it’s always in the back of my head; that I can’t take too long with my treatment” – Psychologist at a MHCI

An organisation under pressure strains possibilities to improve or innovation current activities; there is no time to adjust when errors in (prior) judgment occur, and there are even fewer resources to truly innovate (case study youth MHCIs, see appendix 2). This is in line with the findings of Head on addressing wicked problems: “Institutional learning, addressing the long-term causes of the problems, tends to occur – if at all – only when the immediate pressures have been alleviated” (Head, 2008, p. 114). As such, MHCIs are not yet fit to go through a transition of this magnitude. Complex systems are unpredictable, so going through a system’s transition will need both allocation of resources and enough space to react and reflect on unexpected situations. Both are challenges for MHCIs at the moment.

### Increasing external pressure on MHCIs > figure 27

Next to experiencing internal pressure, external pressure on MHCIs (and mental healthcare in general) is increasing (figure 27, previous page). Just taking one look at the 90.000 people on a waiting list for mental care explains a great deal, but other factors are contributing to external pressure as well.

As welfare in the Netherlands grows, the demand for care too shows an increase, both in terms of quality and quantity (Varkevisser, 2018). Next to that, healthcare is increasingly perceived as a ‘right’, rather than a service that can have a commercial value (Schut, 2018b), even though the

healthcare system is built on market mechanism principles. So, demand is rising, but the capacity of MHCIs is not necessarily growing with it.

Another factor contributing to the external pressure is the healthcare sector's long history with cost reduction efforts (Varkevisser, 2018; Schut, 2018b). As opposed to many other industries, the healthcare sector provides services that are hard to automate, while the inflation of wages does continue, meaning that the total costs rise as well (Baumol, 2012). This makes the demand for lower costs hard to meet.

An outcome of the evaluation of the results (paragraph 5.2), is that this external pressure doesn't seem to be something individuals in MHCIs care for. If anything, external pressure can have the contrasting effect that it evokes resistance in individuals.

#### Amplifying effect of personal resistance and personal willingness > figure 28

Within the MHCIs, a spectrum of people can be observed, who portray different levels of motivation and openness to change. On the one end, there are the people who are intrinsically motivated to change their personal work or the faults they encounter in the system. If you place these people on the framework, both their individual situation and capability for action align. On the other end, there are the people who resist change in the system; their (negative) personal interpretation of the situation blocks any subsequent action (figure 28, next page). This spectrum of personal resistance and personal willingness is similar to the Bell curve principle, which means that the majority of MHCi employees are in the middle section (Interview with director of a mental healthcare institution, 2019). These people are not necessarily *against* change but won't initiate it. Or, they might want to change, but don't know how to initiate it.

There are a lot of (personal) reasons why people might oppose to change; they might be afraid to lose their jobs, have built their career on an entirely different idea, have put a lot of effort into doing it the way it is currently done, or just don't have the mind space to address change due to pressure in daily work. It is also possible that people don't trust the change. For example, even though a new technology or innovation

is safer or better, it doesn't necessarily feel that way for practitioners and patients. With the result that new solutions are not being used in practice (Goekoop, 2019; Interview with director of a mental healthcare institution, 2019) (end-user research, see appendix 4).

Part of what organisational inertia means, is that all these possibilities for resistance or willingness accumulate in the organisation. If the balance tips over, people who are normally on the fence might be influenced as well. A positive example of this is that being in an educative institution opens up people to change as well (end-user research, see appendix 4).

#### The dilemma between freedom and regulation > figure 29

Linked to this distribution of personal resistance and personal willingness, is the quality of the people working in the organisation. Not all people in the organisation operate at the same level or necessarily do their best; some professionals treat patients very superficially (Glas, 2019). This kind of person is part of the reason why treatment protocols are important in mental healthcare: they ensure a certain level of quality in a sector where quality is hard to measure. This does, however, come with a disadvantage. Empowering employees—which is achieved through providing autonomy, a sense of belonging, and a feeling of effectiveness (Haxeltine, et al., 2017)—is strongly related to intrinsic motivation and personal improvement (Zhang & Bartol, 2010). By having strict treatment protocols, this empowerment can be taken away. Furthermore, a bureaucratic organisation such as this one discourages creative expression (Hirst, Van Knippenberg, Chen, & Sacramento, 2011).

Moreover, these protocolled and regulated ways of working slow down change in the organisation, as protocols and regulations need to be adapted (figure 29). That brings us to the following dilemma: how to find the right balance between protocolled, controlled ways of working, and having enough freedom so that change is not hard to achieve for organisation members?

#### Having the right people in the organisation to achieve goals > figure 30

Sometimes, the change that is needed within an organisation or a system, is one that needs a specific kind of people, who may not always be present within the organisation.



Figure 28: Personal resistance and personal willingness

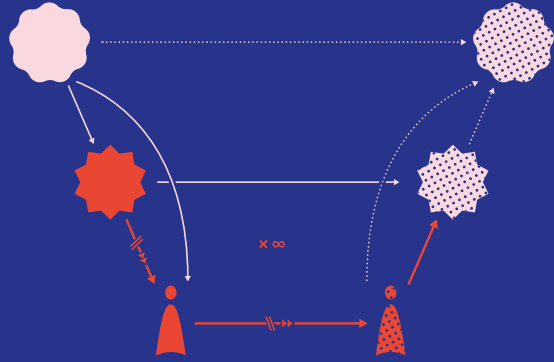
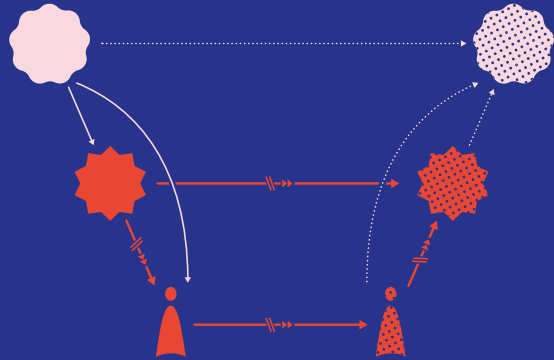


Figure 29: Dilemma between freedom and regulation



- Result
- Suboptimal result
- ⋯ Hindered / indirect movement

- Blocker //
- Enabler >>
- Delayer / neutral >>>

“We always get excited about doing new things. Finishing what you started—actually making sure an idea is implemented—is sometimes less spectacular. I think that requires a different kind of energy, maybe even a different kind of people. It’s not really in our culture to finish it.” – Director of a mental healthcare organisation

Another illustration of this is the affinity (or the lack thereof) of organisation members with certain subjects. Ecology plays a big role in the RP philosophy, so existing knowledge from ecology and adjacent fields can be adapted to the mental healthcare field as well. However, the people working in these fields are very different.

“There’s already a lot of (beta) people working in meteorology, who like this way of (i.e. network) thinking and are good at it. The psychologists and psychiatrists that are working in the field at the present-day have not entered this profession because they like working with computers; they’ve entered because they like working with people. And then you arrive at the classical divide between alpha and beta. These people can really learn a lot from each other.” – Rutger Goekoop, academic expert in patterns in mental healthcare

So, the skills and interests that are needed to look at mental problems from a network perspective might not naturally be present in psychiatrists and psychologists. Alternatively, this can be viewed from the other side as well; it is not about having the wrong people, but about having the wrong capabilities in the organisation, and an inability to attract these capabilities. In both cases, however, gaining these capabilities takes time, and can slow down change in the organisation.

### **3.4.3 Balance between scientific and intuitive efforts for change** **Stabilising effect of science > figure 31**

The scientific field is, on the one hand, an enabler; it can make sure you can test and verify your ideas. But at the same time, radical or visionary ideas tend to be faded out when it has gone through the scientific mill, as a result, delaying opportunities for change (figure 31).

Figure 30: Having the right people in the organisation

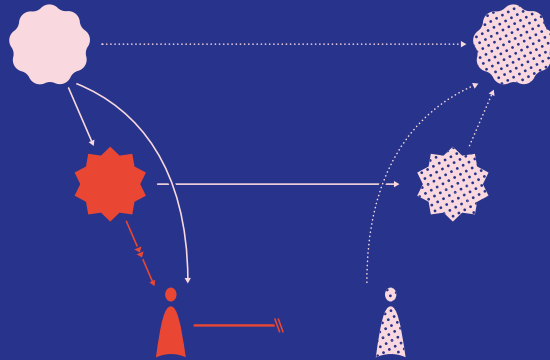
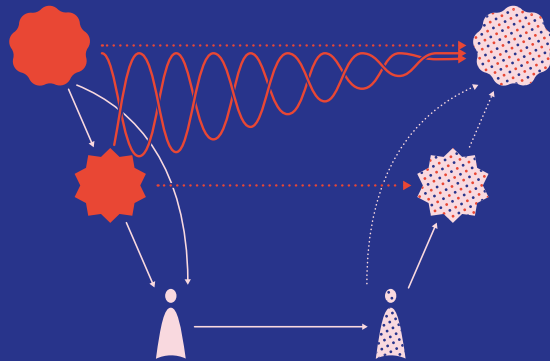


Figure 31: Stabilising effect of science



- Result
- Suboptimal result
- ⋯ Hindered / indirect movement

- ⋈ Blocker
- ▶ Enabler
- ▬ Delayer / neutral

“The 90s was ‘the decade of the brain’. The statements made about that were quite extreme; psychiatry was going to look completely different in 2000, 2010. In reality, in spite of the enormous increase in neuroscientific knowledge, there are only a few new treatments and these have only marginally improved psychiatric treatments.” – Gerrit Glas, professor of Philosophy in Neuroscience and psychiatrist

“I think the scientific field was a lock-in as well. It used to be that people would always ask for scientific evidence. Not because it was necessary, but because it was possible. This is slowly changing, now people just *do*; what works, works.” – Board member of a mental healthcare organisation

#### Practical vs. scientific experiments > figure 32

The transition experiments that are mentioned in **paragraph 2.2.1**, are *practical*, specifically not *scientific*, experiments. This causes a slight tension; you do not have the same freedom to experiment as you do in some socio-technical contexts, and the risk of failure has to be smaller. Some organisational elements need to be informed by science, like treatment protocols. However, there are areas within the mental healthcare sector that don't need this scientific backing (e.g. organisational layout) but show the same inert change patterns. The challenge is to do scientific experiments where necessary, but practical, quicker experiments where possible, like in the following example:

“We now visit people with long-term mental issues at their home, instead of having them come to us. We are working on expanding that so that we can enter the social context even more.” – Director of a mental healthcare organisation

#### Natural inclination takes precedence > figure 33

Slowly and steadily, the mental healthcare sector is gaining knowledge in thinking in patterns and involving environmental factors. More practitioners are starting to have conversations with people in the patient's environment, to understand the problem from multiple perspectives, and to try to change the patient's context (Glas, 2019). For example, people naturally tend to talk in patterns, which might make the shift to this perspective natural.

Figure 32: Practical vs. scientific experiments

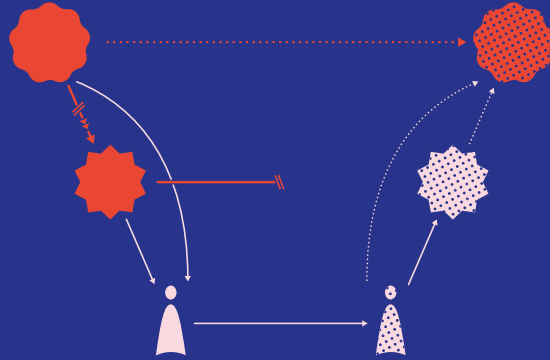
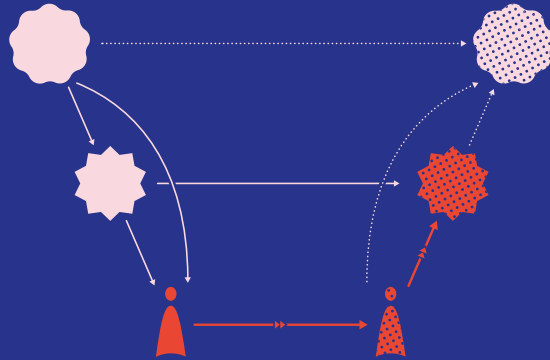


Figure 33: Natural inclination takes precedence



● Result  
● Suboptimal result  
⋯ Hindered / indirect movement

\\ Blocker  
▶ Enabler  
▶▶ Delayer / neutral

“When you really sit down with and listen to clients, and let go of DSM for a moment, you’ll see that they already talk in interaction patterns.” – Rutger Goekoop, academic expert in patterns in mental healthcare

### **3.4.4 Growing public interest in mental healthcare**

#### **Enabling effect of public interest > figure 34**

The growing interest in mental healthcare is something that can have an enabling effect on the mental healthcare system. Acceptance and recognition of the problems at play in the system can lead to an understanding that change—and space for change—is needed. This, in turn, can lead to an increase in funding possibilities; governmental attention and thus additional resources; and an increase of motivation under organisation members as their problems are acknowledged.

#### **Blocking effect of public interest > figure 35**

The enabling effect of public interest does, however, come with disabling effects as well. For example, incidents like the one with Anne Faber cause a strong increase in media attention for the performance of mental healthcare institutions. These kinds of events often cause a shift from innovation and improvement, to control and regulation (*Interview with the director of a mental healthcare institution, 2019*). What’s more, the scrutiny of the public eye can create a feeling of public distrust, in turn resulting in demotivation among organisation members.

Another aspect of the blocking effect of public interest is the way it can influence the stigmatisation of mental health in society. Negative representation of extreme cases in the media can cause polarisation of how mental health viewed; the nuance of mental health and the distribution of it over society is gets lost. In an evaluation of this theme, it became clear that some of the effects labeled as positive above, can have a negative effect as well.

“Honestly, I think I see a stronger negative effect than a positive effect. Public interest generally leads to less money, rather than more money.” – Board member of a mental healthcare institution

Figure 34: Enabling effect of public interest

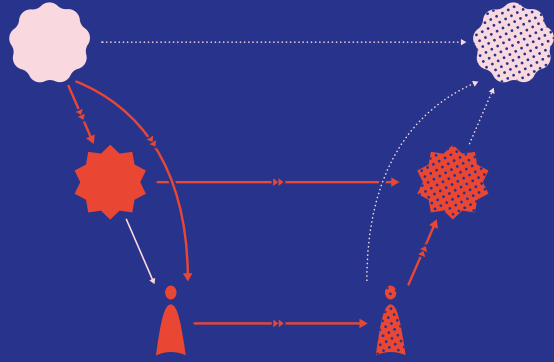
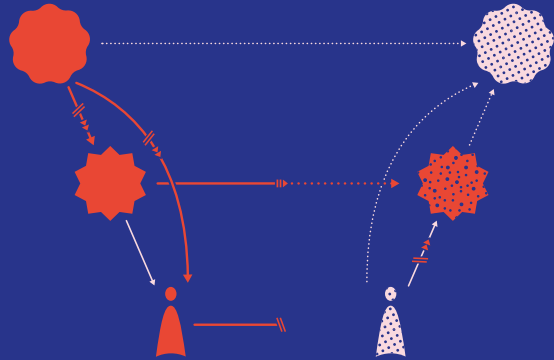


Figure 35: Blocking effect of public interest



● Result  
● Suboptimal result  
⋯ Hindered / indirect movement

|| Blocker  
▶▶ Enabler  
▶▶▶ Delayer / neutral

/ intermezzo

## design choice

an ad-hoc test of the framework  
required a moment for reflection on  
the focus point of this project.

this reflection is discussed in this  
intermezzo.





/ intermezzo

## design choice: a focus point for the strategic repertoire

Based on a first test with the target group, it became clear that the framework on its own did not inform strategy or provide insights to a satisfactory extent. In this chapter, new focus points for the framework and a corresponding strategic repertoire are explored.

Partly, the disappointing outcome was to blame on the test setup (**test setup and results in appendix 6**), which aimed to test the different functions the framework could fulfil in isolation rather than in unison, even though these functions most probably complement each other. Despite this, the results of the test were conclusive enough to ask for an alteration and a clearer focus in the function of the framework.

### Focus possibilities

#### A repertoire aimed specifically at mental healthcare institutions

Tailor the framework to MHCIs specifically, so that it can be used by both the board of directors and MHCI employees. For the former, the framework could be used to inform strategy. For the latter, it can be used during training days (e.g. RP's summer school) to make individuals understand their impact on the system and be inspired by this understanding. A possibility within in this function would be to make it into a game.

#### A repertoire for Redesigning Psychiatry to steer the transition

With this option, the framework is aimed at the more global goal Redesigning Psychiatry is pursuing; to achieve lasting systemic change in the mental healthcare sector, in both system constructs as ruling paradigm. The framework would be developed in such a way that it can support the RP core team in deciding suitable interventions and actions to reach that goal.

#### A repertoire for Redesigning Psychiatry to support MHCIs in change

This option is essentially a combination of the other two options. The

framework would have the RP core team as the main target group, but with the more specific goal of supporting MHCIs in innovation and change.

### Chosen focus

Based on conversations with the RP core team, it became clear that the third option would be most suitable for this project. Even though the framework can be used to understand or plan more general transitional movements in the societal system, the findings from the contextual research primarily provide insight in the blockers and enablers for organisational change. Hence, tailoring the framework to that goal for this project, can add the most value.

Considering that, it would also be an option to focus the framework on MHCIs specifically. However, as the context research shows, these organisations are under constant pressure, making it hard to try out new things. Also, MHCIs themselves might lack the innovative insight needed to use the framework successfully. Taking all this into account, focusing the framework and repertoire at RP as a supporting tool for innovation and change within MHCIs is the most suitable option.



Figure 36: Placing contextual insights on the framework to structure them

/ chapter 4

# synthesis

102 / a strategic repertoire  
for change in the mental  
healthcare sector

110 / a strategy for organisational  
inertia in mental healthcare



## synthesis / 4.1

# a strategic repertoire for change in the mental healthcare sector

In the previous chapter, the main factors that influence change in the mental healthcare sector have been identified. In this chapter, we will look at different strategies to react to these phenomena and go deeper into the particular challenges they aim to solve.

This chapter outlines general strategies for all identified themes (table 3). In the next chapter, a detailed strategy for inertia within mental healthcare organisations is proposed. Inertia is one of the biggest challenges in this system, and neither RP nor MHCIs are equipped to deal with this at this time. Furthermore, RP is already working on developing an approach for system's innovation themselves, making the organisational inertia the most pressing issue to be solved.

### 4.1.1 Overcoming challenges to change in a locked-in system

The mental healthcare system portrays several system lock-ins that are quite challenging to overcome in any kind of situation. In this situation collaboration between different actors of the system is suboptimal, even though transdisciplinary work and collaboration across silos is necessary to work towards resolutions for wicked problems (i.e. symptomatic problems of 'locked-in' systems). This makes the challenge to overcome lock-ins twofold:

- > Finding ways to manoeuvre past lock-ins and wicked problems;
- > Establishing a stronger collaboration between system actors.

The following paragraphs will discuss different strategies to overcome these challenges.

Theme	Strategies
4.1.1 Overcoming challenges to change in a locked-in system	Transition experiments
	Supporting grassroots efforts and niches
	Exchanging knowledge and skill
	Multi-disciplinary design work
	Addressing networked innovation challenges
4.1.2 Dealing with inertia in mental healthcare	Enhancing change capability
	Decreasing inertia through double-loop learning
	Strategic use of personal willingness and personal resistance
	Acquiring missing capabilities
4.1.3 Finding the right balance between scientific and intuitive development	Establish close ties with science field
	Clear identification of elements that need scientific backing
	Increase respect for and trust in intuitive approaches
	Identify intuitive movements and decisions
4.1.4 Making use of the growing public interest in mental healthcare	Start awareness campaign
	Use public attention for own interest
	Increase attention for branding and PR within MHCIs.

Table 3: Overview of the strategic repertoire

### Transition experiments

As discussed in **paragraph 2.2.1**, transition experiments (TEs) are “small-scale, practical experiments with a high potential value for the transition process, but also with a high-risk when it comes to its applicability in the current world” (Kemp & Van den Bosch, 2006, p. 13). Some specific aspects of TEs are important to consider in this specific context.

TEs are often a collaboration between different kinds of actors from the system, which is why special attention should be paid to finding new kinds of partners who are not MHCIs. Even more so because RP is aiming to transition to a system that is weaved in all aspects of society. When searching for new partners, it is advisable to set concrete benchmarks, KPIs or goals that speak to the different partners you need to address (Kemp, 2019).

In line with this, is that a strategic choice should be made when to call the project an ‘experiment’, or not. On the one hand, the word experiment is associated with uncertainty, and can scare people off. In the words of Kemp & Van den Bosch: “Even if the hope is to learn, the intention should be that the project will be successful. [For example,] Users are probably less inclined to live in ‘experimental housing’” (2006, p. 14). On the other hand, promoting a paradigm as ‘the one’ can come across as threatening, leading to resistance. In this case, communicating the alternative paradigm as ‘experiment’ opens up room for innovation and change (Kemp, 2019). In any case, even if the project is not communicated as such, it is important take notice of the learning aspect of the experiment, and build in time for reflection and evaluation.

### Supporting grass-roots efforts and niches

If a system (or the regime of that system) is not performing adequately, there are often also other initiatives present in that system trying to find alternative ways to fulfill the system’s function. These could for example be separate organisations, chapters of MHCIs or individuals. In **paragraph 2.2.3**, we have discussed the importance of network formation processes to empower social innovation initiatives (i.e. grass roots efforts or niches). Therefore, it can be beneficial to support and connect these different kinds of efforts to stimulate transition and change *in general*, rather than a transition in the direction of RP’s vision. This approach



has the added benefit that it allows for the exploration of alternative transition paths and goals, something that is in line with transition management's principle of 'keeping options open' (paragraph 2.2.1).

### Exchanging knowledge and skill

An important factor in the innovation or transition of any system, is a proper exchange of knowledge and skills, so that other people can learn from projects or experiments as well (Kemp, 2019). This was confirmed in the evaluation with experts (chapter 5), as it can provide an overall improvement of quality in the system. This can for example be done through setting up knowledge or collaboration platforms, exchanging experts, alliance networks, or publishing data.

### Multi-disciplinary design work

In paragraph 2.2.4, it became clear that multi-disciplinary design work can be useful in addressing complex or wicked problems. Design is useful because of its iterative approach; its ability to be human-centred; and its continuous consultation. Multi-disciplinarity is useful because of the body of knowledge and perspectives it generates. While performing transition experiments or supporting niches, this knowledge is important to keep in mind. Comparing with RP's current activities, it is advisable to involve more people that are from different disciplines into the process.

### Networked innovation challenges

With the initiation of transition experiments and 'niche collaboration networks', also comes an increase in interorganisational collaboration, which can come with new challenges; people who speak a different 'language' (Bergema et al., 2010) or have different interests. Also, the people working in the collaboration need to have chemistry. To this end, it is advisable to start projects with small goals to test the team and get acquainted without having high stakes (Bergema, 2019). This can also be helpful if partners are inexperienced or uncomfortable with unconcrete projects. Even more important than setting up the network is orchestrating it (Berasategi, Arana & Castellano, 2010; Swan & Scarbrough, 2005). As a lot of the problems that arise in networked innovation concern a conflict of interest of some sort, it is advisable to have a neutral person in the team who can take on a facilitating role. RP could take on this role, even though it is possible that RP is not neutral enough. In that case, impartial facilitators need to be found.

### 4.1.2 Dealing with inertia in mental healthcare

The key problems in this theme, as discussed in paragraph 3.4.2, are the pressure on the system blocking institutional learning, the lack of innovation structure, the absence of people in the organisation to bring innovation projects to the finish line, the dilemma between freedom and regulation, and the amount of people having to change behaviour.

For this theme, the strategy has been thought out more elaborately. The general strategies that form the foundation of the detailed strategy are discussed here, the strategy itself can be found in the next chapter.

#### Enhancing change capability

One of the findings of the contextual research showed that change happens more easily in educative environments. This doesn't necessarily entail schools or universities; it could also be departments or institutions that train professionals in specific methods. This notion is supported by the 'learning' change management style (De Caluwé & Vermaak, 2003; Schaminée, 2018), in which people are placed in a learning environment to make them more aware and open to change. A learning environment could for example be created by setting up a dedicated learning and development programme within the organisation.

#### Decreasing inertia

Godkin & Allcorn (2008) identify *insight inertia* as one of the factors causing organisational inertia; the persistence of faulty mental models, resulting in flawed analyses and actions. A way to resolve this, is to implement double-loop learning mechanisms in the organisation (Argyris & Schön, 1978). Double-loop learning (figure 37) entails learning in which the outcomes of actions are reflected on, and used to adjust one's mental model. Mental models underlie decision-making rules, and subsequently actions. Being able to identify these models as an organisation *and* as individual, is a big step towards effective action. Ways in which this could be done are for example:

- > Ensuring a safe organisational culture in which people are motivated to speak up and feel comfortable to reflect on their own and other's activities. Double loop learning rarely occurs in situations with high psychological threat (Argyris & Schön, 1996; Friedman, 2002). If a

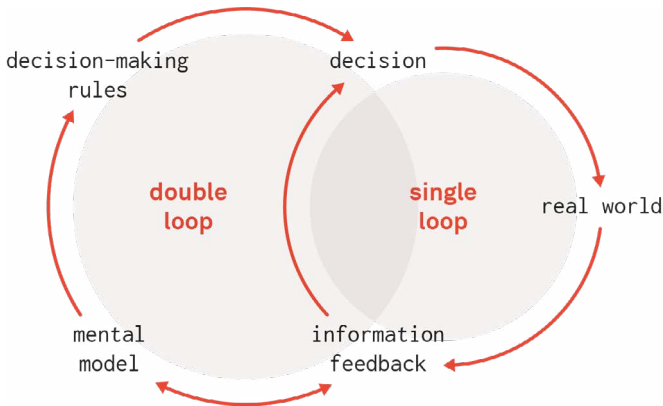


Figure 37: Single-loop learning and double-loop learning (Argyris & Schön, 1978)

safe company culture is too big a step, start by creating a safe space within the organisation for reflection and openness;

- > Promoting collective learning through group reflection (Godkin & Allcorn, 2008).

Godkin & Allcorn propose one other way to resolve insight inertia: Reflective practice. From its conception, design has been identified as a reflective practice (Dorst, 2011; Schön, 1983), which indicates the usefulness of design principles to overcome inertia.

### Strategic use of personal willingness and personal resistance

As discussed earlier in this report (paragraph 3.4.2), the spectrum of personal willingness and personal resistance resembles a bell curve. In other words, it is a spectrum of *early adopters* and *laggards* (Rogers, 1962), who can have a significant effect on organisational inertia (Godkin & Allcorn, 2008), and need to be addressed differently when trying to stimulate transition (Kemp, 2019). In addressing organisation change, Speculand (2006) alternatively labels this spectrum and proposes a variation of approaches to address each of the groups. Mavericks are already prone to change and just need to be empowered, so that they can ignite other employees as well. Groupies are people who are on the fence at first, and need to be encouraged by management or mavericks. Saboteurs are the ones resisting change, and need to be controlled or even be dismissed from the company. Lastly, double agents are people

who might be the loudest in resisting the change, but become mavericks once they're convinced the change is the right thing to do.

These principles can be used during the implementation of new propositions. For example, design for behaviour change could be initiated to this end, in which special attention is paid to different ways of addressing different kinds of changers. Furthermore, mavericks can be empowered by empowering employees in general, i.e. gaining “the ability to act on goals that matter” (Haxeltine, et al., 2017, p. 7). This can be done through the address of three basic psychological needs:

- > Autonomy; the level to which one can act according to their own interests or desire;
- > Relatedness; feeling like a part of the group;
- > Competence; being aware of the effectiveness of one's actions (ibid.).

### Acquiring missing capabilities

When looking at this theme, it can be viewed from two sides. On the one hand, it can be said that the problem lies with the people, who have the wrong skillset or motivation. On the other, reframing the phenomenon can also lead to the conclusion that it is not a problem with people, but with capabilities. This opens up a range of strategies to address.

One example is to set up an alliance network with companies or organisations that do have the capabilities that are needed to achieve goals. By quickly changing partners once the capabilities are not necessary anymore, or internalised in the organisation, the organisation can be speeded up (Dittrich, Duysters, & De Mand, 2007).

Another possibility is to critically evaluate the capabilities that are needed in the organisation and adopt an active policy on hiring these kinds of people; or to educate people in the needed capabilities where possible.

### 4.1.3 Finding the right balance between scientific and intuitive development

This theme influencing change is less concrete and less researched, which makes it more challenging to find well-founded strategies. Directions for strategies here stem from the contextual findings, and are for example:

- > Establish close ties with science field, to be able to measure results from intuitive actions;
- > When planning a project, make a clear distinction between elements of the project that need scientific backing, and the elements that don't, so that the project is not needlessly delayed by scientific approval;
- > Increase respect for and trust in intuitive (i.e. not evidence-based) approaches, as intuition is based on factual knowledge and personal experiences accumulated in the mind (Dijksterhuis, 2015);
- > Identify intuitive movements and decisions, and explore whether they can be accelerated.

### 4.1.4 Making use of the growing public interest in mental healthcare

As with the balance between science and intuition, the strategies proposed for dealing with (negative) public attention are less researched. However, the strategic design field does provide some directions in the fields of branding and PR:

- > Collaborate with important system players like government, activists, prominent figures from outside the field (e.g. social media influencers) and inside the field (e.g. renowned professors) to start a campaign against stigmatisation;
- > Communicate new paradigm as 'experiment' to avoid resistance among system actors and increase room for project (Kemp, 2019);
- > Tap into public interest to raise awareness for problems in the mental healthcare sector and to tell the 'own' side of the story;
- > Increase attention for branding and PR within MHCIs.

## synthesis / 4.2

# a strategy for organisational inertia in mental healthcare

Based on the more general strategies for organisational inertia discussed in the previous chapter, this chapter proposes a final strategy to address inertia in mental healthcare organisations specifically.

### 4.2.1 Creating capacity for innovation and organisational learning

In chapters 3.4 and 4.1, we have concluded that mental healthcare institutions experience difficulty in getting to a state of organisational learning, due to the pressure the organisations are under. This means that allocating resources to consistent reflection and innovation is lower on the list of priorities as well, even though it can help in solving the problems that cause the pressure. Finding ways to relieve immediate pressure seems like the obvious solution, but attempts at that have not yet been successful. Partly, this can be accounted to the symptomatic nature of the problem; pressure on the system is caused by many factors, which is why addressing pressure directly might do more harm than good. Therefore, this strategy aims to create capacity for innovation and organisational learning, enabling organisations to address systemic problems in both the short and long term.

#### The strategy summarised

In short, the strategy proposes the creation of (semi-)separate spaces within the organisation for innovation, reflection and learning (figure 38, next page). The idea behind this is that these spaces can operate without the presence of disabling pressure, creating room for reflective practice and creativity. Furthermore, it is a first step towards the establishment of a culture in which these activities are standard practice.

From an organisational perspective, there are several reasons why having a separate unit for innovation, reflection and learning is desirable:

- 1 Starting with a separate space is a smaller organisational change, decreasing its chance of rejection by board members, and increasing its chance of success in implementation;
- 2 In an organisation with only a small number of innovative organisation members, creating a space for innovation is a way to realise a critical mass;
- 3 Starting with a separate space without a complete reorganisation gives the possibility to experiment with this new way of working, to judge its efficacy, and to adjust if necessary;
- 4 If the above-mentioned experiment satisfies, this separate space is the first step in making the entire organisation innovative.

This separate unit does, however, come with a challenge. In an evaluation of this proposal (see chapter 5.2), it became clear that having the space too separate will take away ownership from organisation members, resulting in the view that innovation is not their responsibility.

“The danger of creating an autonomous unit is that it makes it easy for the rest of the organisation to push it aside. [...] If the overall perception is that there is ‘work’ and that you can step out of it and do ‘innovative work’, that is dangerous. In the longer term, you want people to think their normal work is their innovative work.” – Expert in innovation in the public sector

Therefore, the challenge is to find the right balance between the ‘separateness’ of the space while maintaining a feeling of ownership in organisation members. In the following paragraphs, the strategy and how it proposes to address this challenge, will be discussed in detail.

#### **4.2.2 Space for innovation**

In this space, innovation projects can be performed independently from day-to-day routines and mindset. It provides a structure for innovation in the organisation, where formerly there was little to none. The space has a three-fold purpose (figure 39, next page):

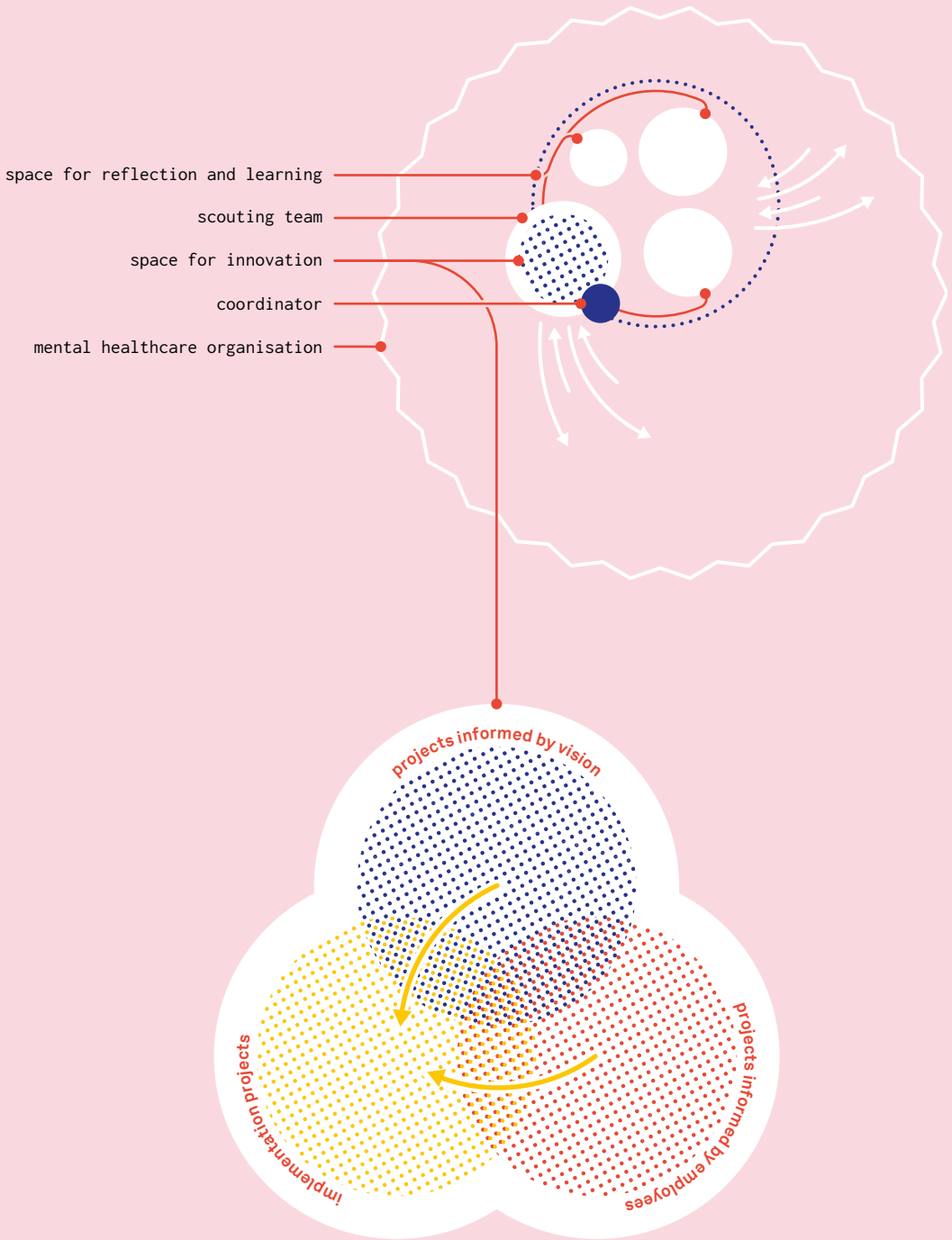


Figure 38: Schematic overview of an innovation structure to address inertia

Figure 39: Three functions of the space for innovation



- 1 Performing projects with the rationale to achieve long-term system change; these projects are mostly informed by the Redesigning Psychiatry vision and have a significant impact on the organisation and mental healthcare in general;
- 2 Performing projects to improve daily practice; these projects stem from ideas brought forward by organisation members;
- 3 Performing projects with the goal to successfully implement new interventions in the organisation.

The project matter of the three variants above can range from interventions supporting daily work, to specific ways of working and organisation structures. The projects follow a design process, as design is a reflective practice (Dorst, 2011; Schön, 1983), something that has been identified as useful in overcoming insight inertia (paragraph 4.1.2) and in dealing with complex problems (Holierhoek & Price, 2019; Norman, 2014; Norman & Stappers, 2015). For that reason, each innovation team consists of at least one designer, together with a mix of people dependent on the project goal. Examples of team members are mental healthcare professionals, organisation managers, change management experts, administrators or systems thinkers.

What the different project variants entail and how they relate will be discussed in the following paragraphs.

#### Projects initiated by employee ideas

This element of the innovation space has the twofold goal to harvest ideas from the floor that would normally go unnoticed, and to empower employees. The idea behind this is that if everyone can bring in ideas and participate in projects, innovation will start to live within the organisation. The projects in this space will probably be mostly incremental, but promising radical ideas may arise from here as well. When an employee has an idea or is already applying changes in his or her work that could be interesting for the entire organisation, projects can be set up to explore the possibilities of developing the idea organisation-wide. How this is done exactly, depends on the idea, but possibilities are to gather rich data for detailing, to perform user participation projects (empowering mavericks), or to set up pilot projects. The project team is composed based on the kind of idea it concerns. The

goal here is to primarily set up the team with organisation members, but if the need is there, external experts could be brought in as well.

### Projects informed by vision

As the transition Redesigning Psychiatry is aiming for involves radical system changes, just executing innovation projects brought forward by employees will probably not bring about the desired change; these projects will mostly involve incremental change and are not necessarily long-term solutions. For that reason, projects informed by the vision are part of the space for innovation as well.

Redesigning Psychiatry is already performing design projects to move towards their vision, often in collaboration with MHCIs as well. Two additions to the current practice would be:

- > To add organisation members to these project teams as well, so that they feel involved in the innovation activities;
- > To initiate projects that are not completely isolated from organisational activities, as is the case now.

### Implementation projects

Implementation projects are focused on finding the best way to implement new (and accepted) propositions in the organisation. Successful implementation asks for attention for the effect a proposition can have in different branches and on different levels of the organisation. The approach for implementing the proposition is informed by these effects. When it primarily involves routine or behaviour change, projects can take a behavioural design approach. When organisation structure and rules play a role as well, change management or system's change approaches need to be incorporated in the process. Team structure depends on the same factors. An example: In a behaviour change projects, employees become end-users, following the bell curve (paragraph 4.1.2). So it could be interesting involve mavericks to find ways to target groupies and double agents.

All in all, implementation projects are equally, maybe even more important than explorative projects. The success of implementation makes or breaks the entire project.

### Relation between project types

Even though vision-informed projects and employee-idea-informed projects come from different perspectives, it could be that the projects show overlap in subject matter. In this case, the projects can be partly or completely combined (figure XX). When this happens, special attention should be paid to each of the project's goals, so that they are not lost in the combination.

When the vision and/or employee-informed projects are successful, and the choice is made to continue development, the projects can transform into implementation projects (figure 39). Possibly, part of the project team is replaced in this phase with people who are better equipped for this particular challenge.

### Coordination

Of course, managing said space for innovation, is a dedicated task. Employee ideas need to be 'harvested', ideas need to be accepted and rejected, teams need to be put together, and the projects need to match each other and the organisation's innovation goals. To this end, the space for innovation has a coordinator and a 'scouting team'.

#### Coordinator

The innovation coordinator has an overview of the projects performed in the innovation space. The coordinator's tasks include:

- > Making sure that vision-oriented and incremental projects are aligned;
- > Ensuring that incremental projects are actually working towards the vision, even if they are just small steps;
- > Judging the suitability of new projects, possibly in collaboration with the Board of Directors and/or Redesigning Psychiatry;

Some of the organisations that RP's partnered with already have someone in the capacity of 'innovation coordinator', or something similar. In these organisations, this person could fulfil the role of innovation coordinator.

	Vision projects	Employee projects	Implementation projects
Professionals	●	●	●
Administrative workers	●	●	●
HRM-experts			●
Designers	●	●	●
System's thinkers	●		●
Change managers			●

Table 4: Examples of team members and the kind of projects they can be deployed in

### Scouting team

The scouting team is responsible for collecting ideas from the organisation. The kind of people that could be part of the scouting team vary; they could be managers, board members, RP ambassadors, or just innovation enthusiasts. In any case, these are people who work in—are part of—the organisation, and who know people from multiple hierarchical levels. This is because they can actually see people at work and spot good ideas, and because employees can put a face on them; they know who they can go to when they have an idea.

Next to scouting ideas, the scouting team also has a facilitative role in trying to get projects from the ground and getting people together in a team. They have to know the right people in the organisation who might be enthusiastic working on an idea or have the right skills to work on the idea. In this way, initiating a project is not completely the responsibility of the employee with an idea, and the threshold to develop an idea is lowered.

### Team members

The kind of people that are in a team, really depends on the kind of project and the project subject. The possibilities are endless, but **table 4** gives a few examples of possible team members, and the kind of

projects they would participate in. Every team innovation team has at least one designer to support the innovation process. It is also highly recommended that each team has a majority of organisation members, for several reasons:

- > People from within the organisation possess a lot of knowledge that might otherwise go unnoticed;
- > Innovation can become standard practice as time goes by and more people have collaborated in innovation project;
- > Employees feel empowered because of the autonomy felt in the projects.

### 4.2.3 Space for reflection and learning

In the previous chapter (4.1), we've discussed the necessity of reflection and learning to overcome inertia and open employees up to change. The space for reflection and learning is a means to this end, and is closely connected to the space for innovation. The space has three main functionalities, that can sometimes overlap: a place for reflection on mental models, a learning environment, and a test environment.

#### Reflection on mental models

We've discussed the necessity for an environment without psychological threat for reflection on work and mental models. Consistent reflection, in general and on mental models, enables double-loop learning in the organisation, which in turn can decrease the occurrence of *insight inertia*. The favourable option is that organisation culture on its own is safe enough to facilitate this. If this is not the case, or if this is not possible for other reasons (e.g. lack of resources), a separate space is a respectable alternative as a first step towards creating a culture in which being critical of own work and improving on that, is standard practice. This space is independent from managers or other superiors, that might create a feeling of unsafety. Rather, the person in charge of the space for reflection is someone without another role in the organisation so that neutrality can be preserved. Furthermore, it should be emphasised that outcomes of the reflection are not directly communicated to management. Reflection sessions should take place regularly, for example once a month, so that reflection can become standard practice.

### Learning environment

In the learning environment, employees can learn new ways of working through trainings or education days. These can be accommodated by external parties like Redesigning Psychiatry or other MHCIs, or internally accommodated by implementation project teams. The learning environment is also a good place to identify different kinds of ‘changers’ within the organisation (i.e. mavericks, groupies, saboteurs and double agents), that can be scouted for participation in project teams or pilots.

### Testing environment

The testing environment is a space where implementation project teams can perform pilots or user tests to verify new propositions. Dependent on the target group of the project, the change groups recognised in the learning environment can be assembled for the tests.

#### 4.2.4 Relation with large-scale system innovation

Partly, this strategy to address organisational inertia can be seen as a transition experiment (paragraphs 2.2.2 and 4.1.1). In this way, addressing inertia is just one element of the system transition in a line of parallel experiments. The main learning questions for this experiment being:

How does the creation of an innovation structure, and subsequently culture, in mental healthcare organisations affect...  
 ...the inertia experienced within said organisations?  
 ...the organisations’ ability to be self-sufficient in solving systemic problems?

An important aspect of this strategy, and its potential of impact on a system level, is that the organisations do not experiment in isolation. In this way, best-practices can be shared and scaled up in a quicker manner. This was something that was uncovered in an evaluation of the strategy (paragraph 5.2).

“The way you change the system is to create a system of knowledge transfer. How do you make this new practice, standard practice?” – Expert in innovation in the public sector  
 “Collaboration works better than competition. When you have

competition, nobody shares their good ideas. Now that we've let go of the competitive system, you see things changing faster" –  
Board member of mental healthcare institution

The following suitable ways of exchanging knowledge and experiences came forward in an evaluation of the strategy:

- > Publishing data;
- > Creating employee exchange programmes between institutions;
- > Being open to collaboration between organisations from the start of the project;
- > Giving (free) trainings in the newly developed intervention.

#### 4.2.5 Role for Redesigning Psychiatry

Within this strategy, Redesigning Psychiatry's role has not been specifically mentioned. However, their role is substantial, as it can support MHCIs in their innovation efforts through several ways (**figure 40, next page**). Firstly, the RP vision can give direction to organisations' innovation goals, either through advice or through a translation of the vision into concrete innovation goals for MHCIs. Secondly, RP can coordinate the placement of designers in organisations, making sure the designers are fit to design for complex problems and have knowledge of the RP vision. At the same time, (the designers at) RP can take this opportunity to expand their own skill set towards system and organisation design. Thirdly, it is desirable to maintain close communication with the innovation coordinator, so that the innovation activities and RP's vision can inform each other and remain aligned. Fourthly, RP can continue its educative efforts (i.e. Summer School, Werkatelier, see **paragraph 3.1.3**) in the spaces for reflection and learning. Finally, RP can play a contributing role in exchanging knowledge and capabilities between (partner) organisations.

#### Concrete actions

One of the biggest challenges of the strategy is in persuading MHCIs to embrace the idea of creating an innovation structure, as most MHCIs are not innovation minded (**Evaluation with a board member of a mental healthcare institution, 2020**). In the case of Redesigning Psychiatry, collaborating with partner organisations is a good starting point, as

these organisations have shown a willingness for change already. Of these partner organisations, my advice would be to start a pilot with either GGZ Noord-Holland-Noord (GGZ-NHN) or Parnassia Groep (PG). GGZ-NHN is one of the more innovative MHCIs in the Netherlands, who already has a training academy and a dedicated director for successful implementation and reflection on the success of these implementations. PG is one of the bigger partners of RP when it comes to size and amount of RP-projects, and has a dedicated director for innovation. However, because of the lack of innovation structure and resources in PG, this director is less effective than he potentially could be. Finding a way to structure innovation in PG can open up a lot of possibilities and can be an exemplary step in the right direction.

#### **4.2.6 Moderations to specific organisations**

As not every organisation has the same size, resources, or experience with innovation, the strategy just proposed can be moderated on the following aspects:

- > Amount of innovation projects carried out in the organisation;
- > Space for learning and reflection is completely executed by RP through Summer Schools and Werkateliers;
- > Amount of people in scouting team and total time of the work week spent on scouting;



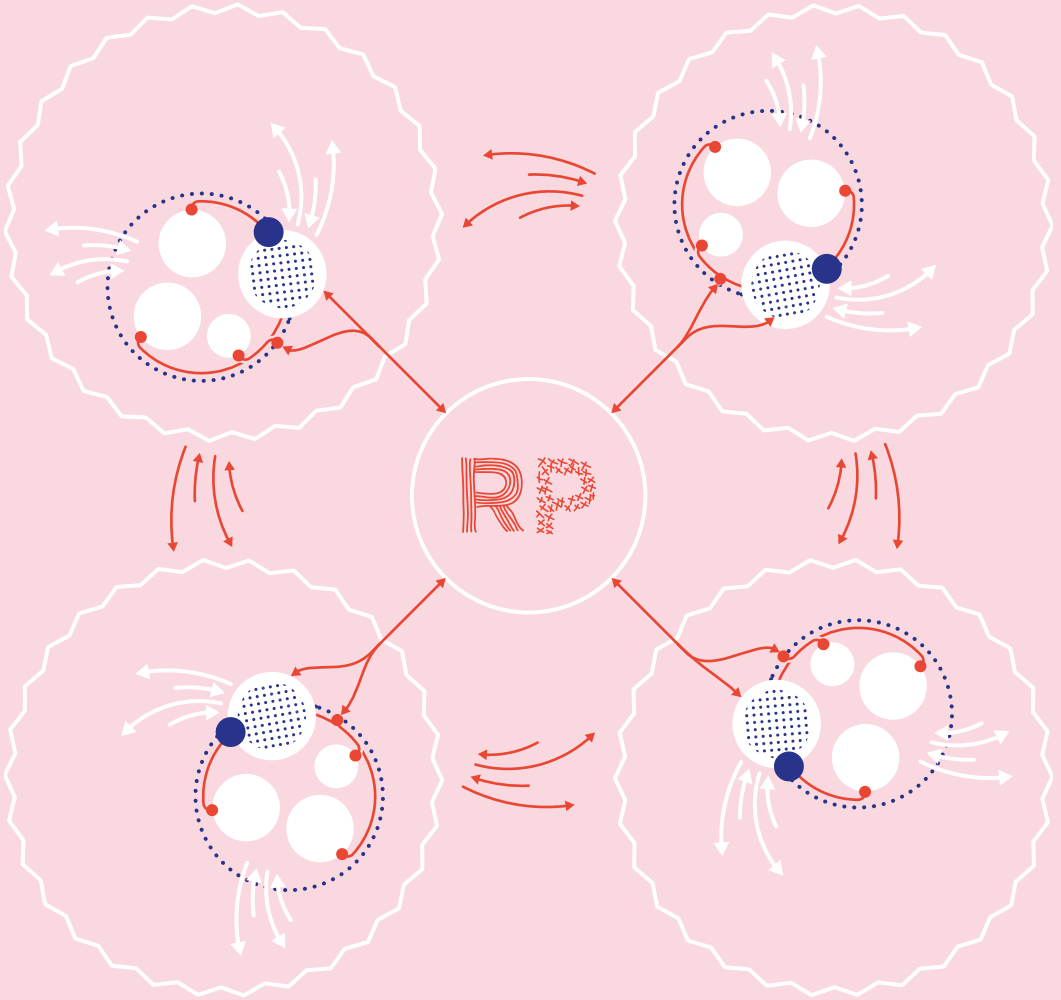


Figure 40: RP's role in the strategy for inertia

/ chapter 5

# evaluation

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## / evaluation

# expert evaluation

Results of this project are hard to validate, as it concerns long-term strategies of which the utility cannot be assessed within a single test. Alternatively, the results will be evaluated with experts in the fields of transitions, complexity and mental healthcare, to see what they think of the results and to possibly enrich the results. In this chapter, the evaluation setup and results are discussed.

Some results of the evaluation have already been processed in the project results, as these had not been completely detailed yet at the time of evaluation. In several instances, the evaluation provided new knowledge that aided in the final detailing.

### 5.1 Evaluation setup

Evaluation of the project results is divided into three parts: evaluation by experts from (the mental healthcare) practice; evaluation by experts in the fields of transitions and complexity; and evaluation by Redesigning Psychiatry. The goal and approach of each of these evaluations is slightly different (table 5).

> A complete evaluation plan can be found in appendix 6.

### 5.2 Theoretic framework

#### Position in relation to other theories

In several evaluations, it became clear that there's a need for a positioning of the framework in relation to similar theories and existing knowledge. One of the reasons for this was that the labels chosen for the different perspectives are tricky for two reasons. Firstly, because some labels have associations from other theories. Secondly, because the generalness of the labels implies a general consensus, even though this is not the case. As an example:

“Sociology is a very broad field, so calling something ‘the sociological perspective’ is risky, as there isn’t really *one* perspective” – Redesigning Psychiatry team member

	Goal	Approach	Expert
<b>Practical evaluation</b>	To assess the descriptive value of the themes and its depictions on the framework, and the fit of the strategies with the mental healthcare sector.	Evaluate each of the theme narratives, propose and evaluate strategies for the theme directly after. Focus on enriching the data.	Board member of (innovative) mental healthcare organisation
<b>Academic evaluation</b>	To have the experts' perspectives on the depiction of change in the framework and find out whether it resembles their own experiences. Also, their perspective on achieving change can be interesting to expand or enrich strategies.	Explain fundamentals of the framework so that it is clear where the framework comes from. Discuss the usability of the framework. If possible, evaluate proposed strategies.	Expert in innovation in the public sector Expert in transition design
<b>Evaluation with Redesigning Psychiatry</b>	To see in what way the theme narratives inspire and activate, and the degree to which the framework helps in understanding those narratives.	Combined approach of contextual and academic evaluation	Team member of the RP core team

Table 5: Overview of goals and approaches for the evaluation

Furthermore, the organisational perspective as described in this report also has its roots in sociology, making the distinction confusing. Alterations the experts proposed were for example to label the sociological perspective as the 'human' perspective, or to name the perspectives by their creators.

"I would call the sociological perspective 'the human perspective' instead, because I do recognise that the human element is missing in the multi-level perspective" – Transition design expert

Connected to this is the terminology of the framework. The terms used in this framework (primarily the term *landscape*) overlap with the terminology of other, better-known, models even though the meaning is not completely the same.

Considering this feedback, it would be interesting to position the framework in relation to the vast number of frameworks and theories that already exist. This can also help in defining the right terms for the framework, that can't be confused with other terms.

### **Taking into account the complexities of the system**

In general, the feeling was that the framework did a good job of portraying dynamics of societal change, but it did lack the complexities that come with societal and systemic change, in specific those of the mental healthcare sector. The framework's strength—being applicable to multiple contexts—simultaneously is its weakness, in that it can be too generic to provide guidance in a specific context. A side note to this finding is that the contextualised framework hasn't been discussed due to a lack of time, although this might fill the gap caused by generalness.

"I think it's useful, but I also think it's still a bit generic. I would ask you to outline the unique challenges. Once you identify what's unique, it might give you insights into useful strategies." - Expert on innovation in the public sector

"The mental healthcare sector is ridden with different power dynamics, so it would be interesting to see that added to the model" – Redesigning Psychiatry team member

### 5.3 Themes influencing change

#### Counterproductive effect of external pressure

In general, the main themes influencing change were received positively and met with recognition. One interesting finding that is worth to mention here. When evaluating internal and external pressure on the mental healthcare sector, an example from practice enabled a slight refinement of the effect of external pressure on the system:

“When it comes to external pressure, the implementation of ROM<sup>3</sup> is a good example. Initially, we wanted to do this ourselves. At some point, however, HICs started to enforce the use of ROM. At that point it became something negative, and nobody wanted to do it anymore. People need to be intrinsically motivated, external pressure often works counterproductively.” – Board member of mental healthcare institution

Whereas external pressure was first just identified as a force blocking institutional learning and innovation, this example provides insight into *why* this is the case.

### 5.4 Strategic repertoire

In general, the response to the strategies proposed was quite positive, with side notes here and there.

#### Importance of specified role of innovation in the organisation

A distinctive outcome of the evaluation of the strategy, was the importance of defining specifically what the role of the space for innovation would be in the mental healthcare organisations. If the space would be too separate, there's a risk that people will not feel like they are responsible for innovation. This can even backfire into people being less innovative in their daily work.

“The danger with a separate unit for innovation is that people tend to say ‘Oh, innovation is done there, we don't have to do that. Let them show what they got’” – Board member of mental healthcare institution

<sup>3</sup> Routine Outcome Management, a quality control method that is frequently used in the mental healthcare sector.

“However, if it [innovation] is sprinkled all over the place, there is no critical mass, which is why I think this overlap is so important.”  
– Expert on innovation in the public sector

Therefore, it is very important that people feel ownership over this unit as well, and that the overlap between the innovation unit and the organisation is properly thought out. In this same line of thought, it is encouraged to keep the threshold for joining innovation projects and bringing forward ideas, as low as possible. Suggestions to address this come forward in the evaluation as well, and have already been processed into the strategy (paragraph 4.2.2).

#### Attention for implementation

Next to the importance of a well-thought overlap between innovation and organisation, the importance of attention for implementation was emphasised. One aspect of this concerns behaviour change; learning new ways of working *and* unlearning old ways of working.

“People really have trouble diverging from their existing way of working. They do want to learn new things, but that doesn’t mean they’ll stop doing the old. They’ll just add it to their way of working, even if it has been proved that the ‘old’ doesn’t work.”  
– Board member of mental healthcare institution

Another aspect is focused on the organisational side of implementation. The following question arises here: is the organisation structured in a way that supports the new proposition, and if not, what should happen to make it so?

“Think about how the people in the organisation change. How does it work in the back office? So, one of the design principles could also be: what kind of people are in the team?” – Expert in innovation in the mental healthcare sector

#### Openness to innovation in public sector organisations

Whereas the private sector generally has a positive connotation with innovation, most public sector organisations appear to be more wary of incorporating innovative processes in the organisation structure. This can be deduced from examples given by experts.



“People [in the board of directors] say ‘we don’t have money’, but what they mean is ‘we don’t have money for *this*’ – Board member of mental healthcare institution about innovation

“When you look at the literature about innovation, the idea is to fail frequently and early on. In the public sector, you need to succeed early. [...] Because there’s such a dominant way of thinking, and people are so suspicious of new ways of thinking, that they will say ‘I told you so’ when you fail. Failure only enforces the mainstream way of working and locks it in.” – Expert on innovation in the public sector

This influences the way innovation proposals need to be brought to important members of the organisation, and the amount of money made available for innovation or change. Strategically, this means that the first step in a collaboration between Redesigning Psychiatry and a mental healthcare institution is to discover the organisation’s openness to change and innovation processes.

“You need to find your entry point, your back door. Usually you can find that by identifying the things the organisation is struggling the most with. [...] Create doubt that the current way of working is not perfect; from there you can convince people.” – Expert on innovation in the public sector

### Importance of collaboration and knowledge exchange

In several evaluations, the importance of collaboration and knowledge exchange as a means to structural system improvement was confirmed. This is important because it enables building on each other’s knowledge and increasing performance in general. For example, the free-market principles that the mental healthcare system was built on, was a strong blocker for change, as everyone kept their ideas to their own. Furthermore, the demonstration of best-practices can portray the efficacy of other ways of working.

“Some hospitals perform poorly, some exceptional, and most perform average. You want to move the bell curve, so that the average become the level of the best, and the best become even better. [...] Create a system of knowledge transfer. How do you make this new practice, standard practice?” – Expert on innovation in the public sector

An interesting refinement to this insight is that intensive multi-actor collaboration is not the only way to resolve lock-ins in the system:

“One year ago, we managed to negotiate a collaboration with VGZ [a Dutch HIC]. They’ve let go of the idea that they need to be responsible for price *and* quality. They do the financials, we do the quality, and we make deals for multiple years based on this principle. [...] So, we invest together, but we [the MHC] perform the innovation projects. As MHC, you get more space to try new things, and it is completely based on trust.” – Board member of mental healthcare organisation



/ chapter 6

# conclusion

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## conclusion / 6.1

# discussion

In this chapter, we will discuss the relevance and limitations of the project results. Furthermore, we will reflect on transition design and how this project has contributed to this emerging field of design.

This project has focused on finding ways to support Redesigning Psychiatry in the transition to a new system for mental healthcare. It has done so by creating a strategic repertoire to address major themes influencing change in the mental healthcare sector, and by proposing a detailed strategy to address organisational inertia in MHCIs. At the foundation of the repertoire lies a theoretic framework that can be used to describe the dynamics of societal and organisational change.

### 6.1.1 The strategic repertoire

This strategic repertoire offers approaches for structural change of all kinds of organisations in the mental healthcare sector. Furthermore, it offers an approach to structure an organisation in a way that it is equipped to perform innovation projects.

The strategic repertoire is a step in the direction of the resolution of complex problems in society. Its effect should, however, not be overestimated. For example, the strategy for inertia offers a way to structure innovation but does not solve all problems relating complexity. If it would, we would only find complex problems in places where no innovation takes place, and this is sadly not the case. What the strategy does do, is making MHCIs more flexible, better able to address problems, and capable of performing projects with a future focus, separate of the systemic problems of today.

### 6.1.2 Academic relevance

There is a plethora of models and frameworks attempting to describe societal change, organisational change, behaviour change, transitions—and so on. None of these models or frameworks completely capture the complex dynamics that are at work in a changing society, and neither does the framework proposed in this body of work.

This framework aims to describe the dynamics of transitions in which human behaviour is of absolute importance and needs to be addressed expressly. It aims to describe the relations between society, organisations, and individual members of a system. The framework can not only be used to describe dynamics of the mental healthcare system, it can be used to describe the dynamics of similar systems as well. This advantage is at the same time a disadvantage however, as its generalness inhibits the framework of being a 'stand-alone'. The framework becomes useful once contextual findings are added to it. The number of models with similar subject matter can be a disadvantage to this project. Right now, this project lacks a proper positioning of the framework in relation to other theories, models and frameworks. Its overlap with some of these can cause confusion, especially in terminology.

### 6.1.3 Reflection on transition design

At its initiation, this project had the secondary goal to add to the growing body of knowledge on transition design. This project has shown that interventions with the purpose to aid transitions can come in various forms. In this case those of organisation and strategy design. Like advised in the transition design approach, these interventions are but one step in a series of steps that have to be taken in the direction of the future vision. In this case, the propositions made in this project are a means to lay the ground for more vision-informed projects, and to equip Redesigning Psychiatry with the necessary skills and knowledge to perform these projects.

In its explorations, this project has ventured away from the emerging transition design approach as described in paragraph 2.2.2. In doing this, it has provided alternative ways to map complex problems and to identify leverage points in the system, resulting in an expanded transition design tool case.

A side note to these expansions is that the majority of this project has focused on achieving *change* in general, rather than transition. Change was a challenge on its own in the mental healthcare sector, which is why this needed to be addressed. Further steps need to be taken to strengthen the project's applicability in transitions.

## conclusion / 6.2

# recommendations

This chapter proposes recommendations for improvement of the project results, based on some of the limitations discussed in the previous chapter.

### 6.2.1 The strategic repertoire

#### Structuring reflection on strategy for organizational inertia

The strategy for organisational inertia proposed in chapter 4 stresses the importance of reflection on the efficacy of new interventions and courses of action. Yet, the strategy itself does not provide a structure for reflection. Partly, this is settled through the presence of an innovation coordinator. It is recommended however to provide a stronger structure for reflection. This can support the innovation coordinators in their responsibilities and ensure that other organisation members are aware of reflective activities as well.

#### Detail methods for knowledge transfer

In both the strategic and the detailed strategy for organizational inertia, the importance of proper knowledge exchange between system actors has been emphasised. However, the approaches proposed to do this remain quite superficial. A recommendation for improvement of the strategies is to further explore the possible ways to exchange knowledge and make this standard practice. In line with Redesigning Psychiatry's strengths, this could be done in the form of a design projec. That enables to find ways to exchange knowledge that are both novel and effective.

#### Implementing double-loop learning

Implementing double-loop learning in an organisation is a challenging activity (see chapter 4.1). Reflecting on mental models as an individual is challenging on its own, let alone as an organisation. This makes the success of the propositions in this project less certain. Therefore, more research and experimentation is needed, to enforce the strategy for creating double-loop learning. As double-loop learning is something that has been around for a long time already, this could be done through case studies of successful attempts.



## 6.2.2 The theoretic framework

### Positioning the framework in relation to other theories

As discussed in the previous chapter, the framework lacks a positioning in relation to other models and theories. As a multitude of such models exists, establishing this positioning was outside the scope of this project. Further research can enable a better detailing of the framework, and can more closely capture societal and organisational dynamics of change. As a result, the framework's applicability to multiple contexts can be improved.

### Alignment of framework with RP and mental healthcare sector

In contrast to the recommendation given above, another direction for research would be to further develop the framework in capturing change dynamics that are unique to the mental healthcare sector. For example, RP has a specific way of viewing behaviour change (see paragraph 2.2.5), that is not distinctively represented in the framework.

### Better defined terminology

Associated with the framework's positioning in relation to other theories, there are opportunities to better define the terminology of the framework. In the current framework, the kinds of entities that fall under each level and the kinds of changes that constitute each arrow are not understandable without clarification. Furthermore, some of the labels chosen for this framework hold meaning in other theories and models as well, causing associations that are undesirable. For example, the term 'landscape' holds a slightly different meaning in this framework, than it does in the original 'multi-level perspective model' (paragraph 2.1.1). A carefully chosen set of labels and terms can solve these problems. In this choice, terms that hold meaning in the mental healthcare field can be considered as well.

conclusion / 6.3

# personal reflection

Well, here we are. More than a year later, I must admit that it feels surreal even typing this last page of the report. Even though this project has literally given me a headache from time to time, I don't regret taking on this challenge.

The mental healthcare field, to me, is endlessly fascinating, which may or may not have something to do with my naivety in the subject and my fascination with anything complex. During my master's degree, I spent quite some time researching the role of the designer in complex problems; *wicked problems*. Despite my research showing that the design process is broadly the same no matter the subject, in doing it myself, I've learned how different these complex projects actually are from the other projects I've done at this faculty. One of my greatest challenges was that I kept 'resetting' to default designer mode: looking for a target user to address, even though 'system actors' were my target users. This level of complexity was not something that I was used to.

Next to this lesson in dealing with complexity, my relentless perfectionism has been put in its place during this project as well. I've learned to prioritize, and to be flexible in your planning. This was always something that I *talked* about doing, but that I didn't actually *do*. When I look back at the beginning stages of my project, there was a lot of insecurity about the direction of the project. Partly, I believe this is inevitable in design. They call it the *fuzzy front end* for a reason. However, how you navigate this no man's land can make a lot of difference. In an attempt to give direction to the project, I had a lot of ideas for exploration, but I didn't get to the point where a few of these ideas got shut down because they weren't necessary. I had to learn the hard way that you cannot do everything. Moreover, that a situation will not get better by avoiding decisions. When comparing the first and second half of my project, I feel like this is this is the aspect in which the two halves show the starkest contrast.

This brings me back to my first statement: I have no regrets in taking on this challenge. Learning to design for complexity has helped me grow as a designer and as an academic. Learning to make realistic choices and put perfectionism on a back burner, has helped me grow as a person. This is a lesson that I'm thankful to have learned so early on in my life, and that I hope to carry with me for the rest of it.

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# transformation

/træn'zɪf.ən/

*noun*

A complete change in the appearance or character of something, especially so that that thing is improved.

