Crisis, what crisis?

A multi-sited ethnography of community mental health care around a psychiatric crisis in Trieste and Utrecht

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CHAPTER 1

General introduction

This thesis ethnographically studies the care practices in a community mental health team (CMHT)[1] in both Trieste, Italy and Utrecht, the Netherlands. I contrast the two sites through an analysis of the day-to-day care practices by studying how care gets its meaning and shape within the relationship between clients[2], formal and informal caregivers, and their environment.

The cities I did fieldwork were chosen with a clear purpose. Trieste is famous for the radical process of deinstitutionalization it went through. In the 1970, a "psychiatric revolution" took place with a radical shift from care in the hospital setting towards care in the community. The psychiatrist Franco Basaglia declared a psychiatric hospital to be a "total institution" that deprived people of their individuality. In his view, moving care to the community was an essential step for clients to gain social roles other than that of patient or client; to become "citizens" again. This historic rupture still shapes the daily care of the CMHT in Trieste, such as a low number of hospital beds, an avoidance of coercive measures, and an open-door policy.

Utrecht is a city in the Netherlands where the deinstitutionalization process has been more gradual compared to Italy. Psychiatric hospitals were reformed instead of closing them, while community care was built up at the same time and mental health care became more specialized. In its aim to reduce the number of beds and organize care in the community in the second decade of this century, Utrecht wanted to learn from Trieste. Together with Sonja van Rooijen, I conducted a study to this end: "Freedom First" (Muusse & Van Rooijen, 2015). This thesis builts forward on this first research, by adapting an empirical ethical approach to make an analysis of how daily care gets its shape and meaning and how caregivers, clients and others strive for this care to be good.

In contrasting the care practices in Trieste and Utrecht, I chose to focus on moments of an anticipated crisis. I am interested in how a psychiatric crisis is cared for at the level of the community rather than in a clinical facility. I articulate how care in the community may present alternatives to hospitalization and possible ways to prevent crises from escalating. A crisis is also a moment when questions arise about what good mental health care entails; for instance, whether the use of coercion is legitimate or whether professionals could explore different interventions. Studying different practices of care around a crisis can help us to think up alternatives to the use of coercion.

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1 In Trieste the CMHT is based in a Community Mental Health Center (CMHC), which includes beds, a dining hall, etc. In Utrecht the CMHT is based in a polyclinical setting without further care facilities. If we address the teams, we use the acronym CMHT for both sites, if we specifically address the center as a physical place in Trieste, we use CMHC.

2 In mental health care, there is an ongoing debate about the terms client/ patient or service usder. I choose to align with the language used at the field sites I studied or (historical) debates I refer to, and to use the term 'client' in general.

To learn about the use of coercion, hospitalization, and its alternatives, I adopt a broad perspective on care around a crisis in which the focus is not so much on acute moments but on everyday care practices. I analyze how relationships between clients, formal and informal caregivers, and the environment play a role in how care around an anticipated crisis takes shape. I do not take crisis as a discrete state, but as a part of a chain of events co-shaped by caregivers, clients, families, and others involved. Care for a crisis, I will demonstrate, can only be understood by studying this trajectory.

The aim of the study, therefore, is to learn more about how caregivers enact forms of good care for a crisis. To this end, I analyze the care practices of the Utrecht and Trieste CMHTs.

My research questions are the following:

- What do professionals do in their attempts to shape good care within the daily practice of the community mental health care teams of both Trieste and Utrecht?
- How do professionals anticipate and respond to "psychiatric crisis" in these two care practices?
- What can we learn about improving community mental health care from the contrasts between the two practices?

These questions are answered in the following chapters, of which three also have been published as journal articles. Each chapter describes the method conducted and gives a short introduction to the research sites. In this general introduction, I will sketch out the field sites in more depth, discuss the research questions and describe my methodological approach and theoretical considerations. I will end the introduction with a short outline of the chapters that follow.

1.1 SHAPING DEINSTITUTIONALIZATION

Differences between the fieldwork sites

The research sites for this study were chosen because the Italian and the Dutch mental health care system, and more specific Trieste and Utrecht's mental health care system, differ on several points:

- Trieste has approximately six times fewer beds than the mental health care system in Utrecht.[3]

3 Trieste had 15 beds per 100,000 inhabitants in 2018 (Personal email conversation. asugi. sanita Trieste). The number of beds in Utrecht region in 2017 was 89 per 100,000 (Vektis). Note that international comparisons can be difficult due to different accountability structures, for instance, if the numbers of days of people hospitalized or the number of physical beds is counted.

- A study that compared the annual incidence of involuntary hospitalization showed that Italy has a relatively low number of involuntary hospitalizations (Sheridan Rains et al., 2019).[4] If we compare the number of involuntary hospitalizations solely between the regions of Utrecht and Trieste for 2019, there are ten times fewer involuntary measures (forced hospitalization and/ or treatment) in Trieste.[5]
- Trieste conducts an open-door policy at all times from the idea that a closed door hampers building relationships and thus recovery. In contrast, in the Netherlands the percentage of beds on closed wards in 2019 was 41% on facilities for admission up to one year. For facilities for long stay this was 19%. (Kroon at al., 2021).
- Research indicates that the system in Trieste is cheaper than a system with more hospital beds, and money is divided in a different way (Muusse & Van Rooijen, 2015).[6] The majority of the budget in Trieste is spent on mental health centers (Mezzina, 2014 & 2016; Ridente & Mezzina, 2016).
- During the process of deinstitutionalization and the implementation of law 180 the suicide rates in Italy stayed stable and even declined in Trieste (Barbui et al., 2018).

To understand the differences between the way community mental health care takes shape in both Trieste and Utrecht, it is important to briefly reflect on how the systems came into being. Historically, Italy and the Netherlands went through different processes of deinstitutionalizing mental health care.

Shaping community mental health care in Trieste

In Trieste, a so-called "psychiatric revolution" took place in the 1970s. This quest of reforming the mental health care system was not limited to Italy. After the Second World War, the asylum-based care system with large-scale isolated hospital grounds began to be questioned elsewhere (Novella, 2010; Shen & Snowden, 2014; Bennett, 1985; Chow

4 This international comparison between 2008 and 2017 in 22 countries in Europe along with Australia and New Zealand, (Sheridan Rains et al., 2019) shows that Italy has the lowest amount of involuntary hospitalization in Europe.

5 If we compare the region Utrecht (bigger than Utrecht city alone) and Trieste, then involuntary measures (forced hospitalization and/ or treatment) are about ten times lower in Trieste. Utrecht (2019) had 217 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by de rechtspraak). In Trieste (2019), there were 21.8 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by asugi. Sanita Trieste). Also, here numbers are indications. There are, for instance, differences in the juridical system.

6 This claim also comes with some caveats. Italy recently faced severe budget cuts due to the recent economic crisis. The budget cuts put the health care system under strain. Previous research showed that the estimated difference in the costs of the system in Utrecht and Trieste is lower by a factor of 10 in Trieste (Muusse & Van Rooijen, 2015).

2013). In Trieste, Basaglia became head of the mental health department and had plans for a radical reform of mental health care. Going back to his own experiences in World War II, he made the analysis of the hospital as a place that deprived people of their individuality and in which the only role was being a patient. A process described by Erving Goffman as "the mortification of self". For Basaglia, it was necessary to enable people to participate in the community, have relations and conduct meaningful activities to reclaim their social roles.

Earlier, Basaglia had worked in the hospital of Gorizia, where he had tried to reform the psychiatric hospital from within, using the model of therapeutic communities. From this experience, he took the lesson that for true change, a reform of the hospital was not enough. What was needed, in his view, was to "break down" the power of the institution by shifting care from the hospital to the community and to put the person-and not diagnosis or disorder- central to the care provided as to be able to build up relationships (Foot, 2014; Portacolone et al., 2015). Marco-a gigantic papier marché horse made by former clients- was taken in a procession from the hospital grounds into the city. This modern horse of Troje became a strong symbol for Trieste's deinstitutionalization process.

While gradually closing the hospital, a system of care in the community was built up with community mental health centers (CMHC) in different parts of the city. Alongside the care provided in the center, a network of organizations, such as family associations and social cooperatives that provided work for former patients, was built up.[7] In this way, a system was created in which care was provided through the CMHCs. An essential part of this development for Basaglia was to facilitate an open discussion with the team and others -patients, volunteers, and family- following the principles of democratic psychiatry (see also Foot, 2014). In these newly developed community centers the aim was to work with a minimum of restraint and an open door policy at all times, following the principle that exclusion by closing doors hampers recovery. As a result of this movement, psychiatric care was also reformed in other cities in Italy. The most well-known result is the implementation of Law 180, which was seen as the first deinstitutionalization law worldwide (Portacolone et al., 2015). This law came into force in 1978; however, the implementation of the law varied greatly between the various regions of Italy (De Vito, 2015).

Although in Trieste the system changed over time, the main principles of this "revolution" still held when I conducted this research (2017-2019)[8]; most care was provided in or

7 Socal cooperatives employ both disabled (30 %) and non-disabled people and run different facilities in the citiy such as a café, a hotel, and a recycling company. It offers work and opportunities for social inclusion (Portacolone et al., 2015)

8 It is important to note that the way mental health care is organized has recently, after my fieldwork, come under pressure from political expediency and budget cuts, due to the economic situation in Italy (Day, 2021). This means that at the moment of writing, not all mental health centers can still provide the 24/7 care that is defined as an important part of the way of working in Trieste.

from the center 24 /7 with a low threshold and no need for referrals. There was one psychiatric ward in the general hospital with six beds for acute admissions, and an open-door policy is conducted both in the centers and at the hospital ward. The specific way alternatives for hospital care are developed, made Trieste a place for "psychiatric tourism" for people from all over the world looking for inspiration to shape community mental health care. This resulted in several reports and books concerned with the question of how it is possible to organize care with a low number of beds and without seclusion facilities (Burns, 2019; Portacolone et al., 2015).

Shaping community mental health care in Utrecht

In the Netherlands, the process of deinstitutionalization had already started before the Second World War, when Arie Querido, a psychiatrist, began to experiment with forms of care in the community. Mental health care in the Netherlands between the 1950s and 1970s was organized in a scattered way on the base of the dominant socio-religious compartmentation of that time (Vijselaar, 2009), with large psychiatric hospitals and the advent of daycare and other facilities. Apart from the psychiatric hospitals, ambulatory care was also developed within different institutions for specific subgroups (ibid.). From the 1970s on, national policy was directed to a more coherent system organized around the intensity of care and the reduction of the number of beds in psychiatric institutions.

In the Netherlands, deinstitutionalization as an ideal was placed on the agenda from the 1970s, inspired by the developments in Italy and the US. Supported living facilities came into being as an alternative to hospitals. The aim was to reduce hospitals' size and organize more care in the community; however, this process was rather slow. In this period, the mental health consumer movement in the Netherlands began, with the aim to strengthen the legal positions of clients in mental health care and to improve the quality of treatment, for instance, by protesting against dehumanizing aspects of the treatment in psychiatric hospitals such as seclusion (Hunsche, 2008). The movement also fought social exclusion, stigma, and discrimination. While further reducing the number of psychiatric beds in the Netherlands, the dominant policy perspective on mental health care during the eigthies of the last century, made a shift from a social psychiatric perspective towards a more medical perspective with a stronger focus on specialization and specific interventions (Hutschemaekers et al., 2002, p.33).

These developments resulted in a process of deinstitutionalization in which alternative and innovative care models in the community were developed in the 1990s and the beginning of this century, such as Flexible Assertive Community Treatment (FACT) and somewhat later Intensive Home Treatment (IHT). Nevertheless, compared to other European countries, the number of psychiatric beds was still relatively high. In the second decade of this century, the high number of beds was the reason for the Dutch

mental health care policy again aiming for a reduction of beds, both from an efficiency perspective as well as having the goal of increasing the quality of life of clients. This resulted in a policy document in 2012 stating that beds should be reduced by a third by 2020, using 2008 as the baseline reference year (Bestuurlijk akkoord, 2012).

Monitoring the developments of this policy aim (Kroon et al., 2019), showed a reduction of 30 % of the clinical beds in 2018. But in shaping deinstitutionalized care, some problems were signalled too. First, the process of building up community based care in some regions went slower than the reduction of beds. It was questioned if care always addressed those people with most complex needs. Also, the aim of enlarging participation and social conclusion was not always met. Lastly, the report signals that the way care was financed was a threshold for regional cooperation between different care domains, including social work.

During this renewed aim of reducing beds, a new interest arose in the experiences in community mental health care in other countries. One of the results was a study into Trieste's mental health care (Muusse & Van Rooijen, 2015). In this report, we stressed that in learning from experiences elsewhere, it is important not only to study the organization of care but to reflect on the values and ideals that are embedded in care practices as well. The current study is a follow-up on this first report by adapting the approach of empirical ethics that studies how care gets its shape and moral orientation from the relationships between patients, formal and informal caregivers, and the environment.

1.2 STUDYING GOOD CARE

The first research question asks what professionals do in their attempts to shape good care within their daily care practice. This question was informed by the realization in previous research (Muusse & van Rooijen, 2015) that in terms of understanding a care practice, describing the organizational model and outcomes was not enough to comprehend how the care system in Trieste was working. To be able to deduct lessons learned, we argued that it was important to address the normative orientation of care as well.[9]

To address the question of how good care is shaped in practice, I adopted an empirical ethics approach in this study. As Willems and Pols state "everybody wants care to be

9 This even became a lesson learned in itself in this project, and the starting point of different "inspiration" meetings in which the values at stake while shaping care in the community were discussed (Van Slooten, 2016)

good, but there is no agreement what this 'good' should look like" (Willems & Pols, 2010, p.162). In contrast with a prescriptive form of (bio)ethics, in an empirical ethics approach the good is not brought in from the outside in the form of principles such as autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 1994), but it is analyzed as it is enacted within practices. The focus on how care gets shaped in practice makes it possible to analyze how caregivers, patients, and relatives strive for this care to be good and how they deal with tensions and dilemmas that may arise.

In the chapters that follow, I therefore analyze the care practices of the CMHTs in Trieste and Utrecht, using John Law's (1994) concept of "modes of ordering" as developed for the analysis of care practices by Ingun Moser (2005). Modes of ordering can be described as specific patterns of ideals, practices and knowledge, in this case, different ways of shaping care practices and the ideas about what makes this care good. Using the concept enabled me to analyze how people share a common understanding about how good care gets its shape, but also helps to unravel the frictions I observed during my fieldwork. I chose to use the concept "modes of ordering" because the plural "modes" accounts for the fact that people, occupations, or institutions can draw on different modes of ordering (see also Muusse et al., 2021). Also, modes of ordering are not exclusive; different modes can sometimes overlap or even fold into each other (Moser, 2005).

Exploring how care gets its normative orientation within the relationship between patients, formal and informal caregivers and the environment meant that my focus was not only on what people did and said. I used participant observation as the main method to make ethnographic descriptions of the care practices in both teams. My focus was also on how non-human actors, such as routines, buildings, and computer systems were part of this relationship that I tried to analyze. Drawing on the work of scholars in empirical ethics that also include material semiotics in their approach (Pols, 2014; Moser, 2005; Mol, 2002 & 2010; Law, 2010 & 2019), I analyzed how these different non-human actors, together with humans, form social relationships in care practices.

1.3 CARING FOR A CRISIS

The second research question asks how professionals anticipate and respond to "psychiatric crisis" in the CMHT's of Trieste and Utrecht. In contrasting the care practices of the two teams, I focus on the moments caregivers suspect that people may face a psychiatric crisis in the near future. In the discussion about how to shape mental health care in the community as good care, addressing the question of how to care for a crisis is of importance. In the Dutch practice, a crisis often means hospitalization and sometimes coercion or forced care. It is these moments, in which the ideals behind

deinstitutionalizing mental health care such as social inclusion, participation, and autonomy (as well as the bads to be avoided such as forced care and seclusion), surface. In addressing care as a practice that gets its meaning and shape within the relationship between patients, formal and informal caregivers and the environment, I analyze how this network is shaped when there is a perceived risk of a crisis.

1.4 CONDUCTING THE FIELDWORK

To answer the questions about daily care practices around a psychiatric crisis and the normativities embedded in these, I conducted fieldwork in both the CMHT of Trieste and of Utrecht. Trained as an anthropologist, I used ethnography as the main method because it offers the possibility to "study at first-hand what people do and say in particular contexts" (Hammersley, 2006, p.4). Ethnography as a method offers a way to study what those involved define as good care and is in line with the theoretical framework of empiric ethics that "analyses ways in which people and things live together in particular practices as micro societies" (Pols, 2014, p. 82) and the values enacted in these practices.

In the CMHT in Utrecht, I conducted fieldwork for five months in total, divided into two periods. In Trieste, I conducted more intense fieldwork in three periods for five weeks. Important to note that by doing fieldwork in Trieste I could draw on the network built, and material already collected during the previous research (Muusse & van Rooijen, 2015) and several other visits to Trieste I made between 2014-2017. Although I have a basic understanding of Italian, in Trieste, I conducted my fieldwork with Dorine Bauduin. She is a former researcher familiar with mental health care in Trieste, who worked as my interpreter. This assistance helped me to get a detailed understanding of the daily care practice.

During the fieldwork, I conducted observations during the daily routines of the care workers, was present at meetings and went along on house visits. I had conversations with those I joined, in which I asked them about things that had just happened and whether they considered this to be good care. These were usually informal conversations, for instance, in the car (Trieste) or on the bike (Utrecht) going to house visits, or during informal moments in the community mental health centers where the teams resided. In more formal interviews, I asked people to reflect on their practice. These additional interviews were held with three groups of respondents:

- (Care) partners of both CMHTs: the selection of relevant care partners for an interview was based on the observational data collected. For instance, in Utrecht the fieldwork showed that there was frequent

contact with the housing company and therefore they were approached for an interview.

- Clients of the teams: on each side, clients were approached for a formal interview (three in Utrecht and four in Trieste) about their experiences with care and support from the CMHT. More importantly, by conducting the fieldwork, I had informal contacts with a much larger group of clients, for instance during house visits, meetings at the CMHTs, lunch, or visits to housing facilities or peer initiatives.
- Workers of the teams: alongside the fieldwork, some team members were approached for an additional interview (five in Utrecht and six in Trieste). The selection of these interviews was based on the iterative character of the research: specific observations led to additional questions, and thus relevant team members were approached to reflect on these questions in an interview. Apart from these interviews, reflection on the daily care process with health care professionals was part of the participant observation.

At the end of the fieldwork, I organized a group discussion with the team at both field sites. In these meetings, the first results of the fieldwork were discussed. During the fieldwork, there was also an exchange between the two teams: the team in Trieste visited the Dutch CMHT and both teams, together with the first author, provided a workshop on the CCITP about crisis care (October 2018, Rotterdam). From the Dutch organization of which the CMHT is a part, there was a longer tradition of conducting visits to Trieste. Some of the workers of the CMHT in Utrecht, including the team leader, had visited Trieste's mental health care sites on at least one occasion.

Analysis

The material collected during the fieldwork was analyzed to get a better understanding of how relations between practices, ideals, and material environments lead to different modes of ordering care. Drawing on an empirical ethics approach, the focus in this analysis is on the relationsips between people and things in a specific situation and how those involved try to shape care that is "good". Contrasting different modes of ordering care makes visible how what is seen as good or important can differ in different modes of ordering care.

To make this analysis, I examined both the description of the (group) interviews and fieldwork notes and looked for recurring themes and contrasts. The first round of analysis was open: the material was read and discussed by the research team and a first selection of important themes was made, such as ways of preventing a crisis or dealing with uncertainty. The following stages of analysis consisted of a combination of open

and selective stages to sharpen the analysis (constant comparative method). This led to a focus on the different themes that are central in the following chapters; for instance how notions of time and space shape specific care practices around a crisis.

This study is designed as a comparative research between the two research sites, using ethnographic methods. Comparing and contrasting sites, places, or cultures has a long and contested history in anthropology, criticized for essentializing cultures. But as Heer (2019) and Pols (2014) point out, contrasting on the level of care practices can also open up the possibility of thinking about and experiencing a place or site "through elsewhere", calling "existing knowledge and frameworks radically into question" (Heer, 2019, p. 284). Comparing alternative practices this way can open up the possibility to ask new questions and "suggestions for the best possible care may be argued for" (Pols, 2014). The comparison I make in this study differs from a deductive comparison, based on predefined categories and measuring specific outcomes.[10] A multi-sided ethnography (Marcus, 1995), such as this study employs, can help to deepen the understanding of the complexity of care practices while avoiding simplified dichotomies or an exaggerated comparison between research sites. This is also why in the thesis, I describe not only the differences but also the similarities between the CMHTs of Trieste and Utrecht.

Juxtaposing the teams in Utrecht and Trieste in this way can therefore teach us about the different ways of dealing with the risk of a crisis in community care. But contrasting the practices in Trieste and Utrecht can also provoke more overarching questions about how good mental health care could be shaped, thereby answering the third research question. As I will show, one of these questions is whether good mental health care means higher specialization or whether good mental health care means a more generalist approach. Another concerns the quest of how to create continuity of care, especially for people with complex needs. In the discussion, I address these questions to formulate lessons learned from this study and discuss the policy implications.

Ethics

Conducting participant observation as a research method means moving along with actors in the field, nurses, clients and others. This means that formal ethics only covers some of the ethical dilemmas one can encounter in the field. The more procedural ways of ethical approval I conducted in this study consisted of The METC from VU University (FWA00017598), which declares that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study. Additional ethical permission was provided

10 In the health sciences comparing systems between countries is also often problematised because differences in financing care, organisational structures and juridical systems makes it difficult to draw conclusion on the level of outcomes (for instance; what counts as coercion can differ from one system to another).

by the ethical commission of the Trimbos-institute (TET). In formal interviews, written informed consent was obtained. In the material presented, I used pseudonyms and changed some personal characteristics where necessary to protect the anonymity of the persons involved.

During the fieldwork, I was open about my role as a researcher. In both teams information about the research with my photo (and of the interpreter in Trieste) and contact details were placed in the hall. Different strategies were used as a member check. First, there was the group discussion in both teams. If agreed upon, interviews transcriptions were sent to the respondents. Respondents were also informed about quotes used in the articles. Some key contacts in the field were given to read the articles before submission and offered their comments and insights.

Alongside this procedural ethics, in qualitative research *ethics in practice* (Guillemin, & Gillam, 2004) or *ethics work* (Banks, 2016) is also of importance because all kinds of ethical dilemmas can arise during the research. Part of ethics in practice is to reflect on one's own role during the research. In my case, this concerned questions around when to be present or not and awareness about clients' vulnerability in specific situations, for instance around a crisis. Sometimes this meant I withdrew from situations that were potentially interesting but in which it was unclear whether those involved agreed (or were able to agree) to my presence. In these situations, it became about finding a balance between being present and keeping distance and finding creative ways to understand what was happening. This could, for instance be by retaining from an acute situation and discussing the dilemmas of those involved afterwards. Ways of being present thus were defined in the relation between me as a researcher and the care professional and others I accompanied. It meant that I tried to be sensitive to changes in situations and whether respondents still consented to the research along the way.

1.5 THESIS OUTLINE

The core of this thesis consists of four chapters (2-5) in which the empirical material is presented. I start in chapters 2 and 3 to describe the research sites in more detail. In Chapter 2 I analyze the daily care practice of the team in Trieste as a way of working on and with relationships, in which spatial metaphors play an important role. These metaphors direct us to the idea that deinstitutionalization is not only about the physical space where care is provided (in or outside the hospital) but hangs together with a social notion of place as well. In Trieste, ideally, service users are embedded in a network of social relations that, if necessary, can buffer a crisis. Care, then, is directed to the network as a whole.

Chapter 3 gives an overview of the work of the Utrecht team, which is part of a differentiated and specialized care landscape. This means the team has to maneuver between different modes of ordering care which can lead to frictions at times. I describe how the relational mode of caring, an important part of the daily care practice in Utrecht -especially for those with more complex needs- at times lacks legitimation in the way care is organized and financed and words to account for.

In chapter 4, I compare both teams in how they deal with the daily uncertainties encountered during their work. Uncertainty turned out to be a recurrent theme in the fieldwork at both sites, and I argue that understanding how this uncertainty work (Hautamäki, 2018) is done is of importance in understanding how care for a crisis gets shaped. One of the ways to deal with uncertainty in both teams is to create continuity in care. But the way this continuity is shaped differs at the two sites. In Trieste's mode of caring, continuity is shaped by the personal relation with caregivers, while in Utrecht, continuity is created by connecting different forms of expertise. We therefore define the practices as two different modes of caring with two different timeframes. I will show that this has consequences for the way uncertainty work is done at each side.

In Chapter 5, the analyses of the previous chapters are used to zoom in on the different ways a crisis is cared for. In this chapter, I draw on the work of John Law (2010) to describe these practices as two different care-control choreographies in which people and the environment together shape the care around a crisis. Using the methaphor of a choreography, two different forms of crisis emerge.

Lastly, in the discussion, I answer the research questions and reflect on what can be learned from the contrast drawn in the empirical chapters and how this translates into lessons for practice, policy and research.

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CHAPTER 2

Working on and with Relationships: Relational Work and Spatial Understandings of Good Care in Community Mental Health care in Trieste

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2.1 ABSTRACT

Deinstitutionalization is often described as an organizational shift of moving care from the psychiatric hospital towards the community. This paper analyses deinstitutionalization as a daily care practice by adopting an empirical ethics approach instead. Deinstitutionalization of mental health care is seen as an important way of improving the quality of lives of people suffering from severe mental illness. But how is this done in practice and which different goods are strived for by those involved? We examine these questions by giving an ethnographic description of community mental health care in Trieste, a city that underwent a radical process of deinstitutionalization in the 1970s. We show that paying attention to the spatial metaphors used in daily care direct us to different notions of good care in which relationships are central. Addressing the question of how daily care practices of mental health care outside the hospital may be constituted and the importance of spatial metaphors used may inform other practices that want to shape community mental health care.

2.2 INTRODUCTION

Along the coastline of Trieste, on the western side of the city, a busy street runs into the center. Along it lie some bars, an expensive hotel, a restaurant and a church. A bit further down is a popular place where Triestiani go for a swim in the sea on warm days. One building is an old, yellowish villa surrounded by a garden. Go through the porch, and you will find a large table in the garden where people sit chatting and smoking cigarettes. The house itself is a two-floor building, with a small balcony just above the entrance. You are now entering Trieste's first community mental health center, a place with an interesting history.

Since the 1970s, Trieste, a city high in Italy's northeast, has been the stage for visitors from all over the world inspired by the way community mental health is done there. The so-called "Trieste model" of mental health care that has been in constant development since then, was inspired by the ideas of Franco Basaglia (1924–1980), a psychiatrist and leading figure in Italy's democratic psychiatry movement. Basaglia proclaimed that the person, rather than the mental health disorder, should be placed at the center of the mental health care system (Portacolone et al., 2015). On the basis of his philosophy, the psychiatric hospital was closed and a radical shift started towards care in the community.

While the community mental health system that has developed since has changed over time, it has maintained its basic principles: no closed doors, no seclusion and a minimum of restraint. The approach in Trieste has also attracted a lot of attention from professional mental health care workers in and outside Italy, raising questions about what one might term the 'active ingredients' of deinstitutionalization in Italy (Barbui &Tansella, 2008), and whether the 'Trieste model' can be translated to other countries (Portacolone et al., 2015).

Shift from Organization to Daily Practice

In this article we want to explore what daily care practices in Trieste can teach us about deinstitutionalization, how care in the community can be shaped, and what makes it good care. We adopt an empirical ethics approach to shift the focus from a sole organizational perspective towards deinstitutionalization—or the "bricks and mortar" as Chow and Priebe (2013) called it—towards the daily practice of care, the values that come matter and how these values relate to notions of space. An empirical ethics approach is useful to make this shift due to its focus on daily practices and its focus on how these practices entail different notions of what is good care (Willems and Pols, 2010). What is "good" is not defined beforehand, but depends on what actors in a specific care practice strive for or bring about as a good practice (Pols, 2014). So the shift we make in this article

is from how deinstitutionalization is organized to how it is practiced in everyday care.[11] We examine how mental health care in the community can be shaped, and what makes it good care or better care—questions that are relevant to other countries where deinstitutionalization is under debate. Due to its radical ideas and its shaping of the process of deinstitutionalization towards care in the community, mental health care in Trieste is an interesting case from which others can learn (Burti, 2001).

Our argument is twofold. First, by drawing on ethnographic fieldwork, we explore the "the goods" the actors in care situations in Trieste strive for, and the "bads" they try to avoid. We demonstrate how professionals build and maintain a social network around people with mental health problems by working with and on relationships. This is crucial to understanding how the practice of community mental health care in Trieste constitutes good care. Drawing on the work of Myriam Winance, we argue that it is necessary to widen our understanding of a care relationship, not just as a relationship between a care professional and a patient, but as a broader care collective in which people and other nonsocial actors—routines, environments and things—interrelate and together make up care practices. We are particularly interested in the role, understanding and practices of mental health care professionals, and in how they deployed to bring about something "good", we take this empirical ethics approach one step further by unraveling the different spatial metaphors that are used to describe different notions "good care". We argue the importance of spatial metaphors to care, showing how spatial understandings of care shape thinking about relationships, and orient actors towards particular forms of good care. We identify two different spatial metaphors in care practice in Trieste that relate to different scenarios for shaping good care. In practice, these can lead to frictions. Paying attention to these frictions helps to understand care as a continuous process of negotiating on the "good".

2.3 BACKGROUND

Basaglia's Legacy

In the 1960s, first in Gorizia and then in Trieste, Franco Basaglia, a young psychiatrist from Venice, started to experiment with new forms of psychiatry. Inspired by thinkers such as Foucault, Fanon and Goffman, Basaglia saw a mental hospital as a "total institution" that deprived people of their identity and turned them into "non-humans". Goffman (1968) describes how the life of patients in a psychiatric hospital was dictated by the routine of the institution, and how they were isolated from the rest of society.

11 We perceive deinstitutionalization first as a form of regional spatiality in which care is transferred from the hospital into the community. But the process of deinstitutionalization also involves the daily care practice that is then implemented in the community. In this, we argue, social notions of space are important.

This led to a "mortification of the self", a process in which an individual was stripped of any former roles, and instead took on a purely institutional role: that of a patient (Chow & Priebe, 2013).

Around Basaglia emerged a movement that, in practice but also in text, film and photography (Foot, 2015b), called for the reform of psychiatry. It was in Gorizia, where Basaglia as a director started to introduce reforms, first by improving the conditions of patients still in hospital: ending restraint, reducing electro-shock treatment, opening up wards, and destroying walls and fences (Foot 2014, 2015a). In 1971, after leaving Gorizia, Basaglia started as a director of the asylum in Trieste. It was there that he started to put his ideas into practice in a more radical way. The plan was no longer to reform mental hospitals from within, but to break them down entirely, as a way of breaking the power of the institution.

The start of the closure of the mental hospital in Trieste in the 1970s did not happen in a vacuum: Since World War II, consensus had been growing on the need for a thorough change in mental health care. Central to this movement was a shared objective that the old asylum-based system of care should be replaced by new community-orientated approaches (Novella, 2010; Shen & Snowden, 2014; Bennett, 1985). The movement in Trieste should thus be understood against the background of this historical context, which was characterized by the social, protest and civil rights movements of the so-called 1968 revolution. In this period, psychiatric institutions became the focus of political struggle and places of social experimentation (Henckes, 2011). Naturally, the process of psychiatric reform varied from one country to another and had various influences: the development of a welfare state, changes in the status and roles of the medical profession, and the needs to reduce costs and contain risk (Henckes, 2011; Chow, Ajaz & Priebe, 2018). But even though reforms were context-bound, developments in Italy—and particularly in Trieste—were an inspiration for the processes of deinstitutionalization taking place in many other parts of the world. Law 180, which called for the closure of psychiatric hospitals throughout Italy, starting by ending new admissions in order to phase them out altogether, was seen as the first deinstitutionalization law and came into force in 1978 (Portacolone et al., 2015). Its actual implementation varied greatly between the various regions of Italy.[12]

12 For instance, not all Italian regions have a 24-h community-based service (Mezzina, 2016). Such uneven coverage is underlain by differences in the availability of resources for mental health care (Barbui & Tansella, 2008). Other authors have indicated political factors. For example, De Vito (2015) states that Italian psychiatric reform in the decades following the implementation of Law no. 180 faced fierce opposition from conservatives, professionals, politicians, and various organizations representing the relatives of psychiatric patients. He claims that the application of Law 180 was sabotaged more or less explicitly by the national government, which in some regions led to the virtual abandonment of chronic patients. See also Fioritti (2018).

Trieste's Mental Health System

The closure of Trieste's San Giovanni Psychiatric Hospital initiated the building of a new system of mental health care in the community. The city's mental health care services are organized on the principle of territorial responsibility, each of the four municipal districts having a Community Mental Health Center (CMHC) with responsibility for all those with mental health problems in his area. Each CMHC team consists of nurses, psychiatrists, psychologists, rehabilitation specialists and social workers. All nurses work on the reception, rotating on intake functions. People can call in or walk in to seek help. Some of them are seeking help for themselves, others are their relatives, neighbors, or partner organizations. There is no waiting list and no need for a referral. The center is also the place where treatment and care are provided and where people can have lunch or just "hang out" for some time during the day. Each CMHC team provides home visits. People also come to the center for therapeutic interventions and to collect medication. For people who need to stay overnight, there are a total of six beds in one-person or two-person rooms. They can receive visits without restrictions. Occasionally, relatives can stay overnight if necessary. On average, people stay 11 days (Mezzina, 2014; Muusse & Van Rooijen, 2015).

At night, two nurses are present to attend to those sleeping at the center. If someone needs psychiatric care after 8.00 p.m., she or he is referred to the crisis department at the general hospital, which has a small acute ward with six beds. The following morning, contact is made with the center in her or his city district. Here, the average stay is three days, though if diagnostic tests or hospital care are needed, some patients may stay longer. To further reduce the number of hospitalizations, this department has recently been experimenting with the organization of Intensive Home Treatment in cases of crisis. Neither the centers nor the hospital ward have seclusion facilities or closed doors: if compulsory care is necessary, a center will organize it by intensifying the care it provides (Mezzina, 2014; Muusse & Van Rooijen, 2015). This may mean, for instance, that mental health care workers, volunteers or family members accompany a service user during the day. Numbers of compulsory care are low compared to other countries, but also in comparison to other regions in Italy (Mezzina, 2016).

As the centers are part of the local health care agency, they are also part of the public health service. They work with the prison, the police, community primary care teams (Health Care Districts e.g., for young, elderly and disabled people) and welfare organizations, which are one of the partners of the CMHC with whom they consult and share planning (Mezzina, 2016). Various other services, including rehabilitation services, are part of the community mental health department. The centers also work with services that are closely related to mental health care, such as self-help groups and family organizations. Of special interest here are the social cooperatives, in which people

with and without a disability work together on an equal basis. Personal projects are usually developed in co-production with coops and associations and through personal health care budgets for complex needs (Ridente & Mezzina, 2016).

2.4 METHODS

Empirical Ethics and Spatial Metaphors

This study describes community mental health care in Trieste from an ethnographic perspective. It focuses particularly on care situations that are labeled as the onset of a psychiatric crisis, and what the actors involved perceive as 'good care' in these situations. To do this we approach care as it is enacted through everyday practices that include people, as well as things and technologies (Mol, Moser, & Pols, 2010; Pols 2012, 2015). What is important in this approach to care ethics is the notion of the "relational interdependence of people as subjects that are caring and cared for" (Pols,2014 p.81). It takes account of the changing relationships between service users, caregivers, material conditions and others, unraveling their relationships and their *intra-normativity* through a focus on everyday care practices (Ibid).

We are particularly interested in how ideas about good care are enacted in daily practice and how the people involved deal with the tensions that sometimes arise (Willems & Pols, 2010). Rather than defining beforehand what this "good" is, we use participant observation to study it in practice (Pols, 2014). In many care situations it is not always apparent what is good and what is bad. What is "good" can be complex and ambivalent; it depends on the situation and is not always easy to translate into practice (Mol, Moser, & Pols, 2010).

In an extension of our empirical ethics approach, we argue that ideas about good care are often related to spatial metaphors. In this, we draw on the work of Mol and Law (1994), who distinguish between regional space and networks space[13] as two different forms of spatiality. Regional space is the physical space, the boundary between here and there. In "regions […] objects are clustered together and boundaries are drawn around each cluster" (p. 643). Network space, in contrast, links objects in space through the relationships between them, rather than through a regional ordering (p. 649). One can be "within" a network space by becoming part of this network, wherever one might be physically located. Internet networks are clear examples of this; they link people together, without them being in the same region. We will show not only how different

13 In the article they distinguish a third form of spatiality, one in which social spaces behave like a fluid. This form is less relevant to the argument we wish to make here.

notions of space are related to different scenarios for shaping good care, but also how there can be tensions between them. Paying attention to such tensions provides insight into the scenarios for shaping good care that are embedded in daily practices. More importantly, such attention can also help us to strengthen these practices.

Fieldwork

The first author has been involved in studies on community mental health care in Trieste since 2014. The first study (in 2014) is included in the report "Freedom first", which was based mostly on interviews, but also included some observational work (Muusse & Van Rooijen, 2015).[14] Having visited Trieste's mental health care services several times since 2014, and two counter visits from care professionals from Trieste to the Netherlands, the idea emerged that it would be valuable to conduct in-depth research from an ethnographic perspective. The current research involved observations divided over three periods in 2017 at one of the city's mental health centers. Although the first author has a basic understanding of Italian, to gain a detailed understanding of daily practice there, she worked with an interpreter who was familiar with mental health care.[15] Together they observed the daily routines of the CMHC referred to above. They joined workers on their daily abouts, attended meetings, and went on home visits with participants, they discussed what they saw as "good care" in these specific situations. In addition to participant observation, we also interviewed service users, relatives, and other stakeholders such as the police, city council, social cooperatives and addiction-care services. As the research focused on the ethnographic work of following care professionals, one specific consequence is that these professionals' perspectives on "good care" are more pronounced than those of the other actors.

Informed consent was obtained for the interviews with service users. All material was anonymized, and no names or other persona details were collected.[16] The field notes and interviews collected during the fieldwork periods were transcribed, and then coded in Maxqda. The process of coding involved open and selective stages. In the open stage, to sharpen the focus of the research and to be sensitive to new questions, the material was analyzed during the fieldwork periods. It was then read multiple times and openly coded, parts being highlighted to identify recurring themes or patterns. This method of analysis made it possible for relationships and the use of spatial metaphors to emerge

14 Central to this research was the question of what, when shaping its own process of deinstitutionalization, Dutch mental health care can learn from Trieste's 40 years of experience of working in the community. For this project we spoke with stakeholders, operators, partners, and had interviews with service users and their networks (Muusse & van Rooijen, 2015).

15 Next to the use of Italian, conversations between the researcher and care workers/service users were conducted in English as well. In this article we try use the Italian term for keywords, but due to this double use of languages, this was not always possible.

16 The METC from VU University (FWA00017598) has declared that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study.

from the data as central themes. This analysis was discussed with the research team and a group of qualitative researchers to strengthen the coherence of the analysis. In the selective stage, we used a second round of analysis to identify cases or situations in which this relational approach was described or in which spatial metaphors were used.

Below, we describe daily care practices in one of the CMHCs in Trieste. Following the theoretical stand of empirical ethics, we have tried to analyze how good care takes shape in everyday practice. In the second part of the article, when our focus shifts towards spatial metaphors, we show how spatial understandings of care orient actors towards particular forms of good care.

2.5 FINDINGS

Working with and on relationships

> *On one of my first days at the center, Mauro, one of the nurses, takes me and the interpreter to see a woman he has known for years. In the car on the way there he tells us that he sometimes jokes that he could divorce his wife, but not this patient. When we arrive at the apartment, he rings the bell twice, telling us that this is how she knows it's him. An elderly lady opens the door. When we enter, I notice that the walls are decorated with painted flowers. Mauro tells us to touch the paintings, explaining that they are made with toothpaste (mint for green) and he says with some pride that the woman is a true artist. He takes his time for a chat with her. We stay in a kitchen-cum-living room, where there are instant noodles and ready-made soup on the table. When he wants to give her depot medication, we go to another room, whose walls are decorated with small strips of insulating tape in the colors blue, yellow and red. It reminds me of Mondrian's painting 'Victory Boogie-Woogie'. The woman and Mauro join us again. The woman explains more about her art, but appears to be in her own world. She gives a long explanation about a connection with the trees and birds in the garden and the pots in her window, but with a logic none of us can follow.*
>
> *Back in the car, Mauro explains a bit more about this woman's situation. He describes it as a fragile equilibrium, but that they try hard to let her live independently, in her own way and in her own home. To make this possible, there are different forms of support, such as this morning's check-ups and the medication from the mental health center. But she is also surrounded by a broader network. Over the years, her administrator and his wife, who*

became voluntary caregivers, do her shopping and check up on her. There is also social assistance to take care of her apartment, and frequent visits from her daughter, who lives in the city. As all these people are in regular contact with the center, the mental health professionals know how she is doing. Mauro also explains that her gas had been turned off for safety reasons (which explains the ready-made soup on the table) and that they have switched to depot medication, even though the mental health center prefers oral medication. This was necessary due to a crisis caused by the woman's not taking medications about six months ago. When we're driving back, I have the feeling that Mauro is proud of what they have managed to achieve with this woman, letting her live independently, in her own way.

A few months later, I hear from other nurses that she was in crisis again, and was staying at the center for a few months. The equilibrium is indeed fragile. (Field notes)

What can we learn from this story about what is perceived as good mental health care in Trieste? In this case description, "knowing" one another is important in the relationship between Mauro and the woman. Mauro rings the bell twice, so she knows it is him. He takes time for us to get to know her a little, by pointing out the paintings, and describing her as a real artist and a unique person. This knowing goes together with being familiar: Mauro points out the personal and long-term nature of the relationship, by jokingly comparing their relationship to his marriage. On the trip there, he had already emphasized that he had known the woman throughout his whole working career.

If we take a step back and look beyond the traditional caregiver–patient relationship, it is clear that the care situation is also shaped by other actors. First, there are people: mental health workers, those from other services who provide support (supported housing); and her personal network (her daughter, and the administrator and his wife). There are also items and objects with specific qualities (her own apartment where she can make her toothpaste paintings without anyone protesting). There are forms and routines of support: the housekeeping, and the regular visits and medication by a nurse she knows well. There are also some restrictions: the gas has been cut off, and it has been decided to work with depot medication (which the mental health department sees as a less preferable option due to the invasive nature of its administration).

To use the words of nurse Mauro, all this is needed "to keep the equilibrium". The word equilibrium- "equilibrio" in Italian—indicates being stable, a term often used in psychiatric care, but it is not the same. Being stable is a situation that can change back to being unstable. Equilibrium, in contrast, is more fragile: it can swing a bit, without

collapsing, but caution and constant work are both required. “Hard work”, Mauro says. “Maintaining the equilibrium” is like a balancing act: skillful and playful at the same time. What is also of interest here is what the director of the mental health care service in Trieste says about working to prevent a crisis:

> *“It’s about creating a social surrounding that functions as a buffer – by providing housing, for instance, or relationships. If you asked a psychiatrist at an international meeting about preventing crisis, he would tell you that the most important thing is to be alert to early warning signs. And that is indeed of great importance. But what may be even more important is this kind of social engineering: working on the social determinants that create stability. Otherwise, the circle maintains itself.” (Interview with the Director of MH Dept in Trieste)*

Here, the social surroundings are defined as an actor in care situations. Their role is to function as an instrument that makes it possible to work in the community without the facility of a closed ward or places for long-term admission. In crisis situations, as Mezzina and Johnson indicate (2008), the social network is involved as much as possible both in building a relationship and in maintaining connections with the outside world. If the network is weak or lacking, it is the task of the mental health care service to create one by working on what is called “social engineering”, i.e., by creating or maintaining housing, jobs, and social relationships. The importance of this social engineering is not purely instrumental: it is also a way of working on the ideal of social inclusion (Mezzina, 2016).

Care Collective

To understand the relational approach to community mental health care in Trieste, it is therefore necessary to be aware of the service users’ social surroundings and to examine the role of all those involved—not only service users and professionals, but also the other people and things involved in specific care situations. Winance (2010) has argued with regard to the analysis of care situations that it may be useful to speak of a care collective, as this will create the space in which it becomes visible that everybody involved has a role in providing care. In her analysis of the process of testing wheelchairs, Winance convincingly shows that a care collective is composed of different elements, people and things. In striving for “good” care, she argues, everybody in the collective plays a part in negotiating what this good is. Seen from this viewpoint, the example of Mauro’s home visit shows how the care situation we observed was shaped both by human actors (the nurse, homecare, the family) and by non-human actors (depot medication, the fact the gas had been cut off, and the privacy of the old lady’s own apartment). This is not all: the actors themselves are “shaped” by the relationships in the care collective, which define

the way Mauro and the old lady relate to each other, the topics they discuss, the things Mauro observes, the medication that is given, and the food she is able to prepare in her own home.

Negotiating Goods

When I was taken on this home visit, I had the sense that Mauro was proud of the situation, of what they had achieved. That is not to say that the situation was easy or self-evident. The reality was complex, and the old lady was impaired in many ways by her disabilities. As Winance (2010) points out, the "good" in care situations is not a perfect situation in absolute terms. She sees this as inherent to care situations, as a collective is all about negotiating and dealing with the resources available: "the good is an arrangement of people and things that is a compromise, allowing life together and allowing motion and emotion for all those involved in the collective" (Ibid: 109). In this case, for instance, this may mean that an intervention that is labeled as less desirable—such as depot medication—is adapted in order to keep this equilibrium. A team leader commented on this in an interview:

> *"The way we normally function is to create continuity in the creation of the relationship, also with the family and others: it allows you to feel what's going on. To create this continuity, we need signals in the context of a person: family, neighbors, school. So actually, we need a good connection with others in the context who receive these signals. If this connection is good, it's very easy to work on prevention." She stresses that a good relationship is an open one, not a formal one. "It's about calling each other, asking what's going on – it's about a trustful connection." (Interview with a team leader of a CMHC in Trieste)*

This gives us some more ideas about what is seen as important in shaping such a care collective: the relationships between the people involved are informal and trustful it is a relationship you can depend on. The aim is to achieve continuity in them. To achieve this, and to sustain relationships with the service users and others, workers should know what is going on. And, by knowing it, the "we" in this case—i.e., the workers in the team—presumably know what kind of support people need. For this to be possible, the workers thus need the network of (family, neighbors, schools etc.) around somebody. As a "good" professional does not—and cannot—act alone, this sometimes means that what is good is negotiable, not only with the service user, but also with other caregivers:

> *On one of the visits I make with a young psychiatrist, she visits a group house where a girl lives. At the family's request, the psychiatrist had reduced sedative medication. The team is now having a meeting about*

the current situation, which they describe as una crisi brutta– a severe crisis. The girl is often aggressive towards the care team, herself and group members. The caregivers would like the psychiatrist to prescribe sedatives. The meeting takes over an hour, with the group house team members referring repeatedly to all the problems they have in her daily care. In the end the psychiatrist decides not to prescribe sedatives, but to switch to other antipsychotics. In the car on the way back, she reflects on the meeting: "For me it was searching. Persuading is also persuading the team: showing that you're there for them and persuading them that sedatives are not a solution." But she stresses the importance of listening to the team and their problems. (Field notes)

Closer examination of the role of the social network reveals a number of other elements that stand out. First, service users need a network around them that is broader than the mental health services. For a network to function as a buffer, the people in it should have a close relationship with the center, and should work together, signaling if something is changing and extra help or support is needed. When asked what he did when somebody refused care, a rehabilitation worker reflected that he would negotiate and persuade, engage in a dialogue and visit more often. But he would also contact neighbors and family. This sometimes gave him a new and different way of entering into a relationship. Being part of this care collective is not strictly voluntary. To make it function, each participant has a responsibility. The responsibility of the mental health care service is articulated as being accessible and accountable, and as responding quickly to a crisis when necessary (Mezzina, 2016). One way to achieve this can be seen in the option patients and others have of walking into the center and being able to talk to a nurse, all without a waiting list. But other parts of the collective, like family, have a responsibility as well:

The next case in the team meeting raises a lot of emotion. The team worries about the time a young woman spends between school and home, as the mother does not watch over her and overestimates her daughter's capabilities. Neither does the mother show up for appointments at the center. In a meeting later that week, the psychiatrist tells that she called in and confronted the mother with the fact that she was not sticking to the agreements that had been made with the team. They all stress the importance of the mother being involved, of her taking her responsibility. (Field notes)

As one of the ideals is that service users should be embedded in a social network in order to be provided with good care, it is not only family, neighbors and friends that are seen as necessary elements in a care collective: so, too, are work, school or housing. For

instance; we observed that nurses immediately contacted the university to reschedule exams for a young man who was brought to the center in a crisis. Again, this network or collective is not only an ideal, but also an instrument; as well as being a way of working on the ideal of moving people "towards society", it is a way of dealing with crisis without the facilities of closed wards. If there is no network, or if a network is in decline, it is seen as a problem, as there is—or soon will be—none to buffer a crisis.

It is important to note that in Italy cultural expectations around family relationships differ from ideas about family life in more northern European countries like the Netherlands. This could make it more easy to create stable networks. But despite the importance of family in the Italian culture, the role of the family in the care collective is not always taken for granted. In other cases we encountered during the fieldwork, the role of the family was problematized, for instance in the case of two young men who both had a "symbiotic" relation with the mother in the opinion of the care professionals. In these cases one of the goals of the care was to provide independent housing for these boys, for instance in a shared apartment with other service users. Another way of "managing" family relations was by trying to schedule the telephone calls of a mother to her sun (only in the evening).

Role of the Professional

If one of the aims of care is to build and sustain relations, then this has an impact of the task scope of care workers: it is less about reducing symptoms as it is about creating and sustaining these relations. Professional therefore must be involved in several domains of service users' lives beyond that of their mental health:

> *It's Saturday afternoon, just after lunch. Some of the care professionals and service users go for a smoke on the small balcony. This morning I joined the psychiatrist on her work. She had four meetings with service users and their families, each of which took about an hour. None of the service users seemed to be urgently in need of something. On the balcony, me and the psychiatrist are reflecting on one of the meetings. It was with a mother and brother of a service user, mainly because the brother was worried that the burden of caring for his sick brother was becoming too much for his mother. The brother in the center's care was in his forties, and still living at home.*
>
> *As he was also financially dependent on his mother, in the meeting his financial situation was discussed. I was surprised by the time the psychiatrist had devoted to arranging social benefits for him: she had looked up the options on the internet and made an appointment to go*

to the municipality with him. I commented that, in the Netherlands, this would not be part of a normal Saturday morning routine for a psychiatrist on most of the mental health care teams I knew. I asked if a social worker wasn't supposed to arrange such things. She stated that it was important to do it herself, because, "as a psychiatrist, you're dealing with a service users' whole life". I commented that the importance of addressing all life domains is also stressed in the Netherlands, but that a psychiatrist focuses mainly on treatment and medication, a social worker on administration, and a nurse on daily assistance. Her reply: "It's not therapeutic to work like that. As a psychiatrist you need to be involved in all life domains to understand what's going on, and to build on a relationship." (Field notes)

Once again, the focus lies on the ability to build relationships—in this case the role of the professional (the psychiatrist). The psychiatrist claims it is important to be involved with a service user's "whole life," and thus that division of labor is not regarded as a therapeutic way of working.

Above, we outlined how building relationships lies at the heart of the "goods" the actors in care situations strive for. Good care is aimed at building and maintaining a social network around people. We argued that, to understand this approach, it is helpful to speak of a care collective that includes people as well as things, techniques and routines. The next thing that stood out when analyzing this relational approach was that ideas of good care were often addressed using spatial metaphors that indicated whether or not people were in the "right place". These metaphors were sometimes about a material place, but also concerted social places—the way people related to others.

Notions of Space

Questions of space and (mental) health care are addressed in the literature on human geography (Krause, Parkin, & Alex 2014). To indicate the importance of place in health care, both physical as cultural, Gesler (1992) coined the term "therapeutic landscape". As social spaces are shaped by social interactions and the material environment, other authors point out that social spaces can be understood as both physical and social at the same time (Pols, 2016; Wood, et al., 2013; Gesler, 1992; Doroud, Fossey & Fortune, 2018; Smith, et al., 2015; Ootes et al., 2013; Ootes, 2009). We do not only consider references to physical locations as spatial notions. In our fieldwork we noticed that spatial metaphors like "inclusion" or "isolation" were also frequently used. These terms do not solely refer to a physical place. Instead, they reflect particular ideas about how people (do or do not) interrelate. To understand how different forms of spatiality are oriented towards particular forms of good care, it can be helpful to use two concepts introduced by Mol and Law who explore different types of spatiality (Mol & Law, 1994). Therefore we

use their concept of a *network space* to make a contrast with *regional space*.
In a regional space, there is a vision of here and there, each being located on its own side of a boundary. This also makes it possible for there to be an "inside" and an "outside" (p. 647). In contrast, a network space links objects in space through the relationships between them, rather than through a regional ordering (p. 649). Network space is not about here or there, but about the way elements—such as people, machine and gestures—hang together (ibid). Using ethnographic data, we show how, in Trieste, these two different forms of spatiality are connected with specific ideas about good care. This can be illustrated by the following discussion about where people eat lunch:

> *When I enter the central room that is used both for team meetings and for lunch, the table is already set. Some service users are seated, others walk in. There is one large table for ten people, with some smaller ones around it. I take a place opposite a man in the corner. We chat a bit and it turns out that he was born in the Netherlands but has forgotten most of the language: we practice 'goedemorgen' together. Then a woman in a white uniform comes in with a lunch trolley.*
>
> *One man gets his food a bit earlier than the others. He is moving around a lot, mumbling to himself. He stands out because of his outfit. He is wearing only cycling shorts, is covered in tattoos and has lots of bracelets and strips of cotton around one arm. I often encounter this man near the railway station, talking to himself. His feet, injured and malformed, remind me of the "walking feet" I remember from the homeless shelter where I used to work in Amsterdam. Nobody seems to mind him. He eats his food at enormous speed and then leaves the room.*
>
> *After choosing between two menu options, the others get a primo consisting of pasta or rice with vegetables, and a secondo with meat – in today's case, chicken. As the plates have already been prepared in the kitchen, there is no choice regarding the amount of food or anything else. Nurse Mauro had explained sometime earlier that the hygiene rules do not allow service users to cook in the health center or to help distributing the meals. Afterwards, some service users help clear away the dishes. I try to do so, too, but am told not to, since I am a guest. (Field notes)*

On my first visits to the center, the social and material organization of the lunch was causing lot of discussions and team meetings. Recently the central department has planned to reallocate the places where people had their lunch. Rather than giving out meals in the center—where a group of service users had lunch every day—the idea is to

create other options, such as organizing a cooking project in a group apartment, or eating at a local restaurant. One reason for this change had been an analysis of the situation at the centers showing that, for a small number of service users, the centers had become the only point of reference. This applied particularly to men aged between 45 and 55 whose condition was chronic. The head of the rehabilitation service explained that many things, including work programs and training, had already been tried for this group in the past, but without success. She stated that the idea behind the decision to relocate lunch was to reallocate activities and resources from the center to the community:

> *About 10 years ago we started various projects, all of them intended to make a move towards society. (…). The idea is to strengthen links with the community by creating new projects around distributing meals. These links are important, as they help us work on social cohesion. That is of importance, as it makes it easier to manage problems. (Interview with the head of the rehabilitation service)*

But not everyone at the center agrees with this vision. A nurse explains to me that the center is a point of contact, a place for meeting each other. As lunch provides a means for staying in contact with some of the users—especially those who are more difficult to reach—it is an instrument that helps to check how people are doing and also provides an opportunity to work on relationships with them. On the other hand, most mental health professionals acknowledge that some users depended on the center. For those who had few contacts outside, it had become a "mini hospital", without much contact outside the care facility.

If we look at the different spatiality's used in the discussion about where to organize lunch—there are two notions of spatiality, each echoing different ideas of good care, and each in tension with the other. First, there is regional space—physical space; the boundary between "here" and "there"—which is present in the discussion about the location of the lunch. In this notion of spatiality, lunch is an obstacle to an important ideal of good care: the ideal that service users should not live in the "separate world of psychiatry", but should instead be part of the community. As lunch binds people to the center, the rather institutional mode of distributing the food described above—with fixed portions, and where helping was not allowed – does not contribute to the ideal of moving people out of "the institution" into "the community". Moving lunch from a perspective of regional space echoes one aspect of the ideal behind "deinstitutionalization," that patients should be made into citizens by enabling people to take part in the community by moving the place where care is provided. Following Ootes (Ootes et al., 2013; Ootes, 2009), who argues that notions of space are related to notions of citizenship, we could argue that relocating lunch is also a way of working towards this idea of good care. It

goes together with the hope that organizing lunch at various other locations will extend service users' abilities to participate (in the community), for instance by learning how to cook.

Second, there is the spatial metaphor of the network, a social space that refers to relations between people and things and how they hang together. In this network space, the service user is the center of a network or web of people and things that functions best when its participants have close relationships. This network space echoes an important idea about the professionals' provision of good care (see above), where the aim is to stay in a close relationship with service users and to build a network. In this network space, lunch at the center is an important instrument for achieving both at the same time: as people visit the center every day to eat, they meet other people and the care professionals are offered a means of building and maintaining relationships.

The discussion about lunch and the types of spatiality used, direct us towards different ideas of good care that are related to different aspects of the process of deinstitutionalization. From the perspective of regional space—which echoes the ideal of deinstitutionalization in the sense that it is about moving people "outside"—moving the lunch is seen as a way of strengthening the link with the community, and therefore as "good". From a network perspective in which deinstitutionalization is more about the relations between actors and the possibilities abilities to participate in the community, things are more complicated: nurses drew attention to the risk that the relationships with care workers and service users would become weaker if the daily lunch visits to the center disappeared, and that it would then become more difficult to maintain strong relationships and to maintain the network in which, ideally, service users were embedded. The example of the lunch makes clear that deinstitutionalization is more than a shift from the hospital to the community. In practice it asks for finding ways of doing things, articulating good care. By doing this, relationships and social spaces are shaped and reshaped.

Living Independently

Back to the house of the lady who made the toothpaste paintings for another example of how spatial configurations project ideals about good care, but in complex ways. In the philosophy of deinstitutionalization whereby hospital beds are replaced by care in the community, living independently is seen as an aim to strive for. This is reflected in the organization of care described above. The center is located in the community, and to work in such way that there is no need to transfer someone to an institution, the thresholds are low: care is provided where people live. But in daily care practices, things are more complex than a chronological sequence from a regional spatiality (the move from the hospital towards the community) towards a network spatiality (the idea of a

service user who arrives in the community as a relational being and becomes embedded in a network), and the different ideas about good care that are reflected in these spatial metaphors.

How it is more complicated becomes clear in situations were living independently is not always seen as "good" by those involved. During our fieldwork, for instance, there was much discussion amongst nurses about a man in the center's care who was strongly alcohol dependent. Before being admitted to the center he had caused a lot of problems by involving other service users in his drinking. Now he stayed in his own home drinking, and it was difficult for the care workers to contact him. In a telephone meeting with his administrator, a nurse described the situation as a "micro-manicomio". Manicomio—"asylum" or "madhouse"—is the term that was often used during the reforms of the 1970s to stress that psychiatric hospitals were what Basaglia had termed "total institutions" that cut people off from society and deprived them of their individuality. Care workers also used this term to describe situations in which service users lived independently and were simultaneously socially isolated. The use of the term *micro-manicomio* echoes a relational-spatial perspective: people should not be socially isolated, but part of the community. One way of achieving this was by creating and maintaining care collectives. So the deinstitutionalizing principle of living independently in the community is not therefore labeled as "the good" in all situations. It is conditional: the ideal of living independently in the community exists next to the ideal of a person as a relational being who is also embedded in social networks. A good patient is in a relationship with the world around him: making steps outside, possibly in a job, or involved in other daily routines:

> *"The challenge is that users find their way in the normal world, not the shielded world of psychiatry such as a hospital. We can never be the only bridge to social reality, we need more bridges. It's about normalization." (Interview with the Director of MH Dept in Trieste)*

The use of the word *micro-manicomio* also indicates the importance of the sociality of space in providing care. It is not only about the regional place where somebody lives—a person's own apartment. It is also about the network space, which we defined as both physical and social. The word marks a shift from isolation and a parallel world towards spatial network configurations in which people are embedded in relationships, and "in the normal world." There is a realization that it takes time to build these relationships, and that it is the service user who determines the pace. Again and again, professionals in team meetings stressed that things should be done *piano piano*—step by step.

2.6 CONCLUSION

In this article we have asked how mental health care can be shaped in the community, and how it can be thought of as good care. As a practice to learn from, we chose the community mental health care services in Trieste due to the unique and radical process of deinstitutionalization the city has gone through. What could their daily practice of care teach us about the specificities of and notions of good care embedded in everyday community care? We suggest that our analytical method may support an understanding of what is at stake in everyday care practice, here, specifically, in relation to the spatial metaphors implicit in these practices.

Firstly, our analysis of daily care practices developed what we may call a "radical relational approach" (Pols, 2014; Driessen, 2019). This term takes into account that relationality comes in many forms, including things, activities and words. The house visit to the "tooth paste artist" made visible that to understand care practices, it is of importance to widen our scope from the dyadic relationship between care professional and patient, to include a broader care collective of actors that includes material things, buildings and spaces (Winance, 2010).

This analysis showed us how professionals enact good care. They describe situations as "good" when service users are part of a care collective. These relational arrangements foregrounded the sociality built as network space: a "good" situation is a situation in which somebody is in contact with others, participates in meaningful activities and infrastructures, and is integrated into society by being part of a socio-material network. As well as being an ideal to strive for, Trieste's network approach to mental health care is also the instrument for bringing about good care, as creating a network is used as a way of preventing crisis, without relying too much on (scarce) clinical facilities. A good professional in Trieste works on building and maintaining long-term relationships, not only with the service users, but, also with the other nodes in the network that include work, school, places to go to and family. In this perspective good mental health care is not primarily about the reduction of symptoms. Good care is about sustaining and building networks within which individuals may live as well as they can.

This focus on the network has some practical implications: it means that service providers have a specific understanding of what it means to be a mental health professional, whose central competence is to build relationships. A consequence of this radical relational perspective is that it enables health professionals to interfere, before psychiatric symptoms may emerge or increase. More interestingly, it leads to a practice of small, daily interferences and adjustments to keep up the network. An example: in case of a hospitalization not only family is involved, but the professionals also immediately make

an effort to manage relations with employers or school, as to smoothen the return. Another example is the arranging of social benefits by a psychiatrist, as our example showed. To work and maintain these relations in the network is seen as much as part of the job as the reduction of symptoms is. This does, however, demands a certain kind of de-specialization, because all service providers, invest in relationships with their clients and their network. Another consequence is that mental health care professionals are present for a long time in the lives of service users. This can be at odds with the ideal of normalization that is present in mental health care as well. Articulating the Trieste's relational approach to mental health care resonates with criticism on dominant biomedical views in which mental health problems are mainly presented as disorders that can be diagnosed in the individual. These need treatment from medical specialists who may apply evidenced-based interventions (see for this criticism: Van Os et al., 2019). The relational approach decenters the individual by focusing on how these patients do or do not relate to other (social and material) actors in their network.

Secondly, our study shows how deinstitutionalization is not a mere organizational change signified by a reduction of beds or a number of service users moved out of psychiatric institutions. The idea of successful deinstitutionalization relates to a regional understanding of space. An understanding of the relational aspects of care shows that reducing beds and providing housing does not automatically lead to social contacts and becoming part of a community (Pols, 2016).[17] The relational approach as practiced in Trieste mental health care teaches what may be done once the hospital is closed and regional moves have finished.

The analysis of spatial metaphors and how they project ideas about good community care makes visible that deinstitutionalization is not only a chronological sequence that moves from a regional spatiality towards a network spatiality. The discussion about where to provide lunch shows the regional metaphors are still active. This created tension between different understanding of what is good care: while providing lunch at the center supported the creation of relationships and a network between and around service users, moving it to restaurants in the community might serve a different case: the ideal of moving care towards different relationships with different people. The discussion about lunch shows that in daily practice, finding ways of providing good care implies a juggling of different approaches and metaphors. Articulating the metaphors and the goods that are at stake teaches how good care may practically take shape, and how it differs from other practices and their embedded goods. This may help us reflect on what form of good care achieves what in different situations.

17 Pols (2006, 2016) uses the notion of "relational citizenship" to signify becoming part of a network as a way to become a citizen.

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CHAPTER 3

Frying eggs or making a treatment plan? Frictions between different modes of caring in a community mental health team

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3.1 ABSTRACT

In this article, we conduct an empirical ethics approach to unravel the different perspectives on good care that are present in a community mental health team (CMHT) in Utrecht. With the deinstitutionalisation of mental health care, the importance of a close collaboration between the social and medical domains of care on the level of the local community is put in the foreground. Next to organisational thresholds or incentives, this collaboration is shaped by different notions of what good mental health care should entail. Using the concept of modes of ordering care (Moser, 2005), we describe five modes of ordering mental health care that are present in the practice of the CMHT: the medical specialist, the juridical, the community, the relational and the bureaucratic perspective. These different modes of ordering care lead to frictions and misunderstandings, but are mutually enhancing at other times. Unravelling these different modes of ordering care can facilitate collaboration between professionals of different care domains and support a mutual understanding of what needs to be done. More so, the analysis foregrounds that ordering care from a relational approach is important in daily practice, but is in need of stronger legitimation.

3.2 INTRODUCTION

How should we care for people with severe mental illness in the community? This question about how to shape deinstitutionalisation is often addressed in organisational terms. This paper addresses the question from an empirical perspective on care practices: we describe how a team of health-care professionals in Utrecht, the Netherlands shape care in the community for people with severe mental illness (SMI)[18] and where this leads to problems. We ask ourselves which different modes of ordering mental health care are present in the practice of the Community Mental Health Team (CMHT) and we analyse how these modes suggest different types of problems that require particular solutions in order to create good care. We show how the different modes of ordering care relate to each other – sometimes in a mutually enhancing way, but sometimes leading to friction and misunderstandings about how to proceed. By articulating these tensions, we hope to clarify what is at stake.

The study of care practices and their tensions have been approached in different ways. Navne and Svendsen (2018), Pols (2006), Brown and Korczynski (2017) and Zuiderent (2015) address the role of institutional practices, such as the process of decision-making, the standardization of care and accountability practices. Other work highlights the role of professional competition in the way different perspectives on care relate to each other (see, e.g., Sanders & Harrison, 2008). In this paper, we focus on notions of good care that are not attached to a specific institution or occupation. We draw on John Law's (1994) concept of "modes of ordering," as developed for the analysis of care practices by Ingun Moser (2005). We use the concept to unravel the frictions we observed during our fieldwork. The plural "modes" opens up the space to account for the fact that people, occupations or institutions can draw on different modes of ordering. As Moser (2005, p. 669) points out, "in practice people are not caught in any one mode of ordering (…) but rather slip and move between multiple modes of ordering that co-exist, [and] are partially related in complex ways and even folded into each other." The verb "ordering" directs us to the fact that good community mental health care is not a static state or an end goal, but an ongoing process: of discussing, reframing and trying out what works. Analyzing the activity of ordering helps us to render intelligible the recurrent discussions and misunderstandings in the work of the team and its partners. We analyze the work and orderings of professionals working in everyday care: the case managers, clinical nurses and others.

To answer the questions raised in this paper, we turned to the daily practice of caring, by using ethnography as the main method. For each mode of ordering care, we first describe

18 SMI refers to refer to long-term psychiatric disorders that interrupt, destabilize and imperil lives over a long period of time (Drake, Green, Mueser & Goldman,2003). This CMHT was not diagnosis specific. Substance abuse was not an exclusion criterium.

what is seen as a problem and then link this to specific notions of good care. Analyzing care situations in this way relates our analysis to the work to an *empirical ethics of care* (see, e.g., Mol et al., 2010; Pols, 2014; Willems & Pols, 2010). By describing practices and the notions of the good that are embedded in these, we follow Pols et al. (2019) who states that "empirical ethics combines a "sociology of the good" (Thévenot,2001, see also Boltanski & Thévenot, 2006) and a material semiotic approach that does not "apply" theoretical concepts, but studies what these concepts come to be – or how they become enacted – in specific contexts." (Pols et al., 2019, p.100).

3.3 BACKGROUND

The context

The first author conducted fieldwork in a CMHT in Utrecht, the Netherlands. The team came into existence in 2016 due to changes in the policy and funding of Dutch mental health care that started around 2005, which prioritized the reduction of beds in psychiatric hospitals. The changes were aimed both at improving care by moving towards more community-based and recovery-orientated approaches and at reallocating resources and improving efficiency (Bestuurlijk akkoord, 2012).

In Utrecht, this move towards deinstitutionalization was the incentive to restructure care for people with so-called SMI. Across the region, care is now decentralized into different CMHTs, in which specialized mental health treatment and supported living teams work side-by-side to provide care in the community for people with SMI (Taskforce EPA Midden Westelijk Utrecht, 2015). The hope is that this way of working can close the gap between mental health *support* (e.g., assistance with daily activities, the household and administration) and mental health *treatment* (evidenced-based interventions, medication and hospitalization), as noted in policy documents (Commissie Toekomst beschermd wonen, 2015). The other aim is making care more easily accessible by decentralizing mental health care to local communities.

The neighborhood

The first author conducted participant observation in one CMHT located in a neighborhood on the outskirts of Utrecht. Built in the post-war period, the neighborhood contains mostly high-rise buildings with apartments that are rented out by social housing companies. It has 34,000 inhabitants from diverse cultural backgrounds, many of whom face problems like poverty, unemployment, school dropout or criminality. Furthermore, the intensity of demand for and supply of care is relatively high (Zorgverzekeraars Nederland, 2014).

The team

The newly formed CMHT consists of care workers from two different organizations. The first is a mental health care organization that provides treatment in different forms.[19] Staff include a psychologist, a psychiatrist, an expert by experience, a specialized mental health nurse and mental health nurses. In their work, they adopt Flexible Assertive Community Treatment (FACT), a care model that combines individual case management with shared caseload and assertive outreach (Nugter et al., 2016; Van Vugt et al., 2011). The second constituent organization is responsible for sheltered housing and supported living in the community.[20] The workers involved are personal case managers and an expert by experience. Other professions, such as a rehabilitation worker and addiction care specialist, are linked to the team on a consultation basis.

The CMHT thus consists of people from two organizations, working in one team. In practice, this means that professionals in the CMHT work with different administrative structures and different accountability systems. The funding of these forms of care is also different: the supported housing organization is funded by the social support act (Wet Maatschappelijke Ondersteuning in Dutch), which is a collective act under the responsibility of the municipality, while the clinical treatment team is paid by health insurance companies, based on individual diagnoses. This way of financing care therefore bears the risk of enlarging the observed gap between medical and social services (Mason et al., 2015). The combined CMHT tries to bridge this gap.

3.4 METHODS AND ANALYSIS

This article is based on data collected during fieldwork carried out in a CMHT in Utrecht.[21] The first author observed the practice of daily care in the CMHT, with a special focus on notions of good care that are at stake in these practices. To do so, she joined the team in two periods of first three and then two months, accompanying daily team meetings, house visits, and other meetings and activities at the outpatient clinic. She also paid frequent visits to sheltered housing accommodations and a local recovery college.[22]

19 This organization also runs the psychiatric hospital in the city center, a crisis team and different specialized teams for specific diagnoses. The organization has several integrated CMHTs localized in specific areas providing care for people with SMI.

20 This organization has different sheltered housing locations in the city and provides comprehensive support to people who live independently but require additional assistance due to SMI. Some, but not all, also receive treatment from the mental health department or have done so in the past.

21 We studied the practice of community mental health care in one CMHT in Utrecht, as part of a larger project that contrasts community mental health care practices in both Trieste, Italy and Utrecht, the Netherlands, to learn more about different ways to deal with a psychiatric crisis in community care.

22 A recovery college supports people living with mental health problems through adult education rather than through treatment (Newman-Taylor et al., 2016). It is based on self-help and mutual peer support.

During the fieldwork, the first author observed activities and discussed these activities in interviews or more informal conversations with those involved. The fieldwork periods were separated by a break of three months, in order to analyse material and to gain a better understanding of the more long-term developments in the team. At the end of the fieldwork, a group discussion with the team was conducted.

Alongside the participant observation, several standalone interviews were conducted. Eight important partners of the CMHT were selected based on the fieldwork. These informants work for respectively the police, the MH crisis department and clinic, the social welfare team, a housing association, the municipality, an association for rehabilitation and work, and a GP practice. Additional interviews were also conducted with five team members to further clarify the first author's observations and to reflect on their work. At the end of the fieldwork, six service users known to the researcher from previous house visits were approached through their case manager for an interview about their experiences with care and support from the CMHT. The selection of service users was based on previous fieldwork and the willingness of people to participate.

Data analysis

The field notes and interviews collected during the fieldwork periods were transcribed and then coded in MAXQDA using modes of ordering as an theoretical framework. The process of coding involved open and selective stages. In the open stage, to sharpen the focus of the research and be sensitive to new questions, the material was analyzed during the fieldwork periods. After the fieldwork it was then read multiple times and openly coded; parts were highlighted to identify recurring themes or patterns. This analysis was discussed with the research team and a group of qualitative researchers to strengthen the coherence of the analysis. In the selection stage, we used a second round of analysis to identify cases or situations that were indicative of different modes of ordering community mental health care.

Ethics

Ethical approval was obtained from the research institute at the Free University of Amsterdam, and the care institute where the research was conducted.[23] Informed consent was obtained from workers of the team, in formal interview situations and for house visits. During site visits and meetings, the researcher was always open about her role, and in the waiting area of the CMHT, information about the research was provided, including a picture of the researcher and her contact details. All material was anonymized, and no names or other personal details were collected. Pseudonyms are used in this text.

23 The medical ethics committee of the Vrije Universiteit Amsterdam (METC Vumc, FWA00017598) declared that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study.

3.5 FINDINGS

In this section, we will present the analysis of the five modes of ordering we could unravel from the practices. Each mode describes a specific way of defining what the problem is, the solutions to it, and how this aligns with a specific notion of good care. To illustrate the different modes and how they relate to each other, we introduce each mode with a story about Building U, a U shaped apartment building located in the neighborhood where the CMHT provides its care. Many of the CMHT's clients are living in this building.

MODE 1: ORDERING CARE AS A MEDICAL SPECIALIZATION

The first time I visited Building U was together with a case manager from the CMHT. We visited a middle-aged man called Tinus. The team has received complaints from his neighbors that he is moving furniture around at night time. He is often angry and the team thinks he is becoming more suspicious, possibly caused by an increased use of amphetamines. The CMHT wants him to start anti-psychotic medication, but Tinus refuses, since he does not experience problems. The team is contemplating pursuing a legal decision for coercive care.

What is the problem?

Within the CMHT, one of the ways of defining a problem was to focus on an individual and her or his mental health diagnosis based on the classification of symptoms. Care is ordered as a medical specialization. In this mode, treating a person with an illness is central to providing good care. In the story about Building U, treating Tinus' illness for instance should reduce his anxiety and thereby the nuisances he causes his neighbors. Hence, we found this problem definition as well in a discussion about another individual's eligibility for support:

> *The discussion in the morning meeting revolves around the fact that a man in the team's care currently has no psychiatric symptoms. A caseworker asks: "But drinking because of stress is problematic, isn't it?" "It is", confirms the psychiatrist, "but he is not acutely psychotic. The question then is if we should look for a solution for his problems in mental health care or whether social services should support him with finding a place to live" (Field notes)*

In the example above, the importance of psychiatric symptoms to qualify for mental health treatment is highlighted. If the problem is not medical, then a solution for the identified problems might be sought elsewhere. Ordering care from the perspective of medical specialization thus creates a clear division between treatment and support from social services.

What is good care?

When mental health care is ordered as a medical specialization, then care ideally follows a clear trajectory: a call for help from a patient, an intake to assess whether there is a psychiatric problem, a diagnosis, a treatment plan with effective interventions, and the monitoring of progress. This framework of evidenced-based medicine is meant to optimize good care for patients and is based on the philosophical assumptions of psychiatry as a medical enterprise (Ralston, 2013).[24] A specific aspect of this mode of ordering is the relation between care professional and patient. The professional's role is to offer the best or most effective treatment possible, based on clinical knowledge. The patient is an individual with a specific illness diagnosed on the basis of a cluster of symptoms. Care should be aimed at relieving the symptoms in the most effective way and is therefore also time-limited: if symptoms decrease or stabilise, specialized treatment is no longer necessary.

MODE 2: LEGAL LEGITIMATION

Talking to the local police chief about Building U, he sees a group of inhabitants who are causing problems and are in need of support, but they will not call for help or accept support when offered. He formulates the problem in terms of a lack of a mandate to take action when people do not ask for help. "I would love to work more proactively, but in practice things have to escalate before something happens."

What is the problem?

For the treatment offered by the CMHT to work, it requires a motivated, consenting patient. Without this, the staff faces two problems: the treatment path will stagnate, and questions about which ways of intervening are legitimate come to the fore.

> *A clinical nurse brings the case of Mr. Jansen to the morning meeting. He lives in a sheltered housing facility and his condition is declining daily. Clinical nurse: 'The workers of the housing facility ask us "to do our job." But I wonder: what exactly is my job and is what we are doing right? How far do you go if somebody neglects himself? I try to stimulate him to take his meds, I try psycho-education, to activate him (...)'. The psychologist adds: 'I would want to offer him CBT,[25]but he is not motivated…' (Field notes)*

The above example is not an exception. In the practice of the CMHT, patients-like Tinus

24 Evidenced-based medicine relies on classification models to conduct clinical trials at the group level. The resulting information is used to improve the effectiveness of clinical practice for individual patients (van Os et al., 2019).

25 CBT stands for Cognitive Behavioural Therapy.

whom we encountered in Building U- often do not explicitly ask for help or consent to the offered interventions. Then, the problem of "how far one can go" comes to the fore:

> *In a group conversation about my research, we discuss ways of intervening, besides a juridical intervention. One of the case managers recalls that he accompanied a service user to the dentist, even drove him there." It worked", he adds, "the next time he went on his own." They did, however, have a discussion about it in the team, he says, because "you still intervene in somebody's life." (CMHT group discussion)*

In this example, all forms of care that intervene in someone's life are problematized as interference with a person's autonomy. Yet this raises another crucial question: How to care without interfering? From a legal perspective, if somebody does not consent, the only option to care is to wait until the situation escalates and then intervene on legal grounds.

What is good care?

A specific aspect of ordering care from a legal perspective is that the patient is an autonomous individual and has the legal right to self-determination. This autonomy is underlined by the juridical principle of informed consent. Care providers should ideally be open and transparent about different treatment options and should refrain from interfering in the process of decision-making (Widdershoven et al., 2000). This juridical view on autonomy is closely linked to and sometimes interwoven with the ordering of care as a medical specialization. The difference is that it is not the doctor who knows best how to treat an illness, but rather an autonomous patient that must decide on different treatment options. In this logic, interfering in a patient's life – especially without explicit consent – is problematic. The only moment that interference becomes legitimate is when a patient is no longer seen as able to make autonomous decisions or when he becomes a danger to himself or others. At that point, the juridical status changes and forced care is possible.[26]

MODE 3: CARING FOR THE LOCAL COMMUNITY

A safety manager of the municipality describes Building U as a cluster of people with a web of problems. In the building she sees illegal activities ranging from drug dealing to illegal prostitution. She wants to start a project with different stakeholders to address these problems on a community level.

26 After fieldwork was completed, a new law concerning compulsory care was introduced in the Netherlands (see De Waardt et al., 2020).

What is the problem?

In this third story about Building U, it is not only the individual but also the community that is in need of care:

> *"I remember situations in which I thought: this no longer holds. A situation in which you couldn't find a place for someone. That is a difficulty, because it is key for the community approach's success or failure. Those neighbors are looking at you. You are the health professional. And if they think: "Oh, you do not act, you just let us rot. That's how things work?" (…) That is what I mean with trust: you have to show it, to the neighborhood and the community. You have to show them that you want to be there for them. You are not only there for the service user, but also for the neighbors". (Interview, worker social welfare team)*

In ordering care in terms of the local community, two instruments are seen as important. The first is outreach and working proactively. Providing care is not necessarily limited to people with a formal mental health diagnosis; outreach for those not yet in care is thus a legitimate action, because it can prevent escalations that can harm the whole local community.

The second instrument is working together on the level of the local community and to share responsibility by forming alliances between care professionals and social welfare organizations:

> *When I enter the meeting room, professionals from the local social welfare team, the supported living team, the GP, a general practice mental health professional, a mental health nurse, and the team leader of the CMHT are present. They are here for a monthly lunch meeting to discuss "complicated cases", with the idea of sharing the responsibility. At the beginning of the meeting, the GP addresses me personally: "It is important for your research to take on board that in here, social and medical organizations sit around the table on the level of the local neighborhood to organize a strongly-built basic care network. We want to learn how to do this by mutually discussing individual cases." This morning, they discuss the difficulties of providing care for a woman with multiple problems. They first discuss how to restore contact between the woman and mental health care services, but as the discussion evolves and her social situation is described in more detail, they decide to start with smaller steps to decrease her social isolation. (Field notes)*

In this mode of ordering care, there is an idea of shared responsibility to take care of the more vulnerable members of the local community. Ideally, this means shifting the perspective from one's own organisational logic towards a mutual community perspective. This shared responsibility is not always easy to coordinate among the separate organisations. Furthermore, privacy laws make it difficult to share knowledge. But different actors find innovative ways to overcome these obstacles, for instance by holding consultation meetings as the one described above.

What is good care?

In contrast to ordering care from a medical specialist perspective, with its focus on the individual patient, good care from the perspective of the local community includes all local citizens. It also means being accountable for people even where it is not (yet) clear if there is a diagnosable mental disorder. In contrast to the juridical mode of ordering care, intervening without consent can be the right thing to do if the wellbeing of the local community is taken into account. Continuity of care and assertive outreach are important in this mode of care. Furthermore, problems that CMHT service users face daily, such as poverty, nuisances and poor living conditions, are actively addressed with other partners.

MODE 4: A RELATIONAL APPROACH

Speaking to a social worker about Building U, he stresses that care is not only about taking action, but also about working on relations: "People have to get to know you and you have to know them. It is about trust (…). You need caregivers who, so to speak, crawl into the building."

What is the problem?

In this mode of ordering care, the problem is not so much the illness itself but people's relations and networks. Relating – especially initiating and maintaining contact – is seen as an important part of the work of the CMHT, especially if people are avoiding care. The team has developed creative ways to establish relations:

In an interview with a mental health nurse, we discuss the scope of her work and the importance of patients being motivated for treatment. Then she makes a switch: she refers to a situation in which she does not follow her strict task description as a mental health specialist:

> *R: (…) "I have a client," she recalls, "with him, trust is really difficult and his house is a mess. He is 23 years old, dependent on alcohol and cannabis, and looks really bad. Then I come in and I fry him some eggs. (…)Those are the good parts of the job, the flexibility."*

I: "So on the one hand there should be a request for help and a treatment plan…"

R: "Yes, but thinking outside the box is also very important." (Interview, clinical nurse)

The clinical nurse shifts from ordering care as a medical specialization to ordering care from a relational approach, by mentioning that in some situations she combines the role of being a nurse with frying eggs. Theoretically, this could lead to friction about which action is right, yet in practice she cherishes this double-sidedness. What is "good" here is being flexible, thinking outside the box, doing what is necessary to make contact and motivate others for certain behaviors.

During the fieldwork, there were many examples of professionals relating to clients in creative ways. Seduction, or what Driessen (2017) calls "will work" – work aimed at aligning the other's wants with one's own – can be a part of this:

We are both working on a laptop in the "office garden" of the community mental health care team when the case manager recalls the case of a woman who was known to be "difficult," refusing care:

R: "So I thought of an intervention to enter the house. I knew her coffee machine was broken and I had a spare one. I rang the bell and the woman opens the door.

"You can go "pierewaaaien,"[27] the woman said. "Oh, you are lucky, I know the meaning of 'pierewaaiden," I replied. "It means I have to leave, right? I will not leave. Maybe I can do some groceries for you? And here you have a coffee machine." Then I was allowed in and after a while she said: "It appears that you can stay…" (Field notes)

What is good care?

In ordering care from a relational approach, the focus is not only on the individual, be it a citizen or a patient, but also on the relations between patients, caregivers and others. Caring is working *on* these relations – trying to establish or maintain them – and *with* these relations – to avoid a crisis, for instance (Muusse et al., 2020). Bringing in the relations between clients and caregivers is also central in an ethics of care that

27 The Dutch 'pierenwaaien' refers to going out, or partying, but is used in this context to tell someone to go away.

focuses on the interdependence of people (Tronto, 1993; Voskes, 2014). In contrast to the ordering of care as a medical specialization, care here is not so much an outcome of a time-limited treatment trajectory, but an ongoing process. As Pols (2006) points out, there is no clear directive or general method that prescribes how these relationships should be crafted; it depends on circumstances, personal styles and who is involved. What is the good thing to do can differ along the way.

In this mode of ordering care, it is impossible for care workers to only address mental illness as a discrete medical domain; they have to engage in non-medical domains of peoples' life (work, finances, health). In doing this, the division between treatment and support becomes blurred. Good care is now about doing both: frying eggs while attending to psychiatric problems.

Ordering care from a relational perspective offers the legitimation for care professionals to intervene in non-medical domains of peoples' lives. This is what the social worker refers to in his story about Building U, when he talks about the need for people who are able "to crawl into the building," to make contact with the inhabitants of Building U. Good care is building trust, knowing people and intervening when necessary from within the established relationship.

MODE 5: BUREAUCRATIC ACCOUNTABILITY

To address the problems in Building U the worker of the social welfare team points out that the way care organized should support the relational approach: "You need people who have the time to work without a fixed caseload, to reach out to the people who are not seen by anybody".

What is the problem?

In this mode of ordering care, the organization and finical structure defines what is good care. In this mode, two problems are central: raising health-care costs and waiting lists. To solve these problems, care should be efficient and cost effective. A way to achieve this is by making the organization and accountability of care more transparent and regulating the working time of professionals. We specify what this means for clinical nurses in the team, because observations showed that they most frequently juggled with the accountability system they had to work with.[28] To receive treatment from the CMHT, you need to have a diagnosis so that a DBC can be opened. DBC stands for *diagnose behandel combinatie* and is a registration system in which clinical workers have to register all their working hours in order to get their work reimbursed by the health

28 As mentioned above, part of the team is paid by the social welfare act, and accountability for their work is organized differently.

insurance company. This is a quite specific task. Richard, a specialized clinical nurse, shows me how it works:

> *He shows me a computer screen that consists of four parts. Part one is about productivity: Richard's exact working hours are set against the norm set by the institute. Every moment of the day should have a code. I ask whether these norms influence his work. "Not directly," he replies, "our team leader is understanding. But the system sometimes irritates me. I try to keep thinking: I do what I have to do for the patient." (Field notes)*

Here Richard frames the tension the system is causing him as an ethical dilemma: he feels stress when he is not living up to the norms set by the system, but he feels ethical commitment to do what "he has to do for the patient." Similar dilemmas are described by Brown and Korczynski (2017) in studying home care work. They describe how by spending more (private) time with patients than provided by the system, care workers found a way to keep their autonomy and their ideals of what good care entails (the "caring self"). We observed a similar strategy: clinical workers offered the care they perceived as necessary and then tried to fit it in the accountability system as much as possible. This does not mean that how care is legitimized does not influence their practice of caring. The protocols for opening a DBC for instance play an important role in the decision-making process of who qualifies as a patient for the team.

What is good care?

One of the goals of the DBC system is to increase transparency regarding price and performance (Tummers, 2010), thus making care more transparent and efficient. This specific way of financing and organizing mental health care and the corresponding accountability system is normative; it strengthens the idea that care should be focused on an individual with diagnosable, treatable problems. It therefore supports the ordering of care from a medical specialist perspective, while creating problems to account for other forms of care that are not directly linked to caseload reasoning and temporality, with a clear diagnosis and linear treatment path. This encompasses activities such as caring for the local community or a relational approach, which cannot be paid for using this DBC system.

3.6 MODES OF ORDERING THAT CLASH OR ENHANCE EACH OTHER

As can be seen in the examples above, the different modes of ordering care sometimes enhance each other, but at other moments they lead to frictions. How does this work?

We bring in one more example:

> *The discussion starts with a remark by the psychologist about how far the team's responsibility reaches: "What is our responsibility if somebody is referred to our team with a stack of problems, maybe for over 20 years already?"*
>
> *The psychologist remarks that the team sometimes takes people into care even when they lack the specific expertise, because the person is not receiving treatment from other diagnosis-specific outpatient teams that do not engage in outreach. She points out that one of the differences is that the CMHT, in contrast to those teams, works on demand. "You could say that we are then causing under-treatment by taking somebody into care. For instance with borderline [personality disorder]. I know schema therapy is the first treatment advised, but we are not trained in it." What the team then does is to engage in making contact, and support the patient in daily life, motivating them for care. But is this good care, or under-treatment? The opinions differ.*
>
> *A case manager comments: "When I started working here, I was told that this team would end the endless discussions about which patient belongs where. But in practice it is not solved at all." A clinical nurse adds: "When I started, I had the assignment to get people into treatment who are hard to engage, to work on outreach. But in our team there is a strong focus on the diagnosis and if it is treatable, yes or no. If not, then we refer somebody to a social worker or the GP." She recalls the case of Anna, a woman with a long care history, dealing with trauma, personality disorder and addiction problems, but who lacked treatment motivation. "If we then state: we have to refer her because we are not really treating her, I do not think that is correct. In fact, we do a lot: we make contact, we stabilize the situation. She is doing better, despite the persisting problems."*
>
> *Second nurse: "I want to add something positive. We have a lot of these kind of referrals, so obviously, people can find us and that is because we are now [known] in the local neighborhood." (Field notes)*

In the above discussion, different modes of ordering care come to the fore. First, the psychologist problematizes taking people into care who are not getting appropriate care, based on their diagnosis. Can you consider this good care, or is the team facilitating under-treatment? This question reflects the mode of ordering care as a medical

specialization, in which good care is connected to a diagnosis and evidenced-based interventions. Second, the clinical nurse points out the team's over-concentration on diagnosis and that supporting people in daily life is just as important. Here, care is ordered from a relational approach; it is about different life domains and building relations. Third, there is the perspective of the local community, which is brought in by the final remark from the second nurse. The fact that a lot of people who have problems obtaining care elsewhere end up in their team's support is not seen as a problem, but as something positive: obviously they are being successful in making connections with the local community.

In the example above, the modes of ordering mental health care as a medical specialization and a relational approach clash. From the perspective of relational working, care can be more than clinically proven treatment: supporting daily life is also part of good care and is seen as the task of the CMHT. This is especially so for people facing multiple problems, but who are hard to engage in care or where there is no clear treatment request. For this group, it is much harder to set out a clear time-limited treatment path, aimed at symptom relief.

The tensions between the two modes do not arise on a level playfield. Ordering care as a medical specialization is supported by the idea of evidenced-based working and the DBC bureaucratic way of ordering care, while ordering care from a relational perspective has no such strongly articulated legitimation and a lack of professional specialization. This distinction is strengthened by the policy decision to finance treatment and support separately. This lack of legitimation makes a lot of the daily relational work of the CMHT's clinical nurses and case managers precarious; nevertheless, the need to work in this way is often clear to all involved.

The role of these institutional dynamics in legitimizing care resonates with Lester's (2009) analysis of the way clinicians in an eating disorder clinic must make translations between different care frames. In this process, clinicians have a role she describes as 'brokers' wherein they reframe their own descriptions of what is going on in terms of the managed care model used by insurance companies. Lester describes how in these everyday ethical negotiations clinical workers need to balance contradictory or conflicting imperatives to legitimize their actions and decisions.

This ethical distress that institutional strains put on caregivers to legitimize specific ways of caring is also highlighted by Brodwin (2013) who points out that the everyday ethical questions clinicians in a community mental health team have to face are not only about what constitutes as good mental health care, but also who will benefit the most from treatment. He describes how clinicians thus become involved in forms of "boundary

work," (Gieryn, 1983). In doing so, clinical workers take on the role of gatekeepers to care. In our team, this boundary work got shape by questioning the legitimacy of the treatment of people who do not fit easily in the medial specialist mode of ordering care, such as Anna in the example.

It is important to note that these discussions are taking place against the background of the CMHT's position in the local care landscape, which contains highly specialized polyclinic teams organized around a specific diagnosis, and the CMHT, which also offers specialized mental health care, but is not aimed at a specific diagnosis and is embedded in the local community. So the CMHT has a double assignment: its mission is to be both present and engaged in the local community and to provide highly specialized mental health care. The team must care for all and care for a few at the same time.

Ordering care from a medical specialist perspective versus a relational perspective is not, however, in tension in all situations: if a relational approach is lacking, then the team knows that in practice there is the risk that treatment will never reach the patient or will be less successful. A relational approach is thus no longer in tension with, but a prerequisite or partner for, specialized care. The workers of the CMHT know this from experience, and fry eggs while making up treatment plans.

3.7 CONCLUSION AND DISCUSSION

In this paper, we described dilemmas related to multiple perspectives on good community mental health care, using multiple stories about Building U. We unraveled the stories as different modes of ordering care that are present in the daily discussions about the work of the CMHT. Below, we highlight three important contrasts between the different modes of ordering care:

First, in the different modes of ordering care, the objects of care differ. In ordering care as a medical specialization, the object of care is an individual with an illness. In contrast, in the community and relational approach, care is not only aimed at the individual but also the local community; it takes into account the fact that people are part of a social network. These forms of collective care fit poorly, however, into the way in which care is organized and financed around caseloads. This tension is all the more clear in the double task of the CMHT, in which workers simultaneously have to care for a few (those in need of specialized care) and for all (the local community). Combining these two tasks puts a strain on the CMHT workers, especially because work that is not registered as "productive"in the DBC's terms is much more difficult to justify.

Second, the different modes of ordering care emphasize different views of autonomy. The juridical and medical specialist modes entail an individualized, negative concept of autonomy or freedom, namely freedom from interference (Berlin, 1969; Widdershoven et al., 2000). In contrast, in the community perspective or relational approach, the emphasis is not so much on the individual but on the relations between people and things. In these modes of ordering care autonomy is viewed relationally: from within relations, options for interference, outreach and will work are explored. We observed these clashing visions of autonomy in discussions about the legitimacy to interfere in a person's life. Unraveling the different modes of ordering at stake in these discussions can help to sharpen the formulation of these dilemmas and open up creative ways of dealing with the binary opposition between coercion and care that is often created (Jerak-Zuiderent, 2012; Lawn et al., 2016).

Third, the different modes of ordering care entail different ideas about continuity of care. Is care a temporary intervention or a long-term, more cyclical process (Hautamäki, 2018; Lester, 2009)? This question was important in the discussions about whom to take in as a patient and whom to refer elsewhere. In a relational mode of ordering care, building relations and trust is essential and takes time. But the caseload approach to ordering care structures care as a more temporary intervention. This opposition between temporality and continuity of care at moments causes insecurity about what is proper care or treatment.

What can we learn from this?

Different notions on good care are often described and explained from an organizational perspective or in the light of professional competition. In our research, we approached the question by turning to daily care practices instead, with ethnography as our main method. In our analysis, we followed Thévenot (2001) by describing the "variation (..) of what is good" (ibid, p.59) in care practice. The concept of modes of ordering points to the way these goods, and also what is taken to be the problem is part of a particular way of ordering practice (Moser, 2005). With this approach, our research demonstrates that people are not necessarily caught up in one mode of ordering care, but shift between different modes.

Our research made visible how clinical workers in daily care have to juggle with these different notions of good community mental health care and the tensions that may arise between them. But this is not a level playing field. The medical specialist mode is strengthened by the juridical and bureaucratic perspectives, while strong institutional legitimation is often lacking for the relational perspective. At moments, this leads to an insecurity among team members regarding whether the relational approach that they often engage in is indeed "good care".

These findings point to the necessity for a consciousness that working in the context of these different modes creates ambivalence and other difficulties, especially in caring for those with more complex problems that are not easily addressed within a "managed care model" in which care is standardized and time limited (e.g. Lester, 2009). Unraveling these different modes of ordering care can facilitate collaboration between professionals of different care domains and support a mutual understanding of what needs to be done. More so, it can give a "reflexive backup" (Pols, 2006, p. 426) to those forms of care in lack of an administrative or organizational legitimation. The awareness among practitioners and policymakers of these dynamics could be helpful by developing new ways of facilitating (mental) health care workers in working together in both serving individuals with complex mental problems and the community they live in.

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CHAPTER 4

Uncertainty work: Dealing with a psychiatric crisis in the community

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4.1 ABSTRACT

The quest for how to deal with a crisis in a community setting is important with the aim of deinstitutionalizing mental health care, and reducing hospitalization and coercion. In this article, we argue that to understand how this can be done, we need to shift the attention from acute moments to daily uncertainty work conducted in community mental health teams. By drawing on an empirical ethics approach, we contrast the modes of caring of two teams in Utrecht and Trieste. Our analysis shows how temporality structures, such as watchful waiting, are important in dealing with the uncertainty of a crisis.

4.2 INTRODUCTION

In this paper, we describe how the workers in two community mental health care teams (CMHTs) in two different cities in Europe deal with the uncertainty they encounter when anticipating the possibility of a client[29] experiencing a psychiatric crisis while working in a community setting. We argue that contrasting the ways of dealing with this uncertainty in everyday care in an Italian (Trieste) and a Dutch (Utrecht) CMHT can teach us more about how a crisis can be dealt with outside the walls of a psychiatric hospital and the pros and cons of the different ways of working.

We choose to contrast a CMHT in Trieste, Italy, and one in Utrecht, the Netherlands because they differ in some important aspects (Muusse & Van Rooijen, 2015). One of the most salient differences between Trieste and Utrecht is the low number of psychiatric hospital beds available in the former's mental health system. While Trieste has 15 beds per 100,000 inhabitants,[30] in the region of Utrecht, there are 89 per 100,000.[31] There are some other differences in the organization of care that influence the way a crisis is dealt with: In Utrecht's mental health system, there are CMHTs providing ambulatory care, but during a crisis, most people are admitted to a (closed) clinical ward, either voluntarily, or with a juridical measure.[32] In Trieste, in addition to the CMHT, there are six beds in each CMHC and a small psychiatric ward of six beds, and in contrast to Utrecht, all facilities in Trieste conduct an open-door policy. The way of working in Trieste often raises the question of how they manage psychiatric crisis situations in the community with such a low number of clinical beds, no closed doors, and a relatively low amount of forced care. (Barbui & Tansella, 2008; Portacolone et al., 2015).

To answer the question of how to shape community care outside the walls of a psychiatric hospital, we contrast the practices of the CMHTs in Trieste and Utrecht to learn about practical differences in dealing with a crisis in the community and the notions of good care that are at stake. To do this, we analyze the daily care practices of the two CMHTs as forms of uncertainty work (Hautamäki, 2018; Pickersgill, 2011; Moreira, 2009). The uncertainty concept helps us to articulate the importance of every day caring activities

29 In mental health care, there is an ongoing debate about the terms client/patient or service user. We choose to align with the language used at the field sites in the choice of use of terms service users (Trieste) and clients/patients that are used interchangeably in Utrecht. If we address both sides, we use the term clients.

30 Number of beds in 2018. Personal email conversation. asugi. sanita Trieste.

31 Number of beds, Utrecht region, 2017: 89 per 100,000 (Vektis).

32 If we compare the region Utrecht (bigger than Utrecht city alone) and Trieste, then involuntary measures (forced hospitalization and/ or treatment) are about ten times lower. Utrecht (2019) had 217 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by de rechtspraak). In Trieste (2019), there were 21.8 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by asugi. Sanita Trieste). Numbers are indications. There are, for instance, differences in the juridical system.

and routines in understanding how a possible crisis can be prevented or dealt with in the community, even with a low number of beds and forced care, as in Trieste. Our focus, then, is not so much on specific crisis interventions but rather encompasses a shift towards a broader time frame by articulating ways of intervening in the community setting to prevent escalations as forms of uncertainty work.

Using uncertainty work as an analytic tool to describe daily practices of care and how these practices entail different notions of what good care is, relates our analysis to the work of empirical ethics of care (see, for example, Pols, 2014; Willems & Pols, 2010). With ethnography as our primary method, we ask ourselves how uncertainty work takes shape in these two CMHTs, what is seen as good forms of uncertainty work and what can be learned from articulating the differences found between the two teams about dealing with the risk of a crisis in a community setting. To answer these questions, we first describe the practices of the two CMHTs as two different modes of care (Moser, 2005; Law, 1994); a relational mode in Trieste and a mode of care that focuses more on specialization and connecting expertise in Utrecht. Next, we articulate how these different modes of care lead to different forms of uncertainty work and thus to different ways of dealing with the possibility of a crisis in a community setting.

4.3 METHODOLOGICAL CONSIDERATIONS

Conceptualizing uncertainty

Uncertainty is a central concept in care. As Pedersen (2016) states,

> *Because of the case-based and time-dependent character of medical knowledge and practice, it is never possible to know with certainty whether a particular diagnosis is final, whether a procedure will produce the desired result, whether a patient will follow the treatment plan or whether an apparently stable and safe situation remains so. (Pedersen 2016: 1188)*

Knowledge, or the lack thereof, is therefore an important aspect of uncertainty in care settings (see Cribb, 2019; Brown & Gale, 2018). There is the ontological uncertainty about what a psychiatric diagnosis entails (Jutel & Nettleton, 2011; Jutel, 2009; Lane, 2019), the uncertainty caused by quests for categorization, such as the question of who qualifies as a patient (Pickersgill, 2019), and lastly, there is the prognostic uncertainty about what will happen (the outcome) and what ways of intervening are perceived as good care by those involved (Mackintosh & Armstrong, 2020).

In this article, we approach uncertainty as a practice. While classical sociological work around uncertainty deals with overarching concepts such as late modernity and the new risks that emerge with the decline of institutions (Giddens, 1999; Beck 1992), the critique on these theories is that they do not attend to the daily practice in which uncertainty and risks are dealt with. Others, therefore, introduced the terms "risk work" (Brown & Calnan, 2016; Warner & Gabe, 2004; Stanley, 2018; Zinn, 2016) and "uncertainty work" (Hautamäki, 2018; Pickersgill, 2011; Moreira, 2009) to redirect the focus to the practicalities of dealing with uncertainty. Acknowledging that uncertainty is an inherent aspect of care, we describe how uncertainty work in the two CMHTs gets shaped in practice and how this goes together with different qualifications about what is seen as a good way to perform uncertainty work while also uncovering what negatives there are to be avoided and how this can help us to articulate ways of intervening to prevent or deal with a possible crisis in a community setting.

Conducting the research

To answer the questions raised above, the first author observed the daily practices of care in both teams.[33] She joined caregivers in Trieste [34] and Utrecht for several weeks,[35] observing their daily routines, such as home visits, clinical encounters, and team meetings. Next to the fieldwork, she interviewed stakeholders and service users in both cities. A selection of important team partners was made, and these were approached for an interview. Interviews were also conducted with some team members to further reflect on their work. Service users were approached by their case manager for an interview about their experiences with care and support from the CMHT. At the end of the fieldwork, a group discussion with the team was organized at both field sites. During the fieldwork, there was also an exchange between the two teams: the team in Trieste visited the Dutch CMHT, and they mutually took part in an international meeting on crisis prevention.[36] The researcher was always open about her role during site visits and meetings. In the waiting area of the CMHTs, information about the research was provided, including a picture of the researcher and her contact details. All material was

33 In Trieste the CMHT is based in a Community Mental Health Center (CMHC), which includes beds, a dining hall, etc. In Utrecht the CMHT is based in a polyclinical setting without further care facilities. If we address the teams, we use the acronym CMHT for both sites, if we specifically address the center as a physical place in Trieste, we use CMHC.

34 Although the first author has a basic understanding of Italian, this was done together with an interpreter who was familiar with mental health care, so as to get a detailed understanding of the daily practice.

35 In the Netherlands the first author was present in the CMHT of Utrecht across two periods of first three and then two months. In Trieste the fieldwork was divided into three more intense periods of five weeks in total. In addition to this fieldwork, the first author has been involved in studies concerning community mental health care in the Netherlands since 2006 and in Trieste since 2014. The first research in Trieste is reported on in "Freedom First" (Muusse & Van Rooijen, 2015).

36 The Dutch organization of which the CMHT is a part has a longer tradition of conducting visits to Trieste. Some of the workers, including the team leader, visited Trieste on at least one occasion. Both teams, together with the first author, provided a workshop on the CCITP around crisis care (October 2018, Rotterdam)

anonymized, and no names or other personal details were collected. Pseudonyms are used in this text.[37] The first author has been involved in studies on community mental health care in the Netherlands and Trieste for a more extended period. Familiarity with both research sites over an extended period enabled easy and quick access to the field and aided the researcher in understanding what was going on.

4.4 TWO MODES OF ORDERING CARE: BUILDING RELATIONSHIPS OR CONNECTING EXPERTISE

First, we describe the practices of the two CMHTs as two different modes of ordering care in order to sketch out the differences and similarities in both ways of working and the care landscapes they are part of (Muusse et al., 2020; 2021; 2022).

Trieste's mode of ordering care: Working on and with relationships

"la liberta e terapeutica!"—this slogan, going back to the 1970s, can still be found on one of the walls of the former hospital grounds in Trieste, Italy. It was during the 1970s that a "revolution" took place. The psychiatrist Franco Basaglia advocated a radical change. In his analysis of psychiatry as a total institution, he stated that to understand a person, a diagnosis should be placed in "parentheses" (Basaglia 1967, in Burns & Foot, 2020). To be able to make this shift from "patient to citizen" an essential step was to close the psychiatric hospital and organize mental health care in the community instead (see also Foot, 2014; Portacolone et al., 2015). This movement in Trieste led to a specific practice of mental health care characterized by a low number of beds, a minimum of restraint, and an open-door policy.

Central to the mental health system in Trieste are the Community Mental Health Centers (CMHCs). There is no need for a referral to get into the care of a center, and each center has a small number of beds (6–8). With the center as a base, the CMHT provides outreach services for the area they have responsibility for. The center is also the place where treatment and care are provided and where people can have lunch. The centers have the responsibility to be accessible and accountable for the neighborhood and to respond quickly to a crisis when necessary (Mezzina, 2016). This is why the center is also open to neighbors, family, and others. Nurses take a turn in the reception to respond quickly to demands for care. As described elsewhere (Muusse et al., 2020), the care provided by the CMHT in Trieste is characterized as radical relational: care is not only aimed at the individual and his or her (psychiatric) problems but also towards building

37 The METC from VU University (FWA00017598) has declared that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study. Ethical permission was provided by the ethical commission of the Trimbos-institute (TET).

and maintaining a social network around service users. We therefore describe mental health care in Trieste as a relational mode of ordering care.

From the idea that care is relational, different life domains such as housing, social relations, and work are addressed by the CMHT: there is no strict line between support and treatment, and both are seen as tasks of the CMHT. The CMHT works together on projects with different social cooperatives, which provide supported living and sheltered housing, and with other care providers like social services. Referrals are avoided according to the idea that transitions in care could cause ruptures in the relationship between service users and their caregivers.

If there is an acute situation, the CMHT aims to respond to a crisis in the community and avoid acute hospitalization and forced care if possible (Muusse et al., 2022). If necessary, people can be admitted to the center, and the same team then provides care. If a crisis occurs after 20:00, there is a small acute ward with six beds in the general hospital. On the following day, contact is made with the center a service user belongs to, based on the district in which he or she lives.

Utrecht's mode of ordering care: Connecting expertise

In Utrecht, due to a reorganization aimed at providing more community-based care, the CMHT consists of workers from mental health treatment and mental health-supported living organizations that work together to provide specialized mental health care in the community for people with complex mental health problems. Supporting people in self-management and regaining agency are formulated as important goals. Cooperation between the realm of care and the social domain is necessary to make this possible. Therefore, the CMHT is part of a network of different actors such as the GP, first-line mental health treatment and social welfare teams, more specialized mental health treatment aimed at specific diagnoses (e.g., autism or anxiety), and clinical facilities.

To get into the care of the CMHT, people need a referral that states that they are in need of specialized mental health treatment. As described elsewhere (Muusse et al., 2021), treatment for people with a Severe Mental Illness (SMI) at Utrecht's CMHT ideally is temporary; if a situation improves or stabilizes, then specialized treatment is no longer seen as a necessity, and people are referred to other partners in the network for treatment and support (for instance, the GP and social welfare teams). People may also be referred to more specialized treatment for a specific diagnosis if necessary. It is important to connect these different expertise and forms of treatment and support to provide integrated care. We therefore refer to this mode of ordering care as connecting expertise. Although the focus is on specialized treatment, a relational way of working is an important part of the daily care practice (see Muusse et al., 2021).

If an acute situation occurs, the CMHT can prevent and monitor the situation and provide outreach care during office hours. Outside of office hours, there is a separate crisis team working 24/7, and there are specific interventions to provide support around the clock to avoid hospitalization, such as telephone service. If hospitalization is seen as necessary, people are admitted to an acute clinical ward run by a clinical team. During hospitalization, contact with the CMHT and the clinical team is seen as important to facilitate continuity in care.

4.5 UNCERTAINTY WORK IN PRACTICE

Uncertainty work as attempts to categorize: Who qualifies as a patient?
The first form of uncertainty work we describe here involves the categorization practices conducted when accessing a CMHT. The uncertainty at this point in both cities concerns whether someone's problems are indeed categorized as psychiatric or that a person needs to be referred to other service providers. An example from Trieste:

> *The worker from the municipality explains that the municipality and psychiatric care work together on specific projects. Often it concerns people with social problems and a lack of social network.*
>
> *Interviewer: How does this work exactly? In the Netherlands, the cooperation between the two domains is sometimes difficult…*
>
> *Respondent: [laughs] Here also, especially when there is no psychiatric diagnosis but social services have the idea that there are problems indeed. (Interview municipality, Trieste)*

In both cities, in dealing with the uncertainty of whether one qualifies as a patient, defining a psychiatric problem is important. One way of doing this is by setting a diagnosis. Setting a diagnosis is a way to categorize problems into the domain of mental health care instead of defining them as social problems (Mackintosh & Armstrong, 2020, Pickersgill, 2019). In Trieste, going back to Basaglia, the idea of a diagnosis to define a person's problem is highly contested. Still, a diagnostic orientation is needed, next to other factors related to the social implications of a crisis, the impact on the social context, and the network (Mezzina & Vidoni, 1995). In Utrecht, the importance of setting a diagnosis is more pronounced since the task of the CMHT is more specialized than in Trieste: they only have to provide care for those with complex problems in need of specialized mental health care, while the CMHT in Trieste needs to care for all people in their district with problems categorized as psychiatric.

However, defining a problem as a psychiatric or a "fitting" diagnosis is not the only factor in deciding if someone qualifies as a patient for the teams. We observed this in another case in Utrecht, where—although a formal diagnosis is lacking—a woman does get access to the team because the team is convinced that mental health treatment is a necessity:

> *They discuss a new referral. It concerns a woman with all kinds of complaints that are not specific, which, according to the nurse, causes her to "fall between the cracks": she does not receive care anywhere. The nurse states she has all the symptoms of ADHD, but because a complete anamnesis is so far impossible, a diagnosis was never set. The woman has four children, one still living at home. She wants help, but there is no diagnosis. The plan is to get her into care and involve the psychologist to explore possible treatment. (Field notes, Utrecht)*

In addition to a diagnosis, the assessment of the care workers that someone is at risk of "falling between the cracks" with the possibility of a crisis is also a way to enter the CMHT. In such situations, a diagnosis can be "negotiated" (Lane, 2019).

Setting a diagnosis is an important element in both CMHTs, but it is operated differently in the two modes of ordering care. In Trieste's relational approach, once a problem is categorized as psychiatric, the CMHT has to keep providing care for that person since they are responsible for all mental health care in their district and referrals are avoided as much as possible. In Utrecht, the CMHT is part of a more differentiated care landscape with several teams providing different diagnosis- and problem-related types of specialized care. This differentiation increases uncertainty about what exactly is specialized psychiatric care and what kind of problems this might address: are the problems indeed psychiatric problems in need of specialized care, and are they complex enough? The differentiated care landscape provides more possibilities for referral but also more uncertainty around whether a person is in the right place. The idea that specialized care is scarce and waiting lists should be avoided puts extra pressure on the care workers to make a proper "categorization" (Lane, 2019; Mackintosh & Armstrong, 2020; Pickersgill, 2019). The question about who qualifies as a patient in Utrecht is thus more complex: it is not only about whether one is in need of psychiatric care but also about who should provide this care and for how long.

Uncertainty work as a relational endeavor

Once someone is in the care of a CMHT, another source of uncertainty can arise when professionals do not know how service users are doing, for instance, when contact is problematic. In the practice of Trieste, it is stressed that having a relationship with both

the service user and her or his network is an important instrument to know what is going on and to prevent a crisis:

> *Interviewer: "Does it happen you do not see the crisis coming?"*
>
> *Nurse: "Yes, it happens if somebody stays home without frequent contact. Interviewer: What do you do to prevent this?"*
>
> *Nurse: "Some people are more often discussed and validated because there is a necessity. For instance, when someone is living alone, we will pay home visits more frequently. Another reason to pay more attention is the intensity of the disease or if there is a risk of a severe crisis. We also pay extra attention if people refuse contact and do not want to visit the center."*
>
> *Interviewer: "How do you decide that someone needs more frequent visits?"*
>
> *Nurse: "It can be a personal evaluation because you know the person. Then it is easier to notice little signals." (Group interview, Trieste)*

In this example from Trieste, the uncertainty of not knowing what is going on is resolved by relational forms of uncertainty work aimed at (re)establishing contact. Staying close and knowing what is going on, a relational endeavor is important to avoid a possible crisis:

> *The last visit I make with nurse Mauro this morning is to a woman in her sixties. Her neighbors called the center yesterday evening, and a nurse went to see her. We come to see how she has made it through the night. Mauro explains a bit more about her situation: last week, she argued with her daughter and became really upset. She refused to take her medication, and they could not persuade her. Mauro asks questions about her whereabouts. She tells him she has the flu and hasn't eaten the whole day. He tries to persuade her to visit the center and have dinner there, but she refuses. On the way back, Mauro tells me they will continue night visits to offer medication for at least five days. They know from her past that it is important to intervene immediately. (Field notes, Trieste)*

In this example, based on past experiences, there is the fear that the situation will worsen. The uncertainty work performed consists of conducting house visits during and outside office hours and continuing to offer the client medication. The woman accepts

the contact, although she first refuses the medication. But the intervention seems successful: the next day, another nurse takes her to the GP for her somatic symptoms, and she is pleased with the nose spray she has been given. She then comes to the center again for medication and dinner.

In this specific situation, the neighbor called into the center, and the woman was cajoled into visiting the center to have dinner with others. In the group interview, it is stressed that people living alone can be a reason to pay more house visits. These small examples underline that in Trieste, "keeping an eye" on the situation is not only about the dyadic relationship between the professional and the client but about the embeddedness of people in a broader network as well. Working on a stable network and creating and maintaining relationships between different actors in the network and between the network and the CMHT is seen as essential to buffer a crisis (see also Muusse et al., 2020).

Also, in Utrecht, visiting more frequently and (re)building contact is a part of the uncertainty work performed when they do not know how a client is doing. This is structured through a specific instrument: The FACT board. The FACT board is a registration system that helps in deciding whether to scale up care and sharing caseload in situations of uncertainty (Van Veldhuizen et al., 2007):

> *The team discusses a man on the FACT board: they discuss that the team has to visit him more frequently, just to ring the bell to see how he is doing.*
>
> *Psychologist: "We have him in sight. If he becomes more paranoid, we have to watch him more carefully. There is the risk that if he breaks down, it will be a severe case."*
>
> *Nurse: "We hope that in this way, he will ring on our bell when he does become psychotic instead of ending up in a police cell."m (Field notes, Utrecht)*

Here uncertainty arises because it is not clear how the man is doing. As stated in the quote above, knowledge about what is going on is often described as "having a sight" on the situation. This overview should make it possible to act if necessary.

In both teams, relational approaches, such as staying close and knowing what is going on, offer insight into how one is doing, avoiding further uncertainty. One difference between Trieste and Utrecht is how the organization of care facilitates this. In Trieste, there is always one nurse available to act quickly on emergencies, and the team can offer a bed

in the center or seduce people to have lunch or dinner at the center to see how they are doing. More importantly, (ideally) there is contact between the CMHT and the broader network to have an eye on the situation and to involve people in care. In Utrecht, this is different: the CMHT conducts a relational approach to prevent further deterioration as well and uses the instrument of the FACT board to structure this. However, in the way care is organized, the options of Utrecht's CMHT to stay in contact are more limited. They do not have their own center to facilitate low-threshold contact with clients and do not provide treatment outside of office hours. Utrecht's CMHT thus depends on other teams to provide these forms of care, including hospitalization. Uncertainty work, then, means connecting expertise. Another difference is to whom this relational approach is directed. In contrast to Utrecht, in Trieste, it is not only about the individual patient and his or her family. Service users are seen as part of a broader social network with which relations need to be strengthened. Lastly, as described elsewhere (Muusse et al., 2021), ordering care from a relational approach in Utrecht is in need of a more strongly articulated legitimation due to the focus on specialized care.

Continuity of care

Observing the way the CMHTs conduct uncertainty work highlighted the fact that uncertainty work also has a temporal aspect. It is not only about what is going on at this moment, but uncertainty work is also an anticipatory project directed at what might happen in the future. Creating continuity is, therefore, an important way of reducing uncertainty. How this is done, differs between the mode of ordering care in Trieste and Utrecht.

On an organizational level, in Trieste, continuity of care is achieved by making the center the single point of entry in the system (so referrals are absent) and by reducing the possibility of hospitalizing people in an environment other than the CMHT by having a low number of clinical beds. In the view of Trieste, hospital beds are seen as a threshold to create continuity of care because they make it harder to craft long-lasting relationships:

> *"We have to avoid that hospital beds becoming the dominant choice in case of a crisis. Especially when a first crisis occurs, people often go to the psychiatric ward first. But often then, after hospitalization, it is difficult to create continuity. People want things to be the same as before and, therefore, are not always motivated to build contact with a CMHT. That way, it is difficult to create continuity, while we know that in the long run, it is important to do so. That's why we divert immediately - or as soon as possible - the person's care to a CMHC." (Interview, Director CMHT, Trieste)*

In the relational mode of ordering care in Trieste, creating personal continuity by crafting long-lasting relationships between the team and the service users as part of a network is seen as a way to "buffer" for the uncertainty of a crisis that might occur (Muusse et al. 2020). In Utrecht, the CMHT has a different position in the care landscape. Without the function of a center that operates 24/7, the team needs other service providers to create continuity of care. Continuity is thus not always based on a personal relationship but by working together with other service providers:

> *"The point is to bring the knowledge on medical health treatment closer to people and organizations, and that you can jump in if necessary." The team leader explains that it is important to be accessible for consultation in a network, not that everybody is in treatment. (Field notes, Utrecht)*

Another difference with Trieste's CMHT is in what is seen as good mental health care. As we described above, in Utrecht, the CMHT offers specialized mental health care, ideally seen as a temporary and linear intervention. Treatment in Utrecht ideally starts when someone is categorized as needing specialized mental health treatment and ends when this treatment is either successful or has reached a point where no further progress is expected. At this point, people are referred to other service providers such as diagnosis-specific teams, social support, or the GP. The importance of making progress is underlined by the negative way of labeling a situation without it, stating that care than had the risk of turning into "pappen en nathouden".[38] This is a Dutch expression that has a negative connotation and refers to a way of maintaining stability without specific clinical interventions and without any progress being made:

> *Psychiatrist: "We have to avoid a contact of "pappen en nathouden."*
>
> *Preferably we have her in care for a marked period in which we do a good hetero anamnesis. Then a discussion starts on who should provide support when the temporary intervention of the team has ended. Social welfare is suggested but is questioned as well. "*
>
> *Mental health nurse: "You know how that goes, they will ask if she has a support request and since she does not utter her needs, they will probably step out too soon." (Field notes, Utrecht)*

38 This expression was used more often to refer to cases where there was long lasting support without a defined start or end point.

In this example, care is first linked to the idea of making progress and treatment as a temporary intervention. This resonates with a view on care that places treatment in a clinical, linear time frame (see also Hautamäki, 2018).[39] But this linear time frame is questioned as well. We observed that although treatment from Utrecht's CMHT ideally is time-limited, in practice, many patients are in the team's care for more extended periods, often for years. In these cases, the team perceives a patient as too vulnerable to be referred elsewhere. The decision regarding who only needs the care of the team as a temporary intervention and who needs more long-term support is often not easy to answer, and in Utrecht becomes another source of uncertainty. The question of who qualifies as a patient in Utrecht is not only at stake at the beginning of a care trajectory but becomes a recurrent discussion (see Muusse et al., 2021). A case manager explains the dilemma in a group interview:

> *"I discussed this lately with a colleague: We are both involved with a man with a history of homelessness, alcohol abuse, and a mild intellectual disability. He has been doing really well recently, so we visit him less frequently. If I go there, I do not do much more than make a Swedish crossword with him. Sometimes I wonder: What am I doing here exactly? Shouldn't we step out [not provide care anymore, CM]? But the other side is that maybe he will fall back into his drinking behavior and might be doing well because we are there." (Group interview, Utrecht).*

Also, in this example, although the idea of treatment as a temporary intervention is suggested, it is questioned simultaneously by stressing the importance of creating a more long-term care relationship to prevent the risk of a relapse. This recurrent discussion can mean that professionals start to question the legitimacy of the more long-term approach they perceive as necessary.

Both in Trieste and Utrecht, care is often framed as active work, setting up projects (Trieste), or making treatment plans. The difference is that in Trieste, care is framed as a long-term project focused on the service user and his or her network, which encompasses more and less intense periods. In Utrecht, specialized treatment is ideally seen as a temporary, goal-oriented intervention following a more linear time path. However, looking at our fieldwork, a lot of the "work" that carers do in both cities can be described as situations that were not so much about acting and doing. Intense and less intense periods of "watchful waiting" (Baraitser & Brook, 2021) might be a better way to describe situations such as doing crosswords. In order to build up relations, to know

39 A linear way of ordering time also resonated with what is labelled as a "managed care model," in which care is aimed at acute symptoms and time limited. See for instance Lester 2009 & 2019.

how a client is doing, and thus in conducting uncertainty work and preventing a crisis, often more important than doing things is "fostering forms of connection that consist of waiting with, enduring with, staying alongside" (ibid p.11).

Since situations change and clients' conditions improve or deteriorate, caring practices shift over time (as we saw in the example of the man that does crosswords in Utrecht). Another form of uncertainty, then, is which shape continuity in care and watchful waiting should take. In Trieste, watchful waiting can take more or less intense forms, making sure that connections with and within the network are stable enough to signal when more intense forms of care are necessary. In Utrecht, a longer-lasting change in the condition of clients brings the question to the fore of whether someone should be referred to another team.

Creating continuity turns out to be an important part of the uncertainty work conducted at both CMHTs. Having sight on a situation and watchful waiting are important instruments to achieve this. In Trieste, continuity is defined as personal, long-lasting relationships between caregivers, the service user, and her or his network. This is facilitated by the center's function that offers 24/7 care and the fact that there are a minimum of beds to hospitalize service users in another setting. In Utrecht's mode of ordering care as connecting expertise, continuity is ideally created by the collaboration of different organizations in a network-like manner (referring, giving consultation to other services). In practice, though, people are often in the care of the CMHT for more extended periods. Still, the legitimacy of this approach is a recurrent discussion that sometimes causes tension about the right thing to do.

Taking positive risks

Both in Trieste and Utrecht, uncertainty work consists of activities aimed at stabilizing a situation or restoring an equilibrium. Continuity in care and a relational approach are important strategies to achieve this, although how this is done differs. Another part of uncertainty work geared towards maintaining the relationship involves "taking positive risks." An example from Trieste:

> *In a group interview, the team members discuss the situation of a young man living with his father. He states that he has the devil in his head but refuses anti-psychotic medication. So far, "the devil" is telling him good things, but years ago, he attempted suicide in a very violent way. The psychiatrist states that they have decided not to force him to take medication. A nurse asks, "You do not prescribe medication because?" The psychiatrist responds, "He does not want it, but also…., we are afraid that he will then refuse all contact. He states that something good will happen*

on his birthday. I have a bad feeling about it, but I want to give him a chance." In the meantime, they visit the man at home a few times a day and take him out for coffee. When the birthday arrives, nothing happens, and the man is willing to accept medication. (Field notes, Trieste)

In this case, different risks are balanced. There is a risk of suicide if they do not force him to take medication. But this way of solving the uncertainty could mean losing contact with the man, thereby increasing the uncertainty about how he is doing. In Utrecht as well, positive risk-taking is part of the uncertainty work conducted:

We discuss the situation of a young woman who is seen as at risk due to her severe eating disorder. So far, forced hospitalization has been avoided, although a clinical setting can improve her physical and mental condition. But from past experiences, the team knows forced hospitalization bears the risk of jeopardizing her fragile trust in mental health care. Instead, the team invests in a difficult search for an open clinical setting that she is willing to accept. In the meanwhile, they have intensive contact with her. (Field Notes, Utrecht)

Taking risks and reducing uncertainty might seem a contradiction at first sight. But managing contradictions is a vital part of care. If taking a risk is seen as necessary for building and maintaining relationships, positive risk-taking can be understood as a specific form of uncertainty work, both in Trieste and Utrecht.

WHEN UNCERTAINTY WORK FAILS: DIFFERENT WAYS OF INTERVENING.

So far, we have described different aspects of uncertainty work in the daily care practice of the two CMHTs, and how this is facilitated or hindered by how care is organized in the two cities. Finally, we describe what is done when there is the fear that a situation might deteriorate, and the different tactics of uncertainty work undertaken to prevent a crisis do not seem to work, for example, situations where having "sight" on a situation is difficult, contact is difficult to establish, or a client refuses the interventions offered. In both teams, there are dilemmas about when and how to intervene. What is the "right thing" to do when faced with these uncertainties? An example from Utrecht:

The team discusses a man who refuses all contact. He doesn't show up at appointments, and when the case manager drops by his house, he either refuses to open the door or is not there. The man is placed on the FACT board and frequently discussed in the following days. Different team members drop by his house to see if he is there, but they cannot establish contact. They contemplate whether they should put adhesive tape on his

door to check if he still goes out or put a letter under the doorpost with a contact request. But these interventions are also questioned: A nurse asks out loud, "How far can we go? Does someone not have the right to refuse contact?" (Field notes, Utrecht)

Here, uncertainty arises about how the man is doing since the contact is broken. Restoring contact is the uncertainty work that has to be conducted, but the way to perform this is a source of uncertainty itself and makes visible how uncertainty work is also a normative endeavor: is good care respecting the will of the client to refuse contact? Or is good care intervening to have "a sight" on how s/he is doing, like in the example of the woman in Trieste that refused to take her medication?

What is seen as "good care" while facing the uncertainty of a possible crisis differs in Trieste and Utrecht's two modes of care. From the radical relational way of ordering care in Trieste, intervening from within the relationship is seen as good care, while coercive measures such as forced hospitalization or treatment are rather avoided and, in any case, difficult to conduct with the low number of beds available. In Utrecht, a more individual view on autonomy brings to the fore questions like "Does someone have the right to refuse care?" This more juridical way of ordering care limits the options of seducing people to care and conducting relational ways to reduce the uncertainty of a crisis that might occur (Muusse et al., 2022)

4.6 DISCUSSION

In this article, we argued that in the debate on crisis care in psychiatry, we need to re-shift our focus from acute moments and ways of controlling risks towards the more mundane forms of uncertainty work conducted in day-to-day care. This shift towards uncertainty work is important to answer the often raised question we introduced at the beginning of this paper: How can a possible crisis be dealt with in the community, even with such a low number of beds and coercive measures, as in Trieste?

In the relational mode of ordering care in Trieste, uncertainty is mainly dealt with by building up relations with both service users and their network. These long-lasting relationships function as a "buffer" for a crisis and give carers insight into how service users are doing, thus reducing the uncertainty of not knowing what is going on. Building on relations and being able to interfere quickly can also avoid escalations or prevent situations from deteriorating further. The organization of care in the CMHC in Trieste facilitates this mode of ordering care; care is organized so that a quick response is actioned if something seems off, there are no waiting lists, and both outreach and care in

the center are provided by the same team, thus strengthening the relationships between the CMHC's team and the service users. In this mode of ordering care, hospitalization in case of a crisis is not seen as an option to deal with uncertainty about what to do in case of a crisis. Having only a minimum number of beds to use as a "last resort" asks for other ways of dealing with a possible crisis or escalation, such as a low threshold to care, a relational approach, building a network, and flexibility in scaling up care in and outside office hours, to be able to intervene as much as possible before a situation escalates. Moreover, a comprehensive and multidisciplinary team approach – based on the person and his/her social context– is adopted rather than specialized care provided by diverse professionals.

Compared to Trieste, the care landscape in Utrecht is more differentiated, with different teams providing different forms of less or more specialized care and acute wards where people can be hospitalized in case of a crisis. Care of the CMHT is seen as specialized mental health care and, ideally, is goal-oriented and time limited. Although the system in Utrecht as a whole offers more options for different forms of more or less specialized treatment if we compare it to Trieste, the possibilities of Utrecht's CMHT in terms of providing different forms of care are more limited; care is only provided during office hours, and there is no center where people can stay over or have lunch. This means that the CMHT needs to work with other service providers in a network to create continuity of care, scaling care up and down if necessary. This can lead to more uncertainty about who qualifies for specialized treatment and who can be referred to other forms of care (see also Beckers et al., 2019; Koekkoek et al., 2019).

Using uncertainty work as an analytic tool, we could also articulate differences in the normativities in both CMHTs about what is perceived as "good" community mental health. Is "good care" specialized mental health care as a temporary intervention following a linear time path, aimed at a specific diagnosis and grounded in evidenced-based interventions? Or is a more relational, long-lasting approach in which mental health care addresses different life domains a better way to go (see also Lodge, 2012; Killaspy, 2012; Klingemann et al., 2020)? We could argue that in this debate, Trieste's mode of ordering care represents the relational approach, while in Utrecht, the focus is more on specialized treatment. However, also in Utrecht, treatment and support did not always follow a linear time path. Especially when people were perceived as too vulnerable only to receive temporary care, uncertainty work at both sites contained activities that were more cyclical than goal-oriented and could be described as what Annemarie Mol calls "tinkering"; that is, "trying, struggling, failing and trying again" (Mol, 2002, p. 177). We introduced the concept of watchful waiting (Baraitser & Brook, 2021) to describe situations that were not so much goal-oriented but about staying close and building relationships that buffered for a crisis. The quest then becomes how

more or less intense forms of “watchful waiting” can be facilitated, especially in systems where the idea of treatment as a goal-oriented and temporary intervention is dominant.

What does this teach us about dealing with the possibility of a crisis in the community? Our analysis showed how uncertainty is dealt with in different ways in the modes of ordering care applied in Trieste and Utrecht. In Trieste, watchful waiting, building up relationships with service users and the network, and positive risk-taking are important forms of uncertainty work used to deal with the possibility of a crisis and prevent escalations. This approach makes it possible to work in the community with a relatively low number of beds and forced care. Contrasting the practices of Trieste and Utrecht showed how the awareness of the importance of these forms of uncertainty work are facilitated or hindered by both dominant normativities about what is perceived as good care and the way care should be organized. To deal with a crisis outside the hospital walls, these forms of uncertainty work require more administrative or organizational legitimation in the way we organize and value community mental health care.

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CHAPTER 5

“Caring for a Crisis”: Care and Control in Community Mental Health.

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5.1 ABSTRACT

In the debate on coercion in psychiatry, care and control are often juxtaposed. In this article we argue that this dichotomy is not useful to describe the more complex ways service users, care professionals and the specific care setting interrelate in a community mental health team (CMHT). Using the ethnographic approach of empirical ethics, we contrast the ways in which control and care go together in situations of a psychiatric crisis in two CMHTs: one in Trieste (Italy) and one in Utrecht (the Netherlands). The Dutch and Italian CMHTs are interesting to compare, because they differ with regard to the way community care is organized, the amount of coercive measures, the number of psychiatric beds, and the fact that Trieste applies an open-door policy in all care settings. Contrasting the two teams can teach us how in situations of psychiatric crisis, control and care interrelate in different choreographies. We use the term choreography as a metaphor to encapsulate the idea of a crisis situation as a set of coordinated actions from different actors in time and space. This provides two choreographies of handling a crisis in different ways. We argue that applying a strict boundary between care and control hinders the use of the relationship between caregiver and patient in care.

5.2 INTRODUCTION

With the deinstitutionalization of mental health care, there are concerns about how to care for a person experiencing a mental health crisis in the community (Neale, & Rosenheck, 2000; Molodynski, Rugkäsa & Burns, 2010). In debates around this concern, care and control are often juxtaposed; care represents "the good," whereas control is the evil to be avoided (Valenti, et al., 2015; Jerak-Zuiderent,2012; Lawn, et al., 2016). In this article, we take care and control as concepts that overlap in situations of psychiatric crisis. Care and control go together; or even care can be a form of control and control may be caring. We suggest the term"care-control" to analyze the relationships between the two. We use the metaphor of care-control "choreographies" (Cussins, 1996; Law, 2010) to articulate differences. The metaphor of a choreography of a dance helps us to understand how care and control interrelate because it catches both the temporal and the spatial character of care practices around the onset of a psychiatric crisis.

To do this, we turn to the contrasting practices in two community mental health teams (CMHTs): one CMHT in Trieste (Italy) and one team in Utrecht (the Netherlands), and we explore how these practices relate care and control in different ways. This is interesting because the practices differ in the amount of coercive measures and the number of psychiatric beds. Some numbers: Trieste had 15 beds per 100,000 inhabitants (personal email conversation asugi.sanita Trieste) in 2018, vs. 89 per 100,000 inhabitants in the region of Utrecht (2017) (Vektis). Each city uses a different accountability and juridical system. Trieste applies an open-door policy in all care settings and closed the psychiatric hospital (Muusse & Van Rooijen, 2015), whereas in the Netherlands 41% of beds used for admission up to 1 year, and 19% of the beds on facilities for long stay are on closed wards (Kroon, et al., 2021). What can we learn from these differences? Which actors are involved in care-control situations in both sites? How does this lead to different care-control practices, and can we say something about the differences?

To answer these questions, we unravel the different ways in which crisis is understood and handled by adopting an empirical ethics approach in which the focus is on the practice of care and the values that come to matter in these practices (Mol, Moser, & Pols, 2010; Pols, 2014, Willems & Pols, 2010). Ethnography is used as the main research method to examine these daily practices. We first sketch the two care-control choreographies by showing how clients, professionals, and the specific care setting interrelate in the two teams. We then draw out the contrasts between the two choreographies. At the end of the paper we discuss if these alternative ways of understanding the relation between care and control can help in bridging the gap (Valenti et al., 2015) between treatment on a voluntary basis on the one hand, and coercive measures on the other.

5.3 MATERIALS AND METHODS

Ethnography as a Method

To answer the questions about daily care practices around a psychiatric crisis and the normativities embedded in these, we used an ethnographic approach with participant observation as the main method. Ethnography is chosen as a method because it offers the possibility of "studying at firsthand what people do and say in particular contexts," (Hammersly, 2006, p.4) thereby allowing us to observe what is performed as the "good" (Mol, Moser, & Pols, 2010) by those involved in care practices. Ethnography as a method is in line with the theoretical framework of empiric ethics that "analyzes ways in which people and things live together in particular practices as micro societies" (Pols 2014, p. 82) and the values enacted in these practices.

In this study, the first author conducted fieldwork in a CMHT in Utrecht for five months, divided in two periods. In Trieste she conducted more intense fieldwork in three blocks for a total of five weeks. Although the first author has a basic understanding of Italian, in Trieste, communication was aided by an interpreter who was familiar with mental health care, in order to get a detailed understanding of the daily practice. The first author (and interpreter in Trieste) joined workers on their daily routines, including home visits and team meetings. During the fieldwork the focus of the observations was not directed by preselected cases, but was informed by the research question about which ideas about good care are present in situations that were qualified as "the onset" of a crisis. In practice, this led to a broad approach, in which not only patient-centered cases were studied, but also, for instance, the accountability structures in the teams.

During the observations, notes were made by hand, either on the spot (for instance during meetings) or immediately after (for instance, after house visits). More detailed fieldwork reports were written as soon as possible, usually the same day. A distinction was made between observational and more interpretative notes, which were an important part of the iterative character of the research in which analysis is not a separate phase following data collection, but part of the fieldwork.

Next to the participant observation as a method, interviews were held with three groups of respondents:

- (Care) partners of both CMHTs: selection of relevant care partners for an interview was based on the observational data collected. For instance, in Utrecht the fieldwork showed that there was frequent contact with the housing company and therefore, they were approached for an interview [eight in Utrecht, four in Trieste, more interviews with partners were

conducted in a previous study (Muusse & Van Rooijen, 2015).

- Clients of the teams: At each site clients were approached for a formal interview (three in Utrecht, four in Trieste) about their experiences with care and support from the CMHT. More importantly, with a larger number of service users there were frequent and differentiated informal forms of contact during the fieldwork; for instance, during house visits, meetings at the CMHT, lunch, or during visits to housing facilities or peer initiatives.
- Team members: next to the fieldwork, some team members were approached for an additional interview (five in Utrecht, six in Trieste). The selection of these interviews was based on the iterative character of the research: specific observations led to additional questions and thus relevant team members were approached to reflect on these questions in an interview. An example in this paper is the interview of a psychiatrist in which the case of "Miss Westering" is discussed. Apart from these interviews, reflection on the daily care process with team workers was a continuous part of the participant observation; for instance, during travel from and to house visits.

At the end of the fieldwork, a group discussion with the team was organized at both field sites in which the initial results of the fieldwork were discussed and reflected upon with the team. During the fieldwork there was also an exchange between the two teams: the team in Trieste visited the Dutch CMHT and both teams, together with the first author, provided a workshop on the CCITP about crisis care (October 2018, Rotterdam). From the Dutch organization that the CMHT is part of, there is a longer tradition of conducting visits to Trieste. Some of the workers from the CMHT in Utrecht, including the team leader, visited Trieste on at least one occasion.

Position in the Field

Ethnography recognizes that researchers themselves are no neutral outsiders. The researcher is the one doing the interpreting, based on observations from a particular situated and embodied perspective. As Gibbons et al. (Gibbons, Hammersly & Atkinson, 1986) state, this makes reflexivity an important element of conducting qualitative research:

> "Reflexivity implies that the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them. What this represents is a rejection of the idea that social research is, or can be, carried out in some autonomous realm that is insulated from the wider society and from the biography of the researcher, in such a way that its findings can be unaffected by social processes and personal characteristics" (Gibbons, Hammersly & Atkinson, 1986, p. 15).

To attend to the reflective character of qualitative research, it is important that the researcher is transparent about how the situated perspective of the researcher shaped the findings (Malterud, 2001). In this study, the first author had experience with research in community mental health care, both in the Dutch setting and in Trieste. Results from previous research (Muusse & Van Rooijen, 2015) informed the selection of research sites (Trieste and Utrecht) and the research question concerning dealing with crisis situations in a community setting. The fact that the first author was familiar with both research sites for a longer time made it possible to have easy and quick access to the field and aided the researcher in understanding what was going on. The first author is trained as an anthropologist and therefore could observe the daily practice of care and decisions made with relative distance, while still being familiar with the organization of care and most of the language used in the teams, as well as the more specialist medical descriptions.

Analysis of the Material

As stated above, in ethnography, the analysis of data is not a distinct stage of the research (Gibbons, Hammersly & Atkinson, 1986) but a continuous process in which the researcher goes back and forth between empirical and theoretical informed questions and the data collected. After the fieldwork was conducted, both interview transcriptions and field notes were analyzed using Maxqda (2020). The first round of analysis was open: the material was read and discussed by the research team and reread by the first author and a first selection of important themes was made, such as ways of preventing a crisis. The next stages of analysis consisted of a combination of open and selective stages to sharpen the analysis (constant comparative method). This led to a focus on the relation between care and control. In the analysis, we attended to both the similarities and differences between Trieste and Utrecht.

During the analysis, we chose to use the metaphor of a choreography (Cussins, 1998; Law, 2010) to describe the way different actors interrelate in moments of a so-called psychiatric crisis and how different forms of care and control are part of this. Law uses this metaphor to describe the complexities around caring and killing in the context of the foot-and-mouth epidemic among cattle in 2001 in the UK. Law (2010) refers to Cussins (1996) when he describes a choreography as "the arrangement and distribution of events and actors in space and time, sometimes bringing actors together and sometimes keeping them apart." (Law 2010, p. 67). Law points out that in the literal sense the term choreography refers to the writing of a dance, but that in common practice "the term is used to refer to a space-time set of rules or practices which shape but do not determine the actions of the bodies and dancers (Law 2010, p. 68). We use the term care-control choreography as a metaphor to encapsulate the idea of a crisis situation as a set of coordinated actions between different actors in time and space. By contrasting the care-control choreographies of Trieste and Utrecht, we will see that many of the "actors"

entering the scene in both CMHTs are comparable; however, what is enacted, when, by whom and where differs.

Ethics

During site visits and meetings, the first author was always open about her role, and in the waiting area and hall of the CMHTs information about the research was provided, including a picture of the first author and her contact details. Respondents for interviews gave their informed consent. All material was anonymized, and no names or other personal details were collected. Following the anthropological tradition, pseudonyms are used in this text and some personal characteristics are changed when this was necessary to protect the anonymity of the persons involved. The METC from VU University (FWA00017598) has declared that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study. Additional ethical permission was provided by the ethical commission of the Trimbos-institute.

Different strategies were used as a member check. First there was the group discussion in both teams. Additionally, if agreed upon, interview transcriptions were sent to the respondents. Respondents were also informed about quotes used in this article, whether it be fieldwork descriptions or part of an interview. Some key contacts in the field were offered the chance to read the whole article before submission and offered their comments and insights. This did not lead to substantial changes.

5.4 RESULTS: TWO CARE-CONTROL CHOREOGRAPHIES

Historical Background

The "Trieste model" of mental health care that has developed since the 1970s is based on the ideas of Franco Basaglia (1924–1980), an Italian psychiatrist. He stated that the person with the mental illness—and not the disorder—should be placed at the center of the mental health system. In the 1970s, he proposed a different way of organizing Trieste's mental health system: closing the psychiatric hospital and making a radical shift toward organizing mental health care in the community by starting Community Mental Health Centers (CMHC). Important principles in this movement were offering a low threshold to care, working with open doors and minimizing coercion (Foot, 2014; Portacolone et al., 2015). This movement in 1978 led to the implementation of Law 180 in the whole of Italy, which called for the closure of psychiatric hospitals. The actual implementation of this law varied greatly between the various regions of Italy (Fioritti, 2018; De Vito, 2015).

In the Netherlands, the process of deinstitutionalization was more gradual. Different forms of community mental health were already in existence before World War II and served as an example for other countries at that time (Vijselaar, Hoof & Kok, 2009). In the different phases the deinstitutionalization process in the Netherlands went through, the aim was to reduce the number of beds in psychiatric hospitals and enlarge social inclusion, rather than closing the hospital entirely. Psychiatric hospitals now function in cooperation with CMHTs and Flexible Assertive Community Treatment teams (Van Veldhuizen, 2007, Nugter et al., 2016) and other forms of ambulatory care.

CMHT Trieste

Trieste is a city with 205,000 inhabitants in the north of Italy. Each CMHT consists of nurses, psychiatrists, psychologists, rehabilitation specialists and social workers and is located in a Community Mental Health Center (CMHC). The CMHC functions as a single point of responsibility in a catchment area, provides day, office-based and home treatment, and is a drop-in center for service users, neighbors, family and others. Nurses take turns to staff the reception, enabling them to act quickly on demands for care both from patients themselves or others. There is no waiting list and there is no need for a referral to receive care at the CMHT. In the center where the first author conducted observations, there was a total of six beds in one-person or two-person rooms for people who needed to stay overnight. If people are in need of acute psychiatric care after 8:00 p.m., they are referred to the psychiatric crisis department at the general hospital (SPDC- Servizio Psichiatrico di Diagnosi e Cura-psychiatric service for diagnosis and treatment), which has a small acute ward with six beds. Both the CMHC and the psychiatric ward have an open-door policy.

The CMHT works together in projects with different social cooperatives, which provide supported living and sheltered housing, and with other care providers like social services that operate in the same health district. The CMHT has the aim of responding to a crisis in the community, and tries to avoid transitions in care by providing care in the community and by avoiding acute hospitalization (Mezzina 2016; WHO, 2021).

CMHT Utrecht

Utrecht is located in the middle of the Netherlands and is a somewhat larger city than Trieste with approximately 360,000 inhabitants. The CMHT where we conducted our fieldwork consists of care workers from two organizations; one aimed at supported living and the other providing mental health care. A proportion of the patients in the caseload of the team receives care from both organizations. Staff include a psychologist, a psychiatrist, an expert by experience, mental health nurses, and personal case managers. In their work, the CMHT adapts the model of Flexible Asserive Community Treatment (FACT), a care model that combines individual case management with

shared caseload and assertive outreach. In contrast to Trieste, where a referral is not required for care from a CMHT, the team provides care for those that are indicated as being in need of "specialized" mental health care treatment. If there is no indication for treatment or problems are not primarily psychiatric, people are referred to other teams or care domains. The mental health care landscape in Utrecht is thus both more differentiated and fragmented than in Trieste: next to the CMHT there are teams for first-line treatment, teams organized around a specific diagnosis (e.g., Autism Spectrum Disorders) and there are different clinical facilities. Some of them are run by the same mental health organization, while others are located in the general hospitals in the city.

CARE-CONTROL CHOREOGRAPHY IN TRIESTE

What situations are seen as a risk for (the onset of) a crisis both in the CMHT of Trieste and in Utrecht? We start with the care-control choreography in Trieste. We take the care around specific service users and situations as a starting point to show how service users, professionals, and the specific care setting relate to each other.

Identifying a Crisis

How is a crisis defined and identified in Trieste? This is a recurrent theme at the team's daily meetings. A head of a CMHC describes a crisis as follows:

> *Team leader: A crisis is often not the crisis of a person, but the crisis of a context. If there are good relations in the network or family, it's easy to solve problems. Often the relations are not good and then the problem goes in circles, it maintains itself.*
>
> *Interviewer: What about psychiatric symptoms?*
>
> *Team leader: Those problems are there and they are real. You shouldn't deny that, but it's not so much about symptoms themselves, but about symptoms creating difficult behavior. Symptoms are always in a relation where the problems evolve: in the system (Interview, head of CMHC).*

If a crisis is seen as a crisis of a context than different actors enter the stage: next to mental health care, there is the family and the broader social network. They are needed to identify the onset of a crisis:

> *If we talk about the set-up of a crisis, and to intervene at the right moment, it is crucial to be able to listen to the people. Everybody can hear screaming or crying, that is not so difficult. But if someone is whispering, you should be able to hear it as well. (Interview former-director Trieste CMHC)*

Crisis may start with a whisper that may be hard to hear for team members. To hear these whispers the team needs a strong connection with the social network of service users. Identifying a crisis is hence a shared endeavor of the CMHT and the broader social network. The team finds it important to discover the signs of a crisis early on, and to achieve this, the social network is involved as much as possible (Mezzina, 2016).

Caring and Controlling for Riccardo

Here is the situation of Riccardo, a young man who stays at the center during the first period of my fieldwork:

> *When I enter the CMHT's garden together with Arianna, a nurse, Riccardo sits there, smoking, another nurse next to him. Arianna explains that team members always join him when he goes outside because of the risk of him wandering off. She tells me a bit more about his situation. Riccardo came to stay at the center on a voluntary basis a few days ago because there was a "crisi brutta" in which he became physically aggressive as well. He is a young man in his early twenties, but has already been in the care of the CMHT for a couple of years. She states that one of the problems is his relationship with his parents; they were never supportive of treatment or medication. They tried different things—to start an education, to find a job—but it never worked out.*
>
> *During an evening shift a male nurse describes the attitude of the team towards Riccardo as finding an equilibrium between keeping an eye on him and not being too close. I observe an example the next day: a volunteer of a youth organization that they involved in the support of Riccardo takes him out for an ice-cream, in a trattoria down the road. That same afternoon a nurse walks with Riccardo towards the gate of the garden, announcing, "We're going for an ice cream!" "But we did that already today!" another nurse replies. "O.K., a coffee then!' And off they go. (based on field notes)*

In this situation there are different actors in the care and control of his situation. First there is the center. Because the CMHT is in a location with six beds, there is the possibility of admitting Riccardo to the center without transferring the care for him to a separate clinical team. In line with the philosophy of Basaglia, in the center the doors are always open. Yet this does not mean that the movements of Riccardo are not controlled in some way. Instead of a door keeping Riccardo inside, the nurses and others (volunteers, or even the first author by answering the often repeated question "Where is Riccardo?") are involved in keeping an eye on Riccardo and prevent him from wandering off. The staff sits next to him smoking in the garden, and take him outside for an ice cream or a coffee. This

caring for Riccardo is at the same time a way of checking and controlling his movements, guiding and going with him to places where he wants to be, rather than forcing the wishes of the team on his movements. Driessen has coined this way of aligning the wishes of patients with the wishes of professionals as "will-work" (Driessen, 2017).

A closed door controls the movements of patients, but caring and staying close can be understood as forms of controlling movements as well. But they are not the same. A closed door restricts movements by force, and separates those from inside from those outside. Guiding and following movements does something else; it controls movements by engaging in intense contact and staying close. Although this can be directive, the course of the activities is not as determined as if Riccardo would have been behind a closed door. Different negotiations and ways of "being looked after" are possible.

Crisis Care at the SPDC

Guiding and following movements without a closed door works on the psychiatric ward of Trieste's general hospital as well:

> *I join the psychiatrist who is on duty on the late afternoon/evening shift in the SPDC. An ambulance has brought in a young man from the refugee shelter located in Trieste's harbor. He was intimidating people, acting violent and self-harming. When the psychiatrist wants to examine him, the man first does not want to leave his room. Sometime later the man is walking through the corridor in the direction of the exit. He has a bandage around both arms. The psychiatrist and two nurses follow him, one of them blocks the direct access to the door by taking a shortcut through the administrative office. The psychiatrist continuously tries to engage in a conversation with him in a mix of Italian/English during their tour through the hallway, persuading him to stay for the night: "Where would you like to go at this moment of the day? You are sick, please stay for the night." "Really you are too weak now, come on, you have to rest a little" and "tomorrow you can leave, but please rest now- per favore, per favore." The psychiatrist leads him back to the living room by giving him an arm. This process is repeated twice. Formally, he has been admitted voluntarily, so he has the right to leave the ward. The psychiatrist confirms this, but keeps persuading him to stay. She tells him, "Of course the door is open, if you want you can leave. But really, it is wiser if you stay for the night. You want to smoke? You can smoke in your room!" Then the man returns to his room and the ritual repeats itself again. The psychiatrist offers him medication with the explanation that "this will make you calm," which the man accepts. Still, he wants to leave, stating that he has an appointment. The nurse offers him the use of their telephone*

in the administration office to arrange his appointment. In this little office the psychiatrist and the man sit down, and she tries to engage him in a conversation again: "You are so young. What age are you? Twenty? Please sit down, you are in no condition to go," and she points to the bandages around his arms. Again she leads him to his room, linking arms with him. They walk down the corridor together; it appears the man is staying for the night. (based on Field notes)

In this situation, the young man is persuaded to stay for the night because the care professionals found the condition of the man too severe to be out on the streets. They try to control the situation by persuading him to stay, by positioning themselves and by moving into the space to make his exit more difficult. The most important instrument to achieve this is to engage him in a conversation, and in doing so, looking for opening points that they can use in their negotiation with him. He is allowed to smoke in his room for instance, though officially this breaks the house rules. They let him use the telephone and at the same time grasp this opportunity to sit down with him and to have a conversation. They argue, plead, cajole, and almost beg, but never directly force the man to stay. The physical characteristics of this ward—the open door—creates a situation in which the only way to make him stay is to engage in intense contact.

Next to the efforts to engage in a conversation and intense contact to control the situation, the man is made to stay by moving through space in specific ways, without confronting him physically in a direct way. Indeed, it looked like the performance of a dance, where each partner moves in relationship to the other. The psychiatrist physically performed this move by giving him an arm and leading him to the desired location: his room. Once again, controlling movements are performed by guiding; gestures, moves, and ways of touching each other.

Medication as Care-Control

Another part of the care-control choreography in Trieste is offering medication. Offering medication is part of the negotiation between professionals, service users and sometimes the family, as is the case with Riccardo. Medication is a form of care that sometimes needs to be controlled, even if not forced (i.e., checking whether medication has indeed been taken). Yet this controlling is in itself a way of preventing escalations. Many service users come by the center to pick up their medication daily, monthly, or anywhere in between. To have people come over for medication on a regular basis is a combination of caring (by medication) and controlling by checking how the person is doing. It offers the team the possibility to intervene immediately when something seems wrong:

Nurse Mauro is on his way to Ravi, a man who lives with his mother. Ravi

usually visits the center every morning to pick up his medication, but made a call that he wasn't able to come due to a backache. For Nurse Mauro this is a reason to do an unscheduled check-up visit. When we enter the apartment, the mother leads us to the kitchen; Ravi is there, sitting on a wooden bench. Mauro asks how he is doing. Ravi complains about his back and his fear of not being able to move anymore. The mother constantly enters the conversation, explaining how heavy the situation is for her. Mauro asks the mother about her family. The mother welcomes the chance to show photos of the family and the woodwork of her deceased husband. It all takes more than an hour. During this conversation, Mauro hands over the medication to Ravi: pills and a fluid, one with P ("pomeriggo"/ afternoon), one with an S ("serra"/ evening). On the way back I check if it is extra medication. "No," says Mauro, "but I took it since Ravi didn't visit the center this morning." He states that this was a good morning and I ask why. "because there was time to talk," he replies. "This talking is not acute at the moment", Mauro adds, "but it is of importance in the long term, to prevent a crisis." (based on field notes)

Distributing medication in this way can be understood as part of the care-control choreography since it offers the opportunity to check how service users are doing, keep their medication intake stable, and build relationships with the family in order to intervene quickly when necessary.

But the check on medication works in other ways as well. In an interview the director of the MH services points out that medication is part of the relationship between service users and professionals. "Sometimes you have to accept that people refuse medication. The acceptance of medication is often an important step in the larger process towards working on recovery."

Lastly medication can be a way to enable a relationship or conversation. This happened in the SPDC; offering the man calming medication made it easier to engage him in a conversation despite his agitated state. As one of the psychiatrists stated in a conversation about controlling a crisis, "Sometimes it is first sleep, then talk!". Medication, than, opens up ways to enable a relational approach to care. Medication thus is part of the dance around dealing with a crisis and not an isolated intervention.

The Role of the Network

Time to talk—whether this is about woodwork or medication and symptoms—is important in the long run because the aim of the Trieste choreography of caring and controlling is to build a relationship with both the patients and their social networks,

such as the mother of Ravi. This relational embeddedness is important to prevent a crisis. Working on relationships and creating a network could also be witnessed during Riccardo's admission in the center. The staff established contact with the volunteers of a youth organization in the hope that this would create new contacts, involved a social cooperation in their work and tried to find housing together with other young people. Crisis work in these situations works on relationships by building and maintaining the network. A former director of the MH Trieste reflects that:

> *The concept of a crisis in itself is non-existent, it is always in a specific context. And as a professional, it matters what you do in that context. There is always a set-up and if you are organized in the local community then you can intervene in every step. Often, when we call something a crisis, we only see the end of the process, the acute moment. But if you are truly present in the local community you can intervene before that phase and you can make a difference (Interview former- director MH Trieste).*

The realization that a strong social network can not only prevent but also buffer and thus control a crisis means that a lot of the work in Trieste is dedicated to building and maintaining these relationships (Muusse et al., 2020). The network can a be a source of information during a crisis. Contact with the social network creates a care-control network of "many eyes" in which it is easier to check how one is doing, to "hear the whispers" in the build-up to a crisis and to intervene if necessary.

The Juridical System

In the situations with Ravi and Riccardo, although contact was sometimes difficult and required a lot of work, the treatment was voluntary in the sense that the situations were controlled without legal measures and without the use of direct force or coercion. To avoid coercion, professionals engage in negotiations, persuading patients to accept care. If persuading, negotiating and involving the network does not work and the situation is perceived as severe, a community treatment order (CTO, TSO in Italian) may be issued, based on the need for treatment criterium. The absence of a dangerousness criterion relates to the vision of Basaglia, and it is seen as a fundamental step to break the often-made connection between mental disorders and dangerousness (Mezzina, 2018). In Italy the dangerousness criterion is not listed as a requirement for forced treatment (Ferracuti, 2021). The need for treatment criterion prevails. The law stipulates that within a TSO doctors are obliged to seek consent and in that case the involuntary treatments ends.

In Trieste the number of TSOs issued, however, is relatively low, in 2018: there were 30 TSO's for 18 people.[40] If a TSO is issued this is done mostly in a center to avoid transitions in care as much as possible. This means that nurses and others are assigned to support and guide a person with a TSO (even side-by-side when the crisis is severe) in the center and to join them going outside. When a TSO is issued, often different actors are involved to make this intense support possible. These may be relatives, people working for social cooperatives or others within a patient's network.

CARE-CONTROL CHOREOGRAPHY IN UTRECHT

Identifying a Crisis

To understand how in Utrecht the choreography of care-control takes shape and how it contrasts with the care-control choreography in Trieste, we must examine how situations at risk of a crisis are identified. Therefore, it is important to describe a specific instrument that is used in the CMHT in Utrecht: the FACT board.

The FACT board is an excel sheet that is projected on a screen every morning in the team meeting. The excel sheet lists clients who are perceived as being at risk of a crisis. The "board" sheet provides information about the diagnosis, the reason someone is "placed" on the board, along with details about their social network, drug use, juridical status, and the goals and wishes that were formulated together with this client. Every morning possible interventions are discussed, such as adjustments in medication, applying for a juridical measure or intensifying the frequency of house visits. The idea behind the board is that it offers a flexible way to shift between daily teamwork for those (at risk of) being in crisis, and a less intense, individual case management approach in periods when someone is more stable (Van Veldhuizen, 2007).

In the CMHT Utrecht, "being placed on the FACT board" thus means that someone is identified as in crisis or at risk of a crisis, based on the contact with the person self or with the network. This can be down to a number of different reasons. On a random morning, the first author listed the reasons why service users were placed on the FACT board on that particular day. This shows a great diversity of social and medical reasons:

> *Raising of agitation and suspicion, Self-mutilation/Expression of suicidal thoughts/Low body weight/Aggression, Engaging in drinking/Anxiety, (2x)/Superstitious, Intimidating behavior/Just discharged from an hospital admission/At risk of the child being taken away/Weird, compulsive behavior/At risk of eviction. (Field notes)*

40 personal email conversation asugi. sanita Trieste.

The board offers a structured way of identifying the risk for a crisis when it is more or less acute. Once a situation is identified as at risk of deteriorating into a crisis, how is the situation controlled and cared for? Here is the case of Miss Westering, a woman in her fourties who lives together with her husband and two children.

> *I first hear about Miss Westering during an extra meeting that was scheduled because the team is worried about her condition. Without consulting the psychiatrist, she stopped taking medication and the team is afraid she will be hypomanic. Her husband says she is hallucinating. They discuss how they can break the repeating cycle of quitting medication and ending up in a crisis again.*
>
> *The next week a nurse updates the team that Miss Westering called the crisis team and an ambulance twice at night. The team knows from experience that she will stabilize if she starts taking medication, but so far she has refused. What to do? Start supervised medication intake or start a juridical procedure to force her to take medication? A nurse explains to me that providing supervised medication intake is done by another service provider that also works outside of office hours. Another nurse states that they have to be strict and clear because there are children involved. We have to say "This is what we are going to do!"*
>
> *When the meeting has ended, it turns out that Miss Westering's husband is waiting in the CMHT office. He came to the CMHT to ask for help because he didn't sleep the whole night; he was watching over his wife, afraid that she would wander off. They decide to pay her a home visit. When the team returns, they tell me that the situation was severe, and that they want to hospitalize Miss Westering immediately with an Emergency Involuntary Admission (EIA). The next day a case manager tells me that when they came to her house she had already packed her bags; Miss Westering was willing to go to the hospital. She is now at a crisis ward on a voluntary basis. (Field notes)*

In the case of the care-control for Miss Westering, different actors played a role. First there is the CMHT. When a situation around a patient in their care is identified as a crisis, both care and control around a service user is intensified. Just as in Trieste, more team members are involved in a flexible way, and every team member is updated about the situation through the FACT board. Since the team in Utrecht consists of both workers from a treatment organization as well as an organization providing supported living, this also offers the possibility to intensify care by involving the latter. In contrast to

Trieste, a hospital admission in Utrecht may be seen as a good intervention to control the situation and care for the client. More intense treatment and support can be given than the CMHT can provide on an ambulatory basis, for instance when someone is seen to be in need of 24/7 care, which the CMHT in Utrecht does not offer.

Hence, different care partners and different forms of expertise are involved in the care control choreography for Miss Westering: there is a network of different types of professionals and care organizations that enter the stage when a crisis is suspected and the CMHT perceive the situation as risky. A separate organization may be called upon when supervised medication intake seems necessary. In addition there are the emergency services, and as a last resort there is the crisis ward, where clients can be admitted either voluntarily, or against their will with a legal measure. Different from Trieste, continuity of care from the CMHT in Utrecht does not always mean providing care by the same team, but connecting responsible organizations functioning in a network to provide continuity of care. Rather than staying in the care of the same team, in Utrecht a crisis admission means a transfer to a clinical team, and care is coordinated between the two teams and forms of expertise.

The Role of the Network

Next to the CMHT and other mental health facilities, the social network of clients such as Miss Westering is also an important factor in the situation. In Miss Westering's case her husband supports her but also controls her safety by staying up all night to watch over her. Then there are the children. Their vulnerability is a reason for the team to pay extra close attention and in this way they influence the care-control for Miss Westering. This becomes clear during a morning meeting during which the psychiatrist shares her experiences:

> *The psychiatrist talks about a home visit to Miss Westering earlier that week. During the house visit the psychiatrist mentioned that they might apply for a community treatment order [CTO- supervised treatment], but Miss Westering did not show any reaction. The psychiatrist then talked about the children, that it was important for her to be a strong mother. She shares with the team that she hesitated about whether this was the right thing to do and that it felt a bit manipulative. A nurse says, "Now you are being too hard on yourself. It is the truth, isn't it? Negotiating is part of our work" (Field notes).*

We reflect on this in an interview. The psychiatrist explains more about her considerations:

> *"I found it difficult. I prefer to discuss openly and rationally with someone about what is going on and what would be a wise choice and to leave as*

much autonomy to the patient as possible. But on the other hand, it is part of our daily work to cajole people a bit in the direction of those choices we find healthy or wise. It has two sides; I like to be open and direct, and this {to refer to being a good mother CM} felt a bit like manipulation." (Interview, psychiatrist)

The children become part of the care-control choreography when the psychiatrist involves them in the discussion with the woman about taking medication. This is a dilemma for her: when does persuasion become manipulation? Ideally, she respects the autonomy of patients and she openly discusses the different treatment possibilities on the principles of shared decision making. But when such a conversation is not possible, negotiation, or persuasion to avoid further escalation is also part of the job. The problem here is that this care vision based on individual autonomy makes her wonder if engaging in persuading or manipulating is still good care, while acknowledging that it is part of the daily care practice. In Trieste, negotiation and persuasion were not problematized in this way, but rather they were seen as a legitimate way of avoiding coercion from within the relation.

Medication as Care-Control

In the care-control for Miss Westering, medication plays a role in different ways. First, the lack of motivation to continue taking medication is seen as one of the reasons to identify the situation as "at risk." It is not only identified as a risk because medication adherence is seen as important to prevent a crisis in general, but specifically because they know from the history of Miss Westering that quitting medication increases her risk of a crisis. The ideal of the psychiatrist to openly discuss different possibilities about the use of medication and side effects and together come to the best solution does not seem to work. This means that other ways of care-control are employed. If negotiating and persuading do not work, another possibility comes to the fore: forced care.

The Juridical System

The fieldwork was conducted 1 year before a new law concerning forced care was implemented in The Netherlands in 2020 (De Waardt et al., 2020). In the case of miss Westering, the old law was still applicable. In Miss Westering's case this meant that two forms of forced care are discussed. First there is the community treatment order (CTO/ rechterlijke machtiging in Dutch) that is mentioned by the psychiatrist on her home visit to Miss Westering. A CTO is a juridical status at the time of the research that can be applied in a non-acute situation. The CTO contains directions for the client to stick to certain conditions, such as keeping in contact with a psychiatrist or adherence to a course of medication, to avoid forced hospitalization. This CTO thus makes it possible in an ambulatory setting to use a certain force to make sure that service users acquiesce

to these rules without direct coercion being applied. It is seen as "stok achter de deur" (literally, a stick behind the door), a kind of safety net that can be used in case someone does not stick to agreements made. The "CTO" was frequently mentioned in the team as an instrument to align the behavior of clients with the wishes of the team. It was perceived as a way to avoid coercion, while in fact it is part of the law concerning forced care. This dual character of the CTO was discussed in an interview with a nurse:

> *Nurse: We often refer to it as a stick—a "stok achter de deur." It is not really coercion—I mean, it's not like—you do not take those pills, therefore… Interviewer: But it is a juridical measure… Nurse: Yes, of course, but in my opinion, even if one doesn't stick to all the conditions, you still have to engage in a dialogue. It is not like you do not stick to one of the conditions so immediately you are admitted to the hospital. Interviewer: It does not work like that… Nurse: No, only… It is really about one's safety or the safety of others, rather than "you have to." (interview mental health nurse)*

The nurse stresses the relational character of working with this measure; it allows the team to engage in a dialogue with the client in a way that stresses the urgency of the situation. It relates to the dilemma often raised in teams of whether one can intervene when someone refuses care. Again, proceeding from the paradigm that the patient is an autonomous individual and has the legal right to self-determination, care providers ideally are open and transparent and discuss the different treatment possibilities (Widdershoven et al., 2000). But this becomes problematic when people refuse care or even refuse to engage in such a dialogue. From the ideal of individual autonomy the option to intervene without having met the criteria for forced care is seen as problematic (Muusse et al., 2021). Here the dilemma is solved by a juridical back-up for intervening when a relational approach fails.

When the situation of Miss Westering worsened and her husband came to the center in desperation, the emergency involuntary admission procedure was mentioned (EIA/IBS in Dutch). This EIA procedure is a short-term measure for acute and immediate admission and care. It is a way to admit someone to a psychiatric hospital in case of acute danger. This was seen as necessary when they visited Miss Westering that morning; but before it could be issued it was abandoned, because Miss Westering decided to cooperate with a hospital admission.

Miss Westering's situation shows how juridical measures are not only a way to apply forced care but also function as instruments in the relationship with the client to persuade and negotiate. As the use of the conditional CTO shows, the distinction between juridical forms and relational forms of control in practice are not always clear-cut.

CONTRASTING THE TWO CHOREOGRAPHIES

Above we described the care-control choreography around a crisis for both Trieste and Utrecht. Which contrasts are there to be made?

The Start: Identifying a Crisis

In Trieste, a crisis is defined primarily as a crisis of the social network. This has consequences for the way the care-control choreography is shaped; building relationships and strengthening the social network of service users is an essential element in the care-control choreography around a crisis. By building relationships health services, social cooperation's, family, and others are all connected, and these connections can help not only to care for a crisis, but to control it as well. This is why working on relationships and engaging in a dialogue is seen as essential.

In Utrecht, a relational approach is applied as well, but situations are primarily defined as a crisis of the individual, may it be due to medical reasons (e.g., an intensification of symptoms), or more social reasons like being at risk of eviction. Although the network can play an important role in a crisis situation (as we saw in the case of Miss Westering), the care of the team is directed to the individual.

The Dancefloor: One Center or Different Places and Expertise

The CMHT in Trieste is located in a center that offers different possibilities and restrictions to care-control a crisis than the CMHT in Utrecht. The CMHT in Trieste has the possibility to (voluntarily) hospitalize service users with a low threshold in the center without waiting lists, and thus has the ability to offer care 24/7, avoiding discontinuity of care by transferring someone to a clinical facility. People can also visit the center as a day hospital, come there to pick up medication or eat lunch. All these possibilities give the team the opportunity to care-control by observing and reacting quickly if something might seem amiss—like Ravi having a backache. On the other hand, the team has limited possibilities to refer patients to more specialized forms of care; there is no crisis team and only a small psychiatric ward of six beds.

In Utrecht the CMHT is not a direct access point into the care system for people in need of care. The CMHT does not operate from a center, operates during office hours, and is embedded in a differentiated care landscape consisting of different specialized teams to which people can be referred (24/7 crisis team and different options for voluntary and involuntary hospitalization). The CMHT in Utrecht thus needs a strong cooperation with other professional care partners. Continuity is created not by continuity of caregivers as in Trieste, but by connecting different teams and expertise in a successful way.

The Dance: Restricting and Guiding Movements

Both choreographies show that in controlling and caring for a person in a crisis, restricting movements can be important. But the way this is done in Trieste and Utrecht differs considerably. The open-door policy of Trieste has shaped creative ways of moving along with clients: accompanying and guiding movements, staying close, and moving in and outside the center in a non-coercive way (e.g., going for ice creams). In Utrecht, following a person's movement is not part of the daily practice of the CMHT. Restriction of movement takes the shape of hospitalization as a way to control the situation and care for the client. At that point a patient is admitted (voluntarily or not) on a (closed) ward. The transition between freedom of movement and restriction by closed doors thus is more radical in Utrecht compared to the relational way of aligning movements in Trieste, in which a strict form of coercion is avoided and ways of guiding movements can be more or less intensive.

Controlling movements can also be done by applying for juridical measures; in Italy and the Netherlands this step only becomes possible when all other possibilities of voluntary care have failed. There are two important differences in the law between the two countries, though. First, in the Dutch law there was the option of a "conditional" juridical measure (CTO) that functions both as a safety net to avoid a crisis and also as a juridical legitimation for professionals to intervene in situations in which a client was not motivated for care. Second, the need for treatment criterion in the Italian law around forced care restricts the situations in which juridical measures can be applied and enforces the idea (going back to Basaglia) that mental health care is responsible for care and not for custody.

The Esthetics of the Dance: Ideals Regarding Good Care

The choreographies in Trieste and Utrecht not only describe different care-control practices, they also reflect ideals about what is seen as good care around a crisis. In Trieste, the strong emphasis on people as part of a social network and creating continuity of care by providing care from a single team are key elements in what we could call a *relational* care-control choreography. Working on these relationships enables the team to "hear the whispers" of service users and thus to prevent a crisis. This is strengthened by the principle of open doors, which leads to a specific practice of controlling crisis situations in which the relationships are often intensified by staying close to someone in more or less intrusive ways and in which responsibility is shared: the more the service user is capable to handle and run his behavior, the less the service applies side-by-side forms of care-control. Care-control, then, is not a juxtaposition but a continuum—and moving along this continuum by engaging in relationships with the network is a way to avoid forced care. Going out for an ice cream, for instance, is not a form of coercion; however, in this way of caring the situation is indeed controlled.

In Utrecht, mental health care is both more specialized and more fragmented at the same time, with people referred to different teams depending on the specific situation. This means that in a situation of crisis it is of importance to connect these different expertise's. We therefore call this a care-control choreography of connecting expertise. In this choreography, the ideal of respecting the individual autonomy of patients is central. This care vision gives clear directions on how to perform good care when a patient is motivated (making decisions based on informed consent and the agency of the patient) but does not give such a clear answer to the question about what to do when patients are not motivated for care or not willing to engage in contact. This was for instance, reflected in the discussions with the psychiatrist about when negotiation becomes manipulation.

As Pols et al. points out (Pols, Althoff & Bransen, 2017), a strict division between care and control gives care givers little options to act between the two polarities of "doing nothing" from the idea of respecting individual autonomy and "applying coercion." The division between care based on principles of individual autonomy or applying control by forced care than is not so much a continuum as a more or less strict line one has to cross, although we observed that this distinction between juridical and relational forms of control is not always clear-cut in practice.

5.5 DISCUSSION

Our analysis of the two care-control choreographies showed that a crisis is not only about the acute moment. Like in a dance choreography, there is an aspect of time and space: a crisis evolves in a specific situation following a certain time path. The time aspect directs attention to what happens before and after an acute moment and offers an alternative to a predominantly focus on risk (Lawn et al., 2016). Broadening the perspective of crisis care to this wider timeframe is important as to enable care workers to "hear the whispers" that could signal the onset of a crisis and by able to prevent an escalation (Groot et al., 2019).

On both sides, ideally there are no forms of forced care. But in practice people do not always agree with interventions offered by professionals to avoid a crisis, or are not willing to engage in care at all. What to do? This question is addressed in different ways, for instance by developing guidelines for assertive outreach (Akwa, 2021), and developing care models like Assertive Community Treatment (ACT) (Marshall & Lockwood, 2000) and FACT (Van Veldhuizen, 2007). In this paper we addressed the question from an empirical ethical perspective: we described the daily practice of care and the values that are enacted in these. As Brodwin and Velprey (2014) point out; ideas about control

and constraint are connected to the "local shape of practice: the particular techniques, rationales, and limits of treatment that differ from site to site and one historical period to the next" (p. 525). In describing two of those specific practices in detail, we showed how care and control in practice go together in different ways. This relates to earlier work that points out how coercion and autonomy in practice are often interrelated (Hejtmanek, 2014; Banks et al., 2016).

By contrasting the two field sites in Trieste and Utrecht as care-control choreographies we showed that what is perceived as good care around a crisis differ: In Trieste's relational choreography care is positioned as the opposite of exclusion and isolation. Professionals can intervene and persuade from within established relationships but the relationship should be maintained at all times: here, open doors are a prerequisite for good care. While forms of persuasion or interference are not problematized, strict forms of coercion such as a forced hospitalization are to be avoided as much as possible. There is a sense of unease when a relational approach fails and forms of forced care are unavoidable.

In Utrecht's choreography of connecting expertise, the goods and the bads are distributed differently. The good involves respecting individual autonomy, supporting agency and making decisions based on the principles of informed consent. The bads to be avoided are interfering and taking over without a juridical ground. If care on the basis of informed consent does not work, then there is a "flip over" to juridical measures such as a CTO or forced hospitalization to control a crisis. This approach thus draws a more strict line between care and coercion and limits the options in between. As a result, in this choreography the legitimacy of cajoling, interfering or taking over is less clearly defined. But since care is relational (Pols, 2014; Tronto, 2010), caring *without* interfering is impossible. As a consequence, the relational way of working is also an important part of the daily practice of caring for a crisis in Utrecht, but can cause a sense of unease.

Limitations

The findings of the study should be viewed in light of some limitations. First, the design of the research was limited to two teams to make in depth ethnographic fieldwork possible, but obviously this has consequences for the generalizability of the findings. The results describe how care-control around a crisis can be shaped in radically different ways and how both normativites (f.i. the concept of autonomy or relationality), organization of care and the way a crisis is identified are important factors in this. But these findings do not lead to "facts" that are applicable to community mental health in general. The findings are context bound descriptions, that we contrasted to learn about different ways of care-control around a crisis. What this can do is help to open up new ways of understanding care-and control and to formulate new questions in other settings. Future

studies could bring to the fore other important aspects to improve the understanding of the relation between care and control and this could be helpful to determine indicators for good practices in situations around a crisis.

Second, as Malterud (2001) points out, in qualitative (and maybe also in quantitative) research, the researchers position and perspectives has an effect on the research in different ways; on the questions asked, the methods chosen to collect data and the way they are interpreted. This positioning was addressed by being reflective on the role of the researcher, her connection to the field, the methodologies chosen en the theoretical framework that we used.

5.6 CONCLUSION

As our fieldwork showed, care always means influencing and sometimes controlling the other, in more or less intense ways. In the discussion about care and coercion what is at stake is not how forms of control can be avoided at all times, but which forms of care-control are preferred in situations that are defined as (the onset of) a crisis. In the two choreographies we sketched, the connection between care and control is either described in terms of relationships or in terms of autonomy. This provides two choreographies of organizing care and handling a crisis in different ways. Contrasting these different ways of thinking about care-control, can help to open up more relational ways of thinking about caring for a crisis. Applying a strict boundary between care and control hinders the use of the relationship between caregiver and patient in care.

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CHAPTER 6

General discussion

In this thesis, I described the daily care practices of a community mental health team (CMHT) in Trieste and Utrecht, to get a better understanding of how the risk of a psychiatric crisis is dealt with outside the walls of a psychiatric hospital. Moving care to the community- or the deinstitutionalization of mental health care- is seen as an important way of improving the quality of life of people suffering from severe mental illness. Deinstitutionalization, thus, is not only an organizational quest of reducing the number of clinical beds or moving care from the hospital towards the community. It is also an ethical question about what is perceived as good mental health care by the actors involved and how they deal with possible frictions and dilemmas that may arise.

Adopting an empirical ethics approach in my analysis allowed me to focus on how in daily practices, alternative ways of care and support can be shaped on the community level and how the people involved try to bring about good care. I describe how people deal with tensions and dilemmas in their daily care practice and what this can teach us about shaping care on the community level.

In making this analysis, I chose to focus on the moments described by those involved as a psychiatric crisis or situations at risk of a crisis. The way a crisis is dealt with is an essential aspect of shaping deinstitutionalization. On a practical and organizational level, a crisis in many countries often leads to hospitalization of the client; this may hinder the aim of providing care on a community level and enlarging the social inclusion of clients. However, a psychiatric crisis is also a moment that concerns the question of what, exactly, is the problem, and what is the "right" thing to do (interfering or not? (forced) hospitalization? coercion?) and thus what good mental health care entails by those involved is discussed and made explicit.

The CMHTs in Trieste and Utrecht differ in important aspects, such as the number of beds and the amount of involuntary hospitalization.[41] [42] Other differences lie in the more specialized organization of care in the Netherlands and an open-door policy in all care settings in Trieste from the idea that a closed door hampers recovery. By contrasting the care practices in the two CMHTs, I could articulate specific modes of caring around an anticipated psychiatric crisis. In this discussion, I answer the research questions formulated in the introduction:

41 In 2018 Trieste had 15 beds per 100,000 inhabitants. In the region of Utrecht, there were 89 per 100,000. In 2017 (Vektis).

42 An international comparison (Sheridan Rains et al., 2019) shows that Italy has the lowest amount of involuntary hospitalization in Europe. If we compare the region Utrecht (bigger than Utrecht city alone) and Trieste, then involuntary measures (forced hospitalization and/ or treatment) are about ten times lower. Utrecht (2019) had 217 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by de rechtspraak). In Trieste (2019), there were 21.8 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by asugi. Sanita Trieste). Also, here numbers are indications. There are, for instance, differences in the juridical system.

- What do professionals do in their attempts to shape good care within the daily practice of the community mental health care teams of both Trieste and Utrecht?
- How do professionals anticipate and respond to "psychiatric crisis" in these two care practices?
- What can we learn about improving community mental health care from the contrasts between the two practices?

The research presented here started in the Dutch setting, where from 2012 on, there was a renewed aim to reduce psychiatric beds and make a shift towards mental health care on the local community level. As a consequence, the focus in this concluding discussion chapter is mainly on what this contrast can teach the Dutch setting about shaping care in the community. [43] In the first part of this discussion, I describe my findings, and in doing so, I answer the first and second research questions. In the second part, I formulate lessons learned for practice, policy and research, answering my third research question.

6.1 SHAPING GOOD CARE IN THE CMHTS OF TRIESTE AND UTRECHT

TWO MODES OF ORDERING CARE: RELATIONAL CARE OR CONNECTING EXPERTISE

In this thesis, I analyzed the two care systems in Trieste and Utrecht on the level of everyday care. I did this by drawing on John Law's (1994) concept of "modes of ordering," as a small scale of the term discourses that Foucault used (see also Moser, 2005). A mode of ordering can be understood as a specific pattern of values, actions, and knowledge (Pols, 2006). [44]

Relational care in Trieste

Using the concept of modes of ordering care, I described the care practice of the CMHT in Trieste as a relational mode of ordering community mental health care, going back to the 1970s and the so-called "psychiatric revolution" of Basaglia.[45] In this way of ordering

43 This does not mean that Trieste has no learning points or that this is less important. In fact, during the collaboration between Trieste and Utrecht over the years, there has been an exchange in both directions. For instance in sharing experiences around developing peer support and shaping care for people with a dual disorder.

44 Pols uses this description for repertoires, a term closely related to modes of ordering.

45 The history of mental health care in Trieste and the Netherlands is described in the general introduction and separate chapters. Important to note here is that in Italy in the 1960s of the former century, the psychiatrist Basaglia became head of the mental health care department in Trieste. He made an analysis of the psychiatric hospital as a total institution, depriving people of their identity (see also Foot, 2014; Portacolone et al., 2015). He, therefore, promoted the radical closure of the hospital and moving of care to the community as an essential step in reversing this process, to make "patients into citizens again." This radical shift of care from the hospital towards the community, together with the principle of working with open doors at all times, made Trieste an example of deinstitutionalizing mental health care in a radical way.

care, the focus is on people as relational beings who are part of a web of relationships. Ideally, people are part of a strong network that can function as a "buffer" in case of a possible crisis. But these relations can also be weak or even missing entirely. Care is directed towards this network by maintaining and creating relations between clients, caregivers, and others, including non-human actors, such as housing, job opportunities, etc. This means care can be directed towards many aspects of people's lives, such as work, social contacts, and leisure. Furthermore, care is not time-limited but can be more or less intense, depending on the situation. The main focus of care in this mode of ordering is not so much on the symptoms themselves but on building networks that enable clients to participate in a meaningful way in society. This vision of "good" mental health care is strongly articulated in the practice of the CMHT of Trieste and is used as a framework by care professionals in their daily work.

Connecting expertise in Utrecht

In Utrecht's CMHT, I described the mode of ordering care as connecting expertise.[46] In ordering care by connecting expertise, the professionals, influenced by juridical and medical regulation of care, focus on the individual autonomy of clients. In this mode, specialized care should address the individual client's specific needs in the least intrusive and expensive way. In Utrecht's more specialized and differentiated care landscape, different kinds of expertise need to be connected to provide continuity of care. The CMHT can offer polyclinic care and outreach during office hours. If more and different care and support are needed, the team is dependent on other service providers such as a crisis team or clinical wards. As a result, the team workers had to shift between different modes of ordering care, that sometimes enhanced each other and sometimes clashed, but always had to be negotiated.

TWO CARE LANDSCAPES

Describing these different modes of ordering care made visible how care is also shaped by the care landscapes the two teams are part of. In Trieste, referrals are almost impossible since the CMHTs are responsible for all mental health care in their district. There is only a small clinical facility in the general hospital and no specialized teams. The CMHT is based in a CMHC that has 24/7 access, can also provide care outside office hours, and lets people stay in the center when necessary- all while providing care from the same team. The relational approach is supported by the fact that people are often in care for a more extended period, with more and less intense periods of support.

46 The Dutch process of deinstitutionalization already started before the Second World War, but was more gradual than in Trieste, involving reforming the hospital instead of closing it while building up community care at the same time. Several policy documents describe how in this process the aim of deinstitutionalization in the Netherlands in terms of participation and improving the quality of life of patients formally living in a psychiatric hospital got linked to the aim of enlarging efficiency in care and the hope of reducing costs (Hutschemaekers et al., 2002; Vijselaar et al., 2009).

In Utrecht, care is more specialized, involving different teams offering integrated care (the CMHTs) and care organized around specific specializations. As a consequence of the organization of care by different specializations, cooperation between different teams, organizations, and domains is necessary to create continuity of care. The CMHT is ideally seen as a temporary intervention for those needing specialized mental health care. Following the medical model, people ideally are referred to other care providers (e.g.in the social domain) when symptoms decline or stabilize.

Financing care

It is important to note that the way care is financed also differs between Trieste and Utrecht. In Trieste, mental health care is funded with a regional budget. Part of this budget can be spent on personalized health care budgets for those in need of extra care (Ridente & Mezzina, 2016), but the finance system is population-based. In Utrecht, in line with the modes of ordering care at the time of the research, mental health care was financed by insurance companies based on individual diagnoses. In contrast, support and sheltered living were funded through the municipality. These differences in financing care can hamper cooperation between different care domains (Advies Commissie Toekomst beschermd wonen, 2015). In Utrecht, the CMHT I conducted the research was a new initiative to bridge this gap by letting professionals from differently financed organizations work together in one team, despite thresholds in the way care was organized and funded.

Juridical differences

Another difference in the care landscape concerns the juridical system. There are some important differences between the two countries. First, at the time of the research, involuntary care in the Netherlands meant forced hospitalization.[47] In Trieste, forced care care was often provided by the center in cooperation with the network. Since doors are always open in Trieste, nurses and others are assigned to support and guide a person with a community treatment order (CTO; TSO in Italian) in the center and to accompany them outside.

Another difference is that in Trieste, a treatment order may be issued based on the need-for-treatment criterion but not on the dangerousness criterion. This absence of a dangerousness criterion is in stark contrast to the Netherlands and most other European countries (Sheridan Rains et al., 2019). It relates to the vision of Basaglia, who saw the absence of the dangerousness criterion in the new law 180 as a fundamental step to break the often-made connection between mental disorders and dangerousness (Mezzina, 2020).

47 The fieldwork was conducted one year before a new law concerning forced care was implemented in The Netherlands in 2020. The new law offers the possibility of applying forced care in an ambulatory setting as well (De Waardt et al., 2020)

Two different cultures

Besides these differences in modes of ordering care, it is important to point out that some relevant social and cultural differences between Trieste and Utrecht influenced the way the care landscapes at both sites took shape. What is often pointed out in contrast between the Netherlands and Italy is that the latter is a country with a more robust family structure and sense of family responsibility (Portacolone, 2015). Although this strong family structure does facilitate a relational way of working, in this thesis, I did not use "culture" as a central explanatory concept in the analysis. This is for several reasons. First, I aimed to describe how care gets shaped at both field sites. Taking culture as a central concept in the analysis leaves the question of why not all southern European countries with a strong family culture have a mental health system with a strong focus on a relational approach, as in Trieste. Using culture as a catch-all concept and explanation for the differences found would also absolve us of the responsibility to be open to learning from experiences elsewhere, despite cultural differences. Lastly, as Da Roit (2019) points out in her study on long-term care, the differences in family culture do not only have a cultural component but are themselves also shaped by the social policy of the relevant country. Daroit describes how family (financial and care) responsibilities were taken for granted as being the cornerstone of elder care in Italy. In contrast, in the Netherlands, a system of long-term care support financed by the state reduced the family's responsibility.

Different modes of creating continuity of care

Contrasting Trieste's and Utrecht's modes of ordering care also taught us that different modes of care come with different modes of framing time (see also Hautakmäki, 2018). In Utrecht, the CMHT offers specialized mental health care, and this is ideally seen as a temporary and linear intervention with a clear endpoint. The idea of mental health treatment as a linear and temporary intervention differs from Trieste's more cyclical and long-term time approach centered around building relationships, in which there are periods of more and less intensive care. This continuity in the care relation offers the possibility of intervening quickly to avoid escalation or deterioration. Consequently, the ideal of continuity of care, which is seen as an important aspect of dealing with a crisis in both modes of ordering, is operated differently in each city. In Trieste, continuity of care means continuity in the relationships, care is provided by the same team and is time unlimited. In Utrecht's more specialized care landscape, continuity is created by working in networks with other partners and connecting expertise.

DEALING WITH A PSYCHIATRIC CRISIS

By contrasting Trieste's and Utrecht's modes of ordering care, I described what the differences mean for the care around a crisis. I followed John Law in his use of the

term choreography[48] as a metaphor to encapsulate the idea of a crisis as "a set of coordinated actions from different actors in time and space that are not predetermined, but guided by tracks of earlier experiences, routines, expectations and rules" (Law, 2010, p. 68). The metaphor of a dance's choreography helped to understand how care and control can interrelate in different ways because it captures the temporal and spatial character of care around a psychiatric crisis. Care and control can go together in specific choreographies. An example is distributing medication in Trieste: this is a form of care (by medication) but a form of control as well, since it is used to check how people are doing by letting some people (those perceived as in need of this daily check-up) come to the center daily to pick up their medication.

What is a psychiatric crisis?

In analyzing the care-control choreographies in Trieste and Utrecht, a few differences came to the fore. Firstly, what situations are identified as (being at risk of) a psychiatric crisis differ between the two field sites. In Utrecht, crisis situations are primarily defined as a crisis of the individual, be it due to medical or social reasons. In the more linear time frame conducted in the Netherlands, a crisis is defined as a separate phase, including specific guidelines and specialized care (clinical facilities, IHT teams). The team works on prevention and de-escalation, but when the CMHT is no longer able to provide care, a transfer in care is seen as a necessity, usually by a clinical admission or involving other care partners that are able to provide more intense 24/7 care, something the CMHT in Utrecht is not able to provide.

In Trieste, on the other hand, a crisis is seen as a crisis of the client and her or his context and is part of the cyclical approach to care conducted there. People are often in care for long periods, and care can be more or less intense, while ideally, there is always "a line" between clients and their network to make sure to know how one is doing and thus to be able to intervene quickly. This way of working makes it possible to provide care on a daily basis and more intense care when needed, for instance, when situations are identified as a risk for a crisis without a transfer to another care provider. It also enables the team to act on little signals that something might be off. I described, for instance, that a man not coming to the center to pick up medication can be a reason to conduct a house visit; if the team knows from experience this can be important to keep the equilibrium.

Restricting movements

Another important difference between these care-control choreographies is the way movements are restricted at the two sites. In Utrecht, an acute situation often means

48 John Law refers to Cussins (1996) when describing his use of the term choreography as "the arrangement and distribution of events and actors in space and time, sometimes bringing actors together and sometimes keeping them apart" (Law 2010, p. 67)

hospitalization on a (closed) ward. A closed door is not an option in Trieste's mode of caring. Movements are, therefore, sometimes restricted in an alternative way, for example by moving along, staying close, accompanying, guiding, and redirecting movements in a non-coercive yet directive way. To give an example, I described a situation in which a young man was taken out for an ice cream instead of being forced to stay at the center. I referred to the term "will work," coined by Driessen (2017), to articulate these different ways of aligning the wishes of clients with the wishes of professionals, in this case, wishes about where to go and where not to go. These forms of care can be understood as controlling and caring at the same time and are an important part of the care-control choreography in Trieste.

Good ways of intervening

Lastly, I described a difference between the two choreographies in how the teams deal with the question of when and how to intervene in a situation. For instance, when there is uncertainty about how a client is doing, or people refuse the care that is offered. From the relational way of ordering care in Trieste, intervening from within the relationship is seen as good care, while coercive measures such as forced hospitalization or treatment are rather avoided and, in any case, difficult to conduct with the low number of beds available. In Utrecht, the ideal of respecting the individual autonomy of clients is more central. This care vision gives clear directions on how to perform good care when a client is motivated (making decisions based on informed consent and the agency of the client) but does not give such a clear answer to the question of what to do when clients are not motivated for care or not willing to engage in contact (see also Chapter 5).

6.2 LESSONS FOR PRACTICE, POLICY, AND RESEARCH

LESSONS FOR PRACTICE

In contrasting the two care practices, lessons can be learned for both sites. As explained before, the focus in this general discussion is on lessons for the Dutch practice, since the research started in the Dutch setting, where from 2012 on, there was a renewed aim to reduce psychiatric beds. [49] Below I formulate four possible lessons about how care for a crisis on the community level[50] may be shaped:

49 Possible lessons for Trieste that came to the fore during the collaboration between Trieste and Utrecht over the years, were for instance developing peer support and shaping care for people with a dual disorder.

50 Important to note is that if I refer to "community," I am aware that this is not an unproblematic term. I do not want to insinuate that community as in the meaning of neighborhood, is always the ideal that should be promoted or the place where all problems are solved (see Pols 2014; Ootes 2013). If I use the term "community," I address the organizational level where mental health care is provided, e.g., to make the contrast with care in a clinical setting.

Deinstitutionalizing mental health care asks for a shift towards working on networks

Contrasting the practices of Trieste and Utrecht from an empirical ethics perspective underlines that deinstitutionalizing mental health care is not only about the physical move from the hospital into the community or the "bricks and mortar" as Chow and Priebe (2013) described it. From the beginning, the ideal of deinstitutionalization also projected specific ideas about the position of those formally living in psychiatric institutions in society (Pols, 2016) and how to provide care and support to make this possible. Concepts like social inclusion and participation are used to describe the ideal of people not only changing location but also making a social change "from patient into citizen." Turning to the daily practice of care made it possible to go beyond these abstract notions, and articulate specific ways in which these ideals are practiced in everyday care. The research showed that in reorganizing mental health care, the question should not only be how many beds are needed and where those should be (deinstitutionalization as a shift in a physical place), but should also be focused on -and maybe even start with- the question of how to shape good care; that is, what is needed for people to have a meaningful life and be able to do things in a way that is meaningful for them (deinstitutionalization as a social space). By definition, this means adopting a broader view on psychiatric treatment and care, beyond a pure psycho-medical standpoint and including the social environment.

If we start from the idea of people as relational beings as proposed by the ethics of care (Tronto, 1993; Voskes, 2014), ideally, service users are embedded in a strong social network. This network-like view on sociability resonates with what Ootes (Ootes et al., 2013) describes in her work on different forms of citizenship. In a network approach, she describes the one in care as a node in a network, where other nodes are also connected with the one in care but also with each other. This network consists not only of caregivers and receivers but also of the house where one lives, neighbors and friends, the workplace, leisure activities, and so on. Everyone/ everything in the network has a role and can be involved in care and is interdependent on one another. It is the connectivity and interdependency between nodes that makes care radically relational.[51] Participation and social inclusion can then be understood as an ideal form of this network, a form in which people have relationships with others and are able to do things and pick up roles that are meaningful to them.

My analysis of the practices of the CMHTs in Trieste and Utrecht showed how a relational mode of caring in which one is part of a network of mutually interdependent relationships leads to a way of "doing social inclusion" that stands in contrast to a mode of caring in

51 This term is used to underline that relations exist not only between human actors; also things, routines, places, and technologies can be part of a network as non-human actors (Pols, 2014).

which individual autonomy and independence are more central. This difference comes to the fore in the role perceived for mental health care: from the ideal of autonomy and self-management, care in the Dutch setting withdrew from the social domain, as to facilitate social inclusion and normalisation. This move is closely linked to the ideal of the Dutch "participate samenleving," in which a transfer from the domain of care towards the domain of self-management and informal care is promoted.

In Trieste, it is seen as the responsibility of the CMHT to be a linking point between the nodes in a broader network. In this mode of ordering care, it is about directing care of the CMHT towards the whole network: building and maintaining relationships with work, school, neighbors and social activities. In the words of Portacolone et al. (2015), it is seen as the responsibility of mental health care providers to "become the 'missing link' that connects the person to social and community services" (p. 692). The medical director described the network as a "buffer" that can absorb the disruption of a crisis. This means that creating and maintaining networks in Trieste is seen as an essential part of care and part of the task description of the teams.

Describing the practices of "doing social inclusion" of Trieste and Utrecht thus leads to a paradox. As described in the development of the two care systems, the aim of deinstitutionalising mental health care in both Trieste and Utrecht were similar. Deinstitutionalising care is seen as a way to enlarge the social inclusion of clients, a way to better involve the social network in care and a way to enlarge participation and social inclusion. But the route taken to reach these goals was a different one. In Trieste this led to a care practice in which mental health workers are involved in all life domains for often long periods. In the Dutch context the idea was that to enlarge normalisation and social inclusion, mental health care should withdraw itself from the social domain to the exclusive domain of mental health treatment. The paradoxical result was that in this mode of caring, instead of facilitating the role of the social context and informal care, it became more difficult to involve the social network, because the 'nodes' in the network were not connected anymore.

This contrast between Utrecht and Trieste opens up different ways of thinking about the sociability of clients. If we define people as independent, autonomous individuals, relations with others are defined from the individual client. Significant others close to the client (relatives, children) are seen as important to involve in treatment and support. However, care and support are primarily directed to the individual and her or his direct network. Support in other life domains is perceived as important, but this is mainly addressed by connecting expertise, for instance, with other service providers.

In contrast, a view in which the interdependency of people is taken into account can help to underline the importance of not only involving others (both family as well as other important areas such as school, work, etc.) in all phases of care and support but also adopting a network like view in which care is directed towards the whole network the person in care is part of. This shift in perspective could support the different initiatives around involving the network in care currently developing in the Netherlands, such as resource groups (Tjaden et al., 2022) and the initiative of network psychiatry (Mulder et al., 2020).

Watchful waiting

The second lesson to learn from comparing both practices concerns what is important in shaping care on in the community for those with the most complex and persistent problems. I brought to the fore that alongside care as intervention and action, "watchful waiting" is another important aspect of care. With this term coined by Lisa Baraister (2021), I referred to forms of care that are not so much about well-described interventions or actions but about making connections, being there, and trying out what works as an important aspect of dealing with the uncertainty of a crisis in a community setting. It is a term that resonates with concepts such as "tinkering" (Mol, 2002, p.177) and is part of relational mode of ordering care. In describing these relational forms of caring in both teams, it became clear that they are seen as important among professionals but have a bad fit with a way of framing time that is goal-oriented and linear.

This friction is related to the ideal of specialization. The development towards more specialization in mental health care has led to the development of important interventions and guidelines. But a focus on treatment for specific diagnosis also goes together with a form of reductionism in which the complexity of problems and the interference with different life domains are left out of the picture (Glas, 2019). Especially for those with complex, long-term care needs, the move towards specialization can be a bad fit because their problems are intertwined and involve different life domains that do not match the idea of specialization.[52] Addressing the needs of this group has a better fit with a cyclical way of framing time, where both periods of intense or less intense contact can be part of. Care professionals in the teams I studied were well aware of these tensions and combined a more temporary linear approach with a more relational approach and activities that can be linked to "watchful waiting" when they considered this to be necessary (see also Waibel et al., 2012 for the importance of relational continuity in care).

52 As the report of the Dutch council for health (RVS) on cooperation between different domains of care points out, the Dutch care landscape it is not very well equipped to address complex health problems (RVS 2022, see also Nijdam, et al., 2022).

The position of care professionals sometimes became precarious because precisely what is seen as a necessity by professionals to provide good care, was questioned by a system with a lineair timeframe and a focus on specialization. I described for instance how in Utrecht, a nurse questioned whether it was legitimate to visit a man with a long history of homelessness and addiction weekly just to do crosswords, although she felt it was important to do so to have sight on how he was doing and to build a relationship. I therefore argue that facilitating forms of care that are not congruent with a strict linear time frame is important to support the recovery of people, especially those with the most complex needs and should not be hindered in the way care is organized, financed or accounted for.

Redirecting the focus of acute crisis towards creating continuity

In this thesis, I argued that to understand how in Trieste a crisis can be dealt with in the community with a low number of beds and a minimum of coercive measures, we need to re-shift our focus from acute moments and ways of controlling risks towards a broader time frame. This way, a crisis can be understood as part of a longer trajectory instead of an isolated event, and attention can be directed to what happens before and after the acute moment. This resonates with the report "zorg voor veiligheid" (onderzoeksraad voor veiligheid 2019), which points out that in situations where there is an escalation, most of the attention is given to stabilizing a crisis. The risk of this approach is that the necessity of creating continuity before and after this acute moment is not taken into account as much as is needed. In the words of a psychiatrist in Trieste, it is important to break "the cycle" of someone ending up in a crisis over and over again. What is to be learned from the contrast between Utrecht and Trieste is the strong emphasis on the fact that creating continuity needs work on the social fabric: the network one is part of, work, housing, daily activities, and all other life domains. This way, a strong network can function as a buffer that can absorb the disruption of a crisis. This asks for a strong cooperation between different organizations. But it also implies that for those at risk of fallen between the cracks of different organizations, mental health care itself needs to engage with the different life domains.

Deinstitutionalizing mental health care means finding creative ways of dealing with a crisis in the community

This brings to the fore the highly debated question of whether there is such a thing as a required minimum number of psychiatric inpatient beds (Mundt, 2022). What can we learn from the differences in the modes of ordering care between a system with a relatively low versus a relatively high number of beds? In the mode of ordering care in Trieste, inpatient beds are seen as an obstacle to social inclusion. Therefore, there

is only one clinical ward with six beds[53]. When someone is admitted to this ward, they are referred to the center of their own district as soon as possible, also in the case of a crisis.[54] This sets the team in Trieste apart from specialized crisis intervention teams in Utrecht and elsewhere that also work in the community and offer home treatment or walk-in facilities but in which crisis is directed as a separate phase in the care process with often the consequence of a transfer from one team to another.

What is interesting, also for mental health care systems with more hospital beds, is that working with such a low number of beds opens up creative ways of dealing with a crisis in the community. The research showed that if hospitalization is not an option, more time and energy need to be spent on using relationships as an instrument to avoid escalations. I described care practices in Trieste where moving with, seducing, and other forms of "will work" (Driessen, 2017) in which the wishes of clients are aligned with the wishes of professionals and are used to avoid strict forms of coercion. These examples can be helpful in rethinking different ways of reducing hospitalization and strict forms of coercion. This asks for reflection on these everyday relational activities of preventing coercion that can overcome the signaled "flip-over" character of respecting individual autonomy in the Dutch situation. This flip-over consists of either respecting one's autonomy (and not intervening) or taking over on juridical grounds when the juridical dangerousness criterium is reached. But it is also about prioritizing forms of caring, acting, and intervening from within the relationship when there is no acute risk, such as "frying eggs while making treatment plans" described in Chapter 3.

IMPLICATIONS FOR POLICY

I deducted three implications for policy that arise from this study:

Policy should support the shift from acute care towards creating continuity in caring for a crisis

In contrasting Trieste and Utrecht CMHTs, I saw how differences in the organization of care on the level of the community have consequences for how a crisis is cared for. In Trieste, having a low number of beds combined with a CMHC that can provide 24/7 care and someone available to respond quickly to acute situations is important to scale up care in a flexible manner. This was an important prerequisite for being able to address a psychiatric crisis in the community, with a low number of beds, a minimum of coercive measures and an open-door policy. The uncertainty of a crisis is dealt with by creating

53 This clinical facility is both for the city of Trieste as for the broader region.

54 During the research in Trieste there was an experiment with a crisis intervention team that worked in close cooperation with the CMHC to deliver more intense outreach. This caused a discussion in the team because some pointed out that this was incongruent with the ideas of personal continuity. Others stressed that more intense outreach was needed to even further reduce hospitalization in case of a crisis.

continuity in relations and a cyclical timeframe that enables more relational activities (this was described previously as "watchful waiting"). What we can learn from this is that in the discussion about crisis care and reducing coercion, what is needed is not only a focus on what happens in an acute situation or at hospital wards, important as this might be.[55] Of equal importance is to rethink how to better facilitate a relational approach in everyday care for those at risk of "falling between the cracks" and what is needed to give professionals the back-up to work in such a way.

Space for reflection on what good care entails is necessary to shape care in the community

By contrasting Trieste and Utrecht's daily care practices, I was able to articulate how in Trieste, there is a strong narrative on good care, going back to Basaglia and the "psychiatric revolution" of the 1970 that guides care workers in the dilemmas they encounter on a daily basis. This narrative gives workers footholds despite diffeculties that obviously exist when they encounter dilemmas in their daily work. In Utrecht, I encountered a more differentiated landscape in how care is organized, but also more differentiation in the different modes of ordering care present in this practice. In Chapter 3, I described how care professionals of Utrecht's CMHT had to relate to a community, juridical, medical, administrative, and relational mode of ordering care. Because they had to relate to these different modes of ordering, each with their own view on what good care entails, at times this led to uncertainty for the care professionals if what they were doing was indeed good care. Especially when the relational mode of caring clashed with the administrative or medical way of ordering care, workers started to question whether what they were doing was legitimate, although they felt their relational ways of caring were important indeed. Care workers can be supported in their work by raising awareness of the logics present in a specific situation and which values are at stake. This needs a constant process of reflection. Dialogue models such as moral deliberation, resource groups, and peer-supported open dialogue can facilitate this dialogue by discussing dilemmas people encounter.

Policy should support relational ways of working on all levels

By contrasting two practices, this research made visible how the organization of care defines the playing field in which relations between professionals, clients, and others are shaped. In his book 'Person Centred Care in Psychiatry' Gerrit Glas argues that the structure of psychiatry is a normative endeavor on different contextual levels. Next to the micro level of the individual client, there is the meso level of the organizational structure and the macro level of the government. If we want to support a relational

55 In the Netherlands, new models like High Intensive Care have been developed to find new ways of dealing with an escalation in a clinical setting (Van Melle et al., 2021).

mode of ordering care, then this does not only refer to the micro level of caring for a client, for instance by acknowledging the importance of watchful waiting. Also, on the meso and macro level a relational approach should be facilitated and discussed in a dialogical way. Otherwise, important aspects of what defines a care situation as "good" leaves those on micro level without a back-up or legitimation. These discussions can also help to overcome the often-created juxtaposition between relational care assigned to the micro level of practical care and bureaucratic or management modes of ordering to the meso and macro level. We need a system that facilitates relational ways of working and gives professionals the space to prioritize what is necessary to do from a care perspective. For instance, by rethinking the way accountability procedures and devices are shaped and how reshaping these structures can strengthen care practices instead of perceiving accounting and caring as two separate domains that only hinder one another (see also Jerak-Zuiderent, 2015).

RESEARCH INTO DAILY PRACTICE OF CARE

Practices and normativities

In this thesis, I used an empirical ethics approach to contribute to the research into deinstitutionalization and shaping care on the level of the community. This choice was informed by earlier research I conducted in the Trieste mental health system together with Sonja van Rooijen (Muusse & Van Rooijen, 2015). This earlier research taught us that for a good understanding of the way mental health care is done in Trieste, a focus on the organization of care and outcomes, the original assignment, was not enough. In the interviews we conducted, our informants time and again pointed out that their care practice and ideas about what good mental health care entails are closely interlinked. This is not unique, of course. But since mental health care in Trieste has such a strong narrative about what good mental health care entails, going back to Basaglia and the so-called psychiatric revolution, it stood out that we also had to address the dominant values and ideas enacted in this system to understand what was going on. Empirical ethics offers a way to do just this: it directs the focus towards everyday care practices and its normativities.

In the field of research into psychiatry, I believe this empirical ethical approach has something to offer. In the philosophical assumption of psychiatry as a medical enterprise (Ralston, 2013), psychiatry is seen as a model with an objective scientific core of evidenced-based treatment that is contrasted with a soft margin of "values, preferences, clients' interests and clinical intuitions" (Glas, 2019, p. 6). This binary division between objective- subjective has consequences for the research into mental health with its strong focus on evidenced-based interventions. Empirical ethics offers a way to overcome this dualistic "objective-core- subjective-margin model," as Glas describes it, by prioritizing everyday care practices and the normativities embedded in these.

With ethnography as the main method, empirical ethics offers a way to articulate the importance of mundane care practices such as "watchful waiting." These relational practices have a cyclical character and, therefore, a bad fit with the model of evidenced-based interventions based on outcomes. Instead, ethnography offers a way of investigating the various effects of different ways of caring (Mol, 2006, p. 405). This differentiation between *effectiveness* and *effects* that Mol delineates is helpful in articulating different ways of shaping good care. Contrasting practices from different sites helps to understand what hinders and facilitates different ways of good care. More so, ethnographic studies can make visible how the way care is organized on a macro level has intended and unintended effects on everyday care on the micro level of the work floor. This can be used to inform policymakers about these unintended effects so that these can be taken into account in reshaping policy measures. Further research in which practices in different countries are contrasted using an empirical approach and an analysis on outcomes such as the number of beds, suicide rates, and life expectancy could further deepen our understanding of how to shape care on the community level.

Focus on the mundane

The empirical ethics approach also helped to shift the focus from acute situations towards more mundane forms of daily care, to understand how a crisis can be dealt with in the community. This focus on daily care practices is inspired by the work of other studies on care in practice that take lessons from the mundane (e.g., Driessen, 2017; Pols, 2006; Jerak- Zuiderent, 2012; Lester, 2009). Driessen, for instance, describes how redirecting attention towards mundane interactions in dementia care helped her to open up new imaginaries for envisioning good dementia care. In a similar way, in this study, the focus on the daily practices of care in both teams was necessary to understand how the care around a crisis was shaped and thus what is of importance if we want to reshape this practice, for instance, if we want to reduce the use of coercive measures.

Network of people and things

Lastly, the empirical ethics approach helped me to articulate how care for a crisis was shaped differently in the different modes of ordering care. Not only because people acted in a certain way but also because there were different technologies, routines, and physical characteristics that shaped the care practice and influenced each other in mutual ways (see also Pols, 2014). An example is the open-door policy in Trieste. By analyzing the physics of an open door as an actor in a specific situation, I was able to articulate how an open door "does" something in a situation or makes others do certain things: professionals on a psychiatric ward move in specific ways when a door is always open. They stay close, touch each other and move in specific ways. I believe the approach was useful in articulating important parts of daily care routines that shape how a crisis is enacted in the two modes of ordering care, mundane aspects of caring that otherwise

might be overlooked. Viewing care practices as a network in which people and things interrelate is helpful for better describing and understanding other care practices, for instance, to figure out what works and what does not work in care or in describing good practices with the aim of improving care.

6.3 TO CONCLUDE

In this thesis, I contrasted the daily care practices of the CMHTs of Trieste and Utrecht to answer the question of how a crisis can be dealt with on the community level. In this discussion, the emphasis was on the lessons to be learned for the Dutch situation, since the research started with questions about how to further develop community care in the Netherlands. As stated before, this does not imply that for Trieste there is nothing to learn from this contrast. During the mutual exchanges during this and the previous research, this exchange did indeed happen.

Describing the historical development of mental health care ideals promoting deinstitutionalization, such as supporting participation and social inclusion, can be found in both field sites. But Trieste and Italy underwent historically different deinstitutionalization processes. One radical and the other more gradual. It resulted in two distinct practices- one that I described as a relational mode of care and one of connecting expertise. By contrasting these modes of caring, my goal was to articulate what is important in shaping mental health care on the community level: not only at moments of acute crisis but in everyday care practices in which professionals, clients, and others deal with ethical dilemmas regarding how to shape "good care." This asks for a mental health policy that supports relational ways of caring that often have a cyclical instead of linear character and are not easy to define in terms of effectiveness.

Good mental health care starts with analyzing what good care means to those involved. Research into the practice of care can inform policy about what is needed in terms of organization and financing care in such a way that it supports professionals and others in shaping good care in the community.

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A D D E N D U M

Portfolio
Summary
Nederlandse samenvatting
Dankwoord

PORTOFOLIO

A

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PhD period: 2017-2023
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PUBLICATIONS

Chapter 2

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READING GROUPS & SEMINARS

2020- present:	Participation in Reading group on Actor-Network Theory
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2016-present:	Participation in and presenting at Philosophy of Care meetings- Amsterdam UMC
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PRESENTATIONS

2022:	Wetenschappelijk Middagprogramma Parnassia Groep – regio Rijnmond 21 maart- online
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	Fact-platform, 5 maart 2021- online
	Wetenschapslunch Psychiatrie meeting Erasmus MC, 1 november- online
	Herstel voor iedereen 24 maart- online
2020:	Onderzoekssymposium EPA en onvrijwillige zorg, 21 januari- Amsterdam UMC
2019:	EAOF – European Assertive Outrech Foundation, -Verrona: 5-7 September
	International Conference Trieste: Good Practice Services: promoting Human Rights and Recovery in Mental Health,-Trieste 23-26 September 2018
2019:	Democracy and Community Mental Health Care- Trieste 21-23 June 2018

CCITP-- International conference on Crisis, Coercion and Intensive Treatment in Psychiatry- Rotterdam 18-19 oktober

International Conference Trieste: The right and opportunity to have a whole life, Trieste 15-18 november

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SUMMARY

A

In this thesis, I describe and contrast the daily care practices of two community mental health care teams (CMHT). One is located in Trieste, Italy, and the other in Utrecht, the Netherlands. I study these care practices to learn more about how a psychiatric crisis can be dealt with outside the walls of a psychiatric hospital and what is perceived as "good" mental health care by the actors involved. Applying an empirical ethics approach, with ethnography as the main method, enables me to describe how good care gets its meaning within the relationship between patients, formal and informal caregivers, and their environment.

The starting point of this research is the deinstitutionalization of mental health care, with a specific focus on moments perceived as an anticipated or acute crisis. The question of how an anticipated or acute crisis is dealt with is an essential aspect of deinstitutionalizing care. A crisis often means hospitalization and thus can be a barrier to further reducing psychiatric hospital beds and enlarging the social inclusion of patients. Moreover, a crisis can be a moment when questions about what good mental health care entails are at stake; for instance, when or how to intervene and if coercive measures should be applied.

I choose to study and compare the care practices of the CMHT of Trieste and Utrecht because we know from previous research that they differ on some critical points. These are the number of psychiatric hospital beds and the use of forced care (both about a factor of ten lower in Trieste), as well as the fact that Trieste conducts an open-door policy at all times. In Utrecht, the mental health care landscape is more differentiated, and care is more specialized than in Trieste. By contrasting the two practices, we can learn about different ways of caring for a crisis outside the walls of a psychiatric hospital and unravel the ideals and values at stake. Studying different practices of care around a crisis can help us to think up alternatives to hospitalization and the use of coercion.

My research questions explore the following:

- What do professionals do in their attempts to shape good care within the daily practice of the community mental health care teams of both Trieste and Utrecht?
- How do professionals anticipate and respond to "psychiatric crisis" in these two care practices?
- What can we learn about improving community mental health care from the contrasts between the two practices?

In the introductory chapter of this thesis, I sketch out the research sites. I describe how Trieste went through a radical process of deinstitutionalization in the 1970s. Franco Basaglia, the psychiatrist that was appointed as head of the department, made an analysis

of the psychiatric hospital as a total institution that deprived people of their individuality. He stated that in order to reverse this process the hospital should be broken down instead of reforming it. This resulted in a system where most care is provided in the community.

In the Netherlands, the deinstitutionalization process was more gradual; community care was built up while hospital care was reformed but without totally dismantling the mental hospital. This resulted in two different care landscapes, which the teams I studied both co-shaped and are part of.

In Trieste, The CMHT is based in a CMHC with 24/7 access, can provide care outside office hours, and has beds to let people stay in the center when necessary. There is only a small clinical psychiatric facility in the general hospital with six beds and there are no specialized teams. Referrals are almost impossible since the CMHTs are responsible for all mental health care in their district. People are often in the care of the CMHT for a longer time with more and less intense periods of support. While providing care and support, the CMHTs work together with welfare organizations and other stakeholders in the community, for instance, social cooperatives.

In Utrecht, care is more specialized, with different teams organized around different specializations. The CMHT in Utrecht is office-based and provides care during office hours. If more care is needed, then people are referred to other mental health services, such as clinical facilities. Outside the realm of psychiatry, the CMHT can refer to social welfare, GPs, and other care providers that support people with psychiatric vulnerabilities. To create continuity of care, it is essential to connect these different expertises. The care of the CMHT ideally is seen as a temporary intervention aimed at treatment for those needing specialized mental health care.

In Chapter 2, "Working on and with Relationships," I zoom in on the daily care practice of Trieste by articulating how Trieste's care is radically relational. In ordering care from a relational approach, the focus of care in Trieste is not only on the individual with psychiatric problems but also on the relations between patients, caregivers, and others. Care is directed to working on and with these relationships since strong networks are seen as a prerequisite to dealing with a crisis in the community. This strongly articulated vision on what "good mental health care" entails supports the care professionals in their daily work. By analyzing the use of spatial metaphors, I deduce how different forms of spatiality are oriented toward particular notions of good care. Sometimes, this is about the physical space in which care is provided; for instance, in or outside a hospital. But spatial metaphors in Trieste are often also about the social space. A social space concerns the social networks one is (or fails to be) part of. These two notions of spatiality can sometimes lead to friction about what "good" community care entails. Analyzing care

in terms of spatial metaphors shows that deinstitutionalization of care is more complex than the physical move from a hospital to the community. For community mental health care to be "good" in Trieste also entails working on relationships.

In Chapter 3, "Frying Eggs or Making Treatment Plans," I shift to the daily care practice of the CMHT in Utrecht. I describe different visits to an apartment building where some of the CMHT's patients live and the stories about this building from the perspective of different stakeholders I interviewed. I analyze how these stories align with different modes of ordering care that patients, caregivers, and others have to relate to. The relational, juridical, bureaucratic, community and medical modes of ordering care that I unravel all contain different notions of what "good" mental health care entails and, thus, different definitions of what a problem might be and how this can be solved. These modes can enhance each other, partly fold into each other, and lead to frictions at other moments. In practice, workers must shift between these diverse and sometimes clashing modes of caring. I describe how a specialized medical mode of care is more strongly supported by the way care is organized and financed than the relational mode of ordering care. This leads to stress on care workers questioning themselves if what they are doing is indeed "good care."

In the fourth chapter, "Doing Uncertainty Work," I make the first direct contrast between Trieste and Utrecht in describing the way care professionals deal with the uncertainties they face during their daily work. Uncertainty is an inherent aspect of care; for instance, diagnostic or prognostic uncertainties. I borrow the term "uncertainty work" from Hautamäki to redirect the attention from these more theoretical reflections on uncertainty towards the daily care practice in which uncertainty and risks are dealt with. The first uncertainty that came to the fore was the question of who for each team qualifies as a patient. Both teams have an assumed psychiatric diagnosis as a threshold for care by the team, but after this point in Trieste there is no need for referral. In Utrecht, the question of whether one should receive care is ongoing, since people can be referred to more specialized teams or to social welfare or a GP when specialist psychiatric treatment is no longer seen as a necessity. The idea of mental health care as a temporary intervention differs from Trieste's more cyclical and long-term approach. Despite these marked differences, there are also similarities: in both teams, a relational approach is the most important instrument in conducting uncertainty work to avoid a crisis. Building relations and having an overview of how one is doing makes it possible to intervene quickly and avoid escalation or deterioration. I introduced Lisa Baraister's term of "watchful waiting" to describe these ways of "being with" as an essential part of care and an essential part in how a possible crisis can be cared for.

In the fifth chapter, "Caring for a Crisis," I describe what is seen as good care during a crisis and how this differs between the two teams. I define the care around a crisis in

both teams as two different care-control choreographies. Adopting the metaphor of a choreography, in the way John Law used this concept originally developed by Cussins, enabled me to describe care around a crisis as a set of coordinated actions in time and place. Moreover, the metaphor of a dance helped to make it understandable how care and control can interrelate in different ways and are not always juxtaposed. In contrasting the care-control choreography of Trieste and Utrecht, I could articulate how similar "actors" that make up the choreography during a crisis, such as a network or medication, take different roles in Utrecht and Trieste and thus enact other crises at these moments. An important aspect is the difference in how movements are restricted at the two sites. While in Utrecht, acute situations often mean hospitalization on a (closed) ward, a closed door is not an option in the care mode in Trieste. However, at the same time, during a crisis in Trieste movements are sometimes restricted. This happens from within the relationship between caregivers and patients. It is done by moving with someone, staying close, seducing, and sometimes cajoling someone regarding where to go and not to go.

An important difference between the two care-control choreographies is also apparent when teams intervene in a situation. In the relational mode of caring in Trieste, this is done from within the relationship, including forms of negotiation. In Utrecht, the ideal of respecting the individual autonomy of patients is central. This care vision gives clear directions on how to perform good care when a patient is motivated (making decisions based on informed consent and the patient's agency); however, it does not give a clear answer to the question of what to do when patients are not motivated for care or are unwilling to engage in contact. A strict division between care and control gives caregivers few options to act between the two polarities of "doing nothing" and respecting individual autonomy and "applying coercion."

Chapters 4 and 5 also describe which situations are identified as (being at risk of) a psychiatric crisis at the two field sites. My analysis of the practices of the CMHT of Trieste and Utrecht shows how a relational mode of caring in which one is part of a network of mutually interdependent relationships leads to a different way of "caring for a crisis" than a mode of caring in which individual autonomy and independence are more central. The main difference between a crisis in Trieste and Utrecht is that a crisis in the practice of the CMHT in Trieste is seen as a crisis of the context, and is part of the cyclical approach to care conducted. Preventing a crisis and building and maintaining networks by working on relationships are thus intertwined and seen as core tasks of mental health care.

In Utrecht, crises are primarily defined as a crisis of the individual, whether due to medical or social reasons. I describe how these different views on a crisis also have

consequences for the way mental health care sees its role: either as building and maintaining relations between all the nodes in the network of service users, or as a more temporary intervention, primarily directed towards the service users and their important others.

In reviewing the different ways a crisis is cared for in both teams, I argue that we need to re-shift our focus from acute moments and ways of controlling risks towards a broader time frame. This way, a crisis can be understood as a part of a longer trajectory instead of an isolated event, and attention can be directed to what happens before and after the acute moment. I consider care as working on a network of mutually interdependent relationships as an important way to deal with a crisis in a community setting, especially for those with more complex needs. This asks for a mental health policy that supports relational ways of caring that often have a cyclical instead of linear character and are not always easy to define as discrete interventions.

NEDERLANDSTALIGE SAMENVATTING

In dit proefschrift beschrijf ik de dagelijkse zorg praktijk van twee ggz wijkteams, één in Triëst, Italië, de andere in Utrecht, Nederland. Ik bestudeer deze teams omdat ik wil leren hoe ambulante zorg voor mensen in de aanloop naar een mogelijke psychiatrische crisis eruit kan zien en wat deze zorg volgens betrokkenen tot goede zorg maakt. Ik maak hierbij gebruik van het gedachtengoed van de empirisch ethiek. In deze benadering ligt de nadruk op hoe zorg vorm krijgt binnen relaties tussen hulverleners, patienten, naasten en hun omgeving en wat deze betrokkenen zien als goede zorg. Om deze praktijken te beschrijven en te begrijpen heb ik in beide teams een etnografisch onderzoek uitgevoerd.

Het onderzoek vertrekt vanuit het deinstitutionaliseringsstreven van de gzz en focust daarbij op momenten die door betrokkenen worden gedefinieerd als het begin van een (mogelijke) crisis. De reden hiervoor is tweeledig. Ten eerste is een crisis vaak een aanleiding voor een ziekenhuis opname. Daarmee kan het een belemmering zijn voor het verder vormgeven van het deinstitutionaliseringsstreven van de ggz dat samengaat met idealen als het vergroten van sociale inclusie en het reduceren van dwang. Maar een crisis is ook een moment waarop vragen over wat goede zorg behelst op scherp komen te staan, bijvoorbeeld als het gaat over de vraag of er gedwongen zorg moet worden toegepast.

De keuze voor Triëst en Utrecht als onderzoekslocaties is niet willekeurig. Uit eerder onderzoek weten we dat er opvallende verschillen zijn tussen de psychiatrische zorg in Triëst en Utrecht. Het aantal bedden en het gebruik van dwanginterventies zijn beiden een factor 10 lager in Triëst. Een ander belangrijk verschil is dat in Triëst vanuit een specifieke visie op ggz zorg nooit een deur op slot gaat. Het zorglandschap in Utrecht is sterk gedifferentieerd met verschillende vormen van gespecialiseerde zorg. Door deze contrasterende praktijken met elkaar te vergelijken kunnen we leren hoe ggz wijkteams op verschillende manieren met een mogelijke crisis omgaan en welke ideeën over goede zorg daarbij op het spel staan. Dit kan het helpen bij het nadenken over alternatieven voor dwanginterventies.

Ik stel de volgende onderzoeksvragen:

- Wat zien professionals in de wijkteams in Triëst en Utrecht als goede zorg en hoe geven ze daar in hun dagelijks werk vorm aan?
- Hoe gaan professionals in de beide zorgpraktijken om met een mogelijke psychiatrische crisis?
- Wat voor lessen zijn er te leren van de vergelijking tussen de ggz praktijk in Triëst en Utrecht voor het verbeteren van psychiatrische zorg?

In de inleiding van dit proefschrift schets ik eerst de twee zorgpraktijken waar ik onderzoek heb gedaan. Ik beschrijf hoe Triëst in de jaren zeventig van de vorige eeuw een radicaal

proces van het deinstitutionaliseren van de psychiatrische zorg heeft doorlopen. Onder leiding van de psychiater Franco Basaglia, die het psychiatrisch ziekenhuis zag als een instituut dat mensen hun identiteit ontnam, werd het ziekenhuis gefaseerd gesloten en werd bijna alle zorg georganiseerd vanuit ggz wijkcentra. In Nederland was dit proces meer geleidelijk. Wijkzorg werd opgebouwd terwijl de ziekenhuizen werden hervormd, maar niet geheel gesloten. Deze geschiedenissen hebben geresulteerd in twee verschillende zorglandschappen waarvan de twee onderzochte teams niet alleen deel van uitmaken, maar ook mede vorm aangeven.

In Triëst zijn de vier wijkcentra het centrum van de ggz zorg. Het ggz wijkcentrum zelf heeft de mogelijkheid mensen te laten overnachten. In het algemene ziekenhuis is één psychiatrische ggz afdeling van zes bedden voor eerste acute zorg. De ggz wijkcentra dragen territoriale verantwoordelijkheid voor alle ggz zorg in hun district. Hierdoor zijn er (bijna) geen verwijzingen. Mensen zijn vaak langere perioden in zorg, waarin meer en minder intensieve periodes van ondersteuning elkaar kunnen afwisselen en zorgcontinuïteit vanuit de persoonlijke relatie tussen hulpverleners en de cliënt vorm krijgt. Terwijl mensen in zorg zijn van het ggz wijkteam wordt samengewerkt met het sociale domein en andere partners in de wijk, zoals sociale coöperaties.

In Utrecht is het onderzochte ggz wijkteam deel van een veel gedifferentieerder en ook meer gespecialiseerd ggz zorglandschap. Er zijn de ggz wijkteams, maar er zijn ook gespecialiseerde teams georganiseerd rond een specifieke diagnose, organisaties voor beschermd wonen en klinische afdelingen. De zorg van het ggz wijkteam wordt idealiter gezien als een tijdelijke interventie gericht op behandeling voor diegene die in aanmerking komen voor specialistische ggz zorg. Het wijkteam werkt poliklinisch gedurende kantoortijden. Als er meer intensieve zorg nodig is verwijst het ggz wijkteam naar andere vormen van ggz zorg, zoals een klinisch team als een opname nodig lijkt. Buiten het ggz domein wordt er verwezen naar sociale wijkteams, huisartsen en andere zorgpartners die een rol spelen in de ondersteuning van mensen met psychiatrische problemen. Om zorgcontinuïteit te waarborgen is het belangrijk dat deze teams en expertises goed met elkaar samenwerken.

In het tweede hoofdstuk “working on and with relationships” focus ik op de zorgpraktijk van het wijkcentrum in Triëst. Ik beschrijf de dagelijkse zorgpraktijk als radicaal relationeel. Daarmee bedoel ik dat in deze zorgpraktijk de focus niet alleen ligt op de op de cliënt met zijn of haar problemen, maar gericht is op meerdere levensgebieden en het netwerk waar iemand deel van uitmaakt. De opvatting van een netwerk is breed: het gaat naast de triade van client, naaste en zorgverlener ook om huisvesting, school, werk of hobby’s. Zorg is gericht op het onderhouden en creëren van sterke relaties tussen de actoren in dit netwerk, omdat een sterk sociaal netwerk wordt gezien als voorwaarde

voor- en resultaat van goede zorg. Inbedding in een sterk netwerk dient als een buffer om een eventuele crisis op te vangen.

Om deze visie goed te begrijpen analyseer ik hoe hulpverleners tijdens hun dagelijkse werk gebruik maken van ruimtelijke metaforen. Deze metaforen gaan niet allen over de plek waar iemand is (bijvoorbeeld thuis of in het psychiatrische ziekenhuis) maar ook over een meer sociale opvatting van ruimte die gaat over de sociale netwerken waar iemand deel vanuit maakt. De analyse maakt zichtbaar hoe deinstitutionalisering meer behelst dan de fysieke verplaatsing van de zorg van het ziekenhuis naar de wijk. Goede zorg gaat over het bouwen en versterken van sociale netwerken zodat mensen in staat zijn voor hen betekenisvolle activiteiten te ontplooien en daar ondersteuning bij te krijgen.

In het derde hoofdstuk "Frying eggs or making treatment plans" beschrijf ik de zorgpraktijk van het ggz wijkteam in Utrecht. In dit artikel beschrijf ik een flat waar een aantal cliënten van het ggz wijkteam woont. Ik bezoek de flat tijdens huisbezoeken en ook in interviews met samenwerkingspartners van het ggz wijkteam komt deze flat vaak ter sprake. In de verhalen over de flat ontrafel ik verschillende '*modes of ordering'* of repertoires; manieren waarop specifieke zorgpraktijken, relaties en visies op zorg met elkaar verweven zijn. Deze verschillende vormen van zorg kunnen op gespannen voet staan of elkaar juist versterken.

Ik beschrijf in dit hoofdstuk hoe zorgverleners uit het ggz wijkteam zich in hun dagelijks werk steeds moeten verhouden tot bureaucratische, juridische, medisch-specialistische, wijkgerichte en relationele vormen van zorg. Deze repertoires behelzen elk een andere definitie van welke problemen er zijn en hoe deze het beste kunnen worden aangepakt. Hulpverleners zijn goed in staat te navigeren tussen deze repertoires, met elk hun specifieke eisen en ideeën over goede zorg. Uit de analyse blijkt echter dat niet alle repertoires even sterk worden ondersteund in de manier waarop ggz-zorg wordt georganiseerd en gefinancierd. Vooral voor de relationele manier van werken- een belangrijk onderdeel van de dagelijkse zorgpraktijk van het ggz wijkteam in Utrecht- ontbreekt vaak de legitimatie in termen van effectieve een specialistische zorg. Hierdoor gaan hulpverleners zichtzelf afvragen of wat zij doen wel het juiste is.

In hoofdstuk vier "doing uncertainty work" maak ik de eerste vergelijking tussen de ggz wijkteams van Triëst en Uitrecht door te analyseren hoe zorgprofessionals in beide teams omgaan met de onzekerheden die ze tegenkomen in hun dagelijkse werk. Onzekerheid is een inherent onderdeel van zorg, bijvoorbeeld als het gaat om het stellen van diagnoses of het voorspellen van het verloop van ziektes. Ik gebruik de term '*uncertainty work*' – het omgaan met onzekerheid- van Hautamäki om te benadrukken dat naast meer theoretische beschouwingen, omgaan met onzekerheid een belangrijk onderdeel is van

de dagelijkse praktijk in de twee teams.

De eerste onzekerheid die een rol speelt in de zorgpraktijk van beide teams gaat over de vraag wie recht heeft op zorg. In beide teams is het vermoeden van een psychiatrisch probleem de eerste voorwaarde om zorg van het ggz wijkteam te kunnen ontvangen. In Triëst wordt iemand daarna in principe niet meer doorverwezen. Mensen blijven in zorg zolang dit nodig wordt geacht, met vaak meer en minder intensieve periodes waarbij het team steeds een vinger aan de pols houdt. In Utrecht is dit anders. Mensen kunnen verwezen worden naar meer gespecialiseerde teams als de zorg die het ggz wijkteam kan bieden niet toereikend wordt geacht. Vanuit het idee dat de behandeling die het ggz wijkteam biedt tijdelijk is, worden mensen ook verwezen naar het sociale wijkteam of de huisarts. De vraag 'waar hoort een cliënt in zorg te zijn' wordt in tegenstelling tot Triëst in Utrecht dus niet alleen bij aanvang van zorg gesteld, maar komt steeds terug.

Er zijn ook overeenkomsten in de manier waarop beide teams omgaan met de alledaagse onzekerheden die ze tegenkomen. In beide teams is een relationele benadering het belangrijkste instrument om zicht te houden op hoe het met iemand gaat. Door het onderhouden van relaties en aanwezig zijn, wordt het mogelijk om vanuit de opgebouwde relatie in te kunnen grijpen en eventuele escalaties te voorkomen. Ik gebruik de term '*watchful waiting*'- in Nederlands te vertalen als waakvlam zorg-, om te beschrijven hoe deze vormen van zorg een belangrijk deel uit maken van de zorgpraktijken in beide teams.

In het vijfde hoofdstuk "caring for a crisis" beschrijf ik hoe zorg rond een crisis er uit ziet in beide teams en wat betrokkenen hierbij zien als het goede. Ik gebruik hiervoor de metafoor van een choreografie, op de manier waarop John Law in zijn werk deze term van Charis Cussins toepast. De metafoor van een choreografie maakt zichtbaar hoe zorg een proces is dat vorm krijgt op een specifieke plek en tijd en waarin verschillende actoren een rol spelen. De actoren-de dansers- zijn niet alleen de hulpverlener en cliënt; het gaat ook om andere betrokkenen en niet-menselijke 'actoren' als medicatiegebruik of juridische kaders en de setting (het toneel), waar iets plaats vindt (bijvoorbeeld thuis of in een ziekenhuis). Het gebruik van de choreografie-metafoor helpt ook om inzichtelijk te maken hoe zorg en controle niet altijd elkaars tegenpolen zijn, maar in het verlengde van elkaar kunnen liggen. Ik beschrijf bijvoorbeeld hoe het dagelijks verstrekken van medicatie in het ggz wijkcentrum in Triëst een vorm van zorg is, maar tegelijkertijd een manier voor hulpverleners om te controleren hoe het met iemand gaat.

In dit hoofdstuk laat ik zien dat hoewel veel van de 'actoren' die deelnemen aan de choreografie rond een crisis in Triëst en Utrecht hetzelfde zijn, de rollen die ze spelen verschillen. In beide teams worden bijvoorbeeld tijdens een crisis bewegingen van patienten soms ingeperkt. In Utrecht gebeurt dat door iemand op te nemen op een

(gesloten) afdeling. In Triëst zijn de deuren altijd open. Het beperken van bewegingen gebeurt dan door nabij te blijven, mensen te verleiden om op bepaalde plekken wel of juist niet te zijn, ze te overtuigen of te onderhandelen vanuit de relatie die met cliënten wordt opgebouwd.

Een ander contrast is het tijdstip waarop er wordt ingegrepen als er een escalatie dreigt. Hier kan frictie ontstaan tussen ideeën over goede zorg en idealen rond autonomie en zelfbeschikking van clienten. Vanuit een relationele visie op autonomie, waarin eenieder als afhankelijk wordt gezien van anderen, gebeurt ingrijpen in Triëst vanuit de relatie. Dit krijgt de vorm van onderhandelen, overtuigen en het betrekken van anderen. In Utrecht staat een meer individuele opvatting van autonomie en zelfbeschikking centraal. Vanuit het grote belang dat aan deze individuele zelfbeschikking wordt gehecht, is er meer terughoudendheid bij hulpverleners zich ongevraagd met mensen te bemoeien voordat het gevaarscriterium van toepassing is. Dit beperkt de opties om iets te doen tussen de twee uitersten van het respecteren van de individuele autonomie en-als gevaar voor zelf of anderen dreigt- het toepassen van dwang waarbij deze autonomie juist sterk beperkt wordt.

In hoofdstuk vier en vijf ga ik ook in op de vraag hoe beide teams een mogelijke crisis identificeren. In de meer relationele en cyclische benadering van werken in het team in Triëst, wordt een crisis vooral gedefinieerd als een crisis van de context. De oplossing is dan om netwerken te bouwen en te versterken. In Utrecht wordt een crisis gedefinieerd als een crisis van het individu, waarbij zowel sociale als medische factoren een rol kunnen spelen. Dit leidt tot twee verschillende taakopvattingen over ggz zorg. Waar in Triëst de nadruk ligt op bouwen en versterken van netwerken, inclusief school, werk en hobby's, ligt de nadruk in Utrecht meer op een tijdelijke crisisinterventie, gericht op degene die zorg nodig heeft. Naasten worden daar wel bij betrokken, maar de interventie begint bij het individu dat in crisis is.

In de reflectie op de manier waarop beide teams omgaan met crisissituaties kom ik tot de conclusie dat het van belang is de focus te verschuiven van het acute moment van een crisis zelf, naar een breder tijdsperspectief. In dat brede tijdsperspectief wordt een crisis een onderdeel van een langer zorgtraject in plaats van een geïsoleerde gebeurtenis. In beide teams zijn dan relationele manieren van werken zoals de eerder genoemde waakvlam zorg belangrijke manieren om met een crisis om te gaan zonder (gedwongen) opnames of andere dwangmaatregelen. Dit vraagt om een zorgsysteem dat juist deze relationele manieren van werken ondersteunt, vooral voor de mensen met de meest complexe problemen. Het zijn vormen van zorg die niet makkelijk in te passen zijn in losstaande interventies of lineaire zorgtrajecten. Dit vraagt om ruimte in de manier waarop we ggz zorg organiseren, om ook deze vormen van zorg te faciliteren.

DANKWOORD

Een proefschrift schrijven over een onderwerp dat me dicht aan het hart ligt en met een team dat ik zelf kon samenstellen: wat een voorrecht! Het was een luxe om langer in een onderwerp te kunnen duiken, weer terug te gaan naar de afdeling culturele antropologie van de UVA en de kans te hebben om langdurig veldwerk te doen; iets wat vaak niet goed mogelijk is in kortere onderzoeksprojecten.

Zoals zorg relationeel is, is het doen van onderzoek dat ook. Zonder een sterk netwerk gaat dat niet. Belangrijk in dat netwerk was in de eerste plaats mijn promotieteam: onze bijeenkomsten hadden zelden een strakke agenda, maar waren wel altijd inspirerend en liepen vaak uit in levendige discussies over de staat van de ggz. Niels, jij stelde de me de vraag of ik niet wilde promoveren en je plantte daarmee het zaadje voor dit traject. Je snelle schakelen, nieuwsgierigheid en kennis zijn voor mij enorm belangrijk geweest. Hans, we lopen al een hele tijd samen op. Je nam me 17 jaar gelden aan als junior onderzoeker bij het Trimbos- instituut: het instituut waar ik eerder al wel kwam om in de bibliotheek te grasduinen. Wat was ik blij om daar te mogen werken! Hoewel de bibliotheek is gesneuveld (nog steeds eeuwig zonde) werk ik er mede door jou nog steeds met veel plezier. Je stimulans om vooral dat te doen waar mijn talenten liggen gaf mij de ruimte om dit project op te pakken. Je rust en bescheidenheid een les voor iedereen. Jeannette, wat fijn dat jij mijn promotor wilde zijn! Hans heeft ons ooit aan elkaar 'gekoppeld' omdat hij dacht dat we wel een klik zouden hebben. Ik ben blij dat je dit project wilde begeleiden en dat ik van je heb kunnen leren. Je bent een fantastische begeleider; betrokken, positief, vol goede moed en kritisch waar nodig. Wat ik ook enorm heb gewaardeerd is hoe je me betrok in al die netwerken van leuke en interessante mensen die het AMC en de afdeling antropologie rijk is en de etentjes waar iedereen samen kwam in de huis van Kristine.

Dan mijn paranimfen! Ik heb jullie gevraagd omdat jullie twee sterke vrouwen zijn waar ik met vertrouwen op leun. Dorine, samen gingen we op onderzoek in Triëst, officieel omdat jouw Italiaans een stuk beter is dan dat van mij. Maar ondertussen waren je humor, kennis over de ggz en scherpe geest minstens zo belangrijk voor het uitvoeren van dat onderzoek. En dat je me af en toe wegsleepte van mijn bureau naar de opera of een tentoonstelling was ook heerlijk. Milena, wij delen al een tijd ons leven. Van bar tot baby's: we hebben het samen gedaan. Van jou leer ik elke keer weer om niet bang te zijn, ook als het even niet mee zit.

Dit onderzoek was niet mogelijk geweest zonder de steun van de betrokken organisaties en de mensen die daar werken. De meeste zijn in dit proefschrift anoniem gebleven, maar vormen het hart van het onderzoek: de werkers, cliënten, familie en anderen die mij toestonden mee te kijken in de dagelijkse zorgpraktijk van de ggz wijkteams waar ik onderzoek deed. Lister is de organisatie die me in staat stelde onderzoek te verrichten

en dit financieel te ondersteunen. Jan; dank voor je steun! Eerst als directeur van Lister, maar daarna ook door je niet aflatende betrokkenheid, vertrouwen en bevlogenheid. Het blijft inspirerend om met jou van gedachten te wisselen over de ggz en hopelijk blijven we dat nog lang in allerlei vormen doen. Vanuit Lister wil ik ook Juul, Theo, Maurits, Marieke, Sanne en alle anderen bedanken voor de samenwerking: ik hoop dat dit niet een eindpunt is, maar ook weer een begin van waaruit we samen onderzoeken hoe we de resultaten toepasbaar kunnen maken voor jullie praktijk. Vanuit Altrecht kreeg ik steun voor de uitvoering van dit onderzoek door Wilma, Leonieke en Albert, dank daarvoor!

A special thanks goes to the team in Barcola, Trieste and the DSM who welcomed me in their city and services. First Roberto; thank you for providing the opportunity to do this research and your willingness to think along the trajectory. The combination of your activism and professionalism is an inspiration to many. Thank you Elisabeth Pascolo – Fabrici and Tommaso Bonavigo for your support. A special thanks to Francetta, Michelle, Stana, Chiara, Pina and of course Mario, who had the patience to answer my never ending questions. It was an honor to learn from you! Another special thanks is for Ross Ludham, who helped me with correcting my English.

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Dit onderzoek was ook een deur naar andere onderzoeksnetwerken: de deelnemers aan de bijeenkomsten van filosofie van de zorg: Sonja, Ben, Dick, Marja en alle anderen: wat heb ik veel van jullie geleerd. Speciale dank aan mijn *writing comrades* van het Words-out atelier: het heeft me door de lockdown heen gesleept. Krisitne, bedankt voor het opzetten hiervan en Laura, Leonie, Carole, Nienke, Lisette, Isabel, Bregje: ik hoop dat het jullie goed gaat. Het team bij het Amsterdam UMC, Sylvia, Rosalie, Guy, Lia en Yolande; die wetsevaluatie die gedeeltelijk parallel liep aan dit onderzoek gaan we allemaal nooit

meer vergeten. Maarten, Maartje, Karl, Ellen en anderen: met de ANT club blijven we dapper doorlezen, ik kijk er naar uit! En de writing care club waaronder Annelieke, Tanja, Shahana, Kim, Kristine, Eileen en Carole, waar ik leerde dat iedereen-hoe ervaren ook-worstelt met schrijven, maar dat we elkaar wel kunnen steunen in dat proces. Ik neem dat met me mee als een waardevolle les.

In de ANT traditie wil ik niet alleen menselijke, maar ook een niet-menselijke actor bedanken: het water van de nieuwe meer dat bijna elke ochtend geduldig op me wacht. Ik las laatst dat je door te zwemmen niet alleen je lijf, maar ook de kronkels in je hoofd uitstrekt. Maarten, op het moment dat we alle twee iets wat gekreukeld waren nam jij me mee het koude water in, dank daarvoor! Dat is het begin van de rij onmisbare (antropologie) vrienden. Lieve Dorien, Agnes, Nick en Aniek we lopen al een tijd met elkaar mee en dat blijven we gewoon doen. De Oostveentjes, Jasper, Margit; dank dat jullie er zijn, op de voor- of op de achtergrond. Wouter, dank voor de vragen, de gesprekken en de steun voor het onderwerp wat jou ook zo na aan het hart ligt. En al die mensen met wie ik over mijn onderzoek sprak en die een inspiratie waren: Martijn, Doortje, Gerrit en zoveel anderen.

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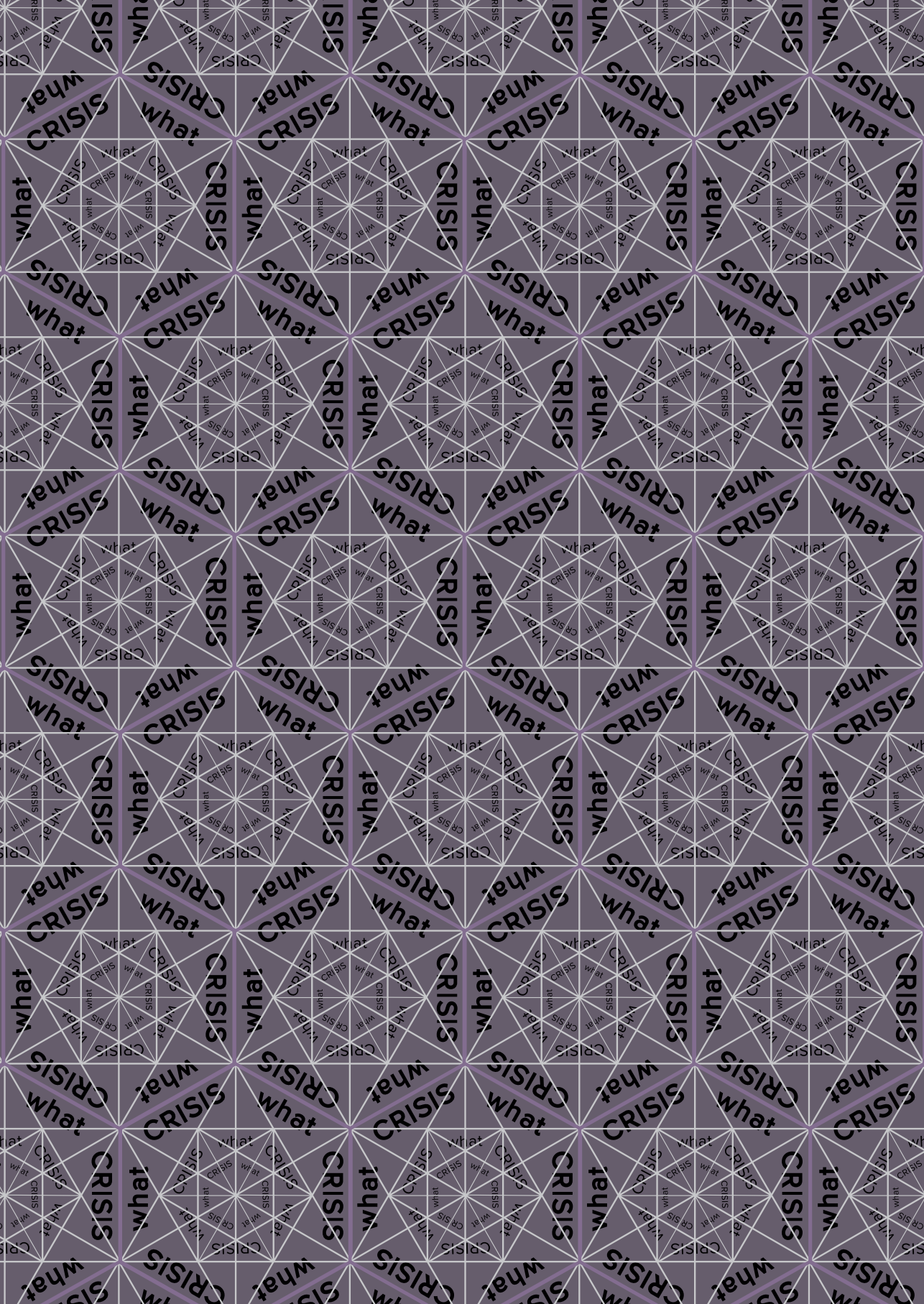
Ik heb vaak de vraag gekregen of het moeilijk is om een proefschrift te schrijven met drie opgroeiende kinderen. Ik ben er van overtuigd dat ik het zonder niet had gekund. Jasper, Huub en Aafje; jullie zijn mijn helden, zetten me met beide benen op de grond en ik ben trots op jullie. En dan de gene die niet bedankt wil worden, maar die weet dat ik koppig genoeg ben om dat toch te doen. Joren; je hebt me steeds weer gesteund en zelfs de voorkant ontworpen. We zijn een sterk team. En nu gaan we weer bandjes kijken en biertjes drinken!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