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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.

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

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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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