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 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.

REFERENCES

Asugi.sanita Trieste, personal email conversation.

Advies Commissie Toekomst beschermd wonen (2015). Van beschermd wonen naar een beschermd thuis. https://vng.nl/files/vng/van-beschermd-wonen_20151109.pdf . [accessed on 10-10-2022]

Baraitser, L. & William B. (2021). Watchful Waiting: Temporalities of Crisis and Care in the UK National Health Service. *Vulnerability and the Politics of Care, 2*, 230–47. https://doi.org/10.5871/bacad/9780197266830.003.0015.

Chow, W., & Priebe, S. (2013). Understanding Psychiatric Institutionalization: A Conceptual Review. *BMC Psychiatry 13*, 169.

Cussins, C. (1996). Ontological Choreography: Agency through Objectification in Infertility Clinics. S*ocial Studies of Science, 26*(3), 575–610. https://doi.org/10.1177/030631296026003004

Da Roit, B. Da, & Bihan, B. Le. (2019). Cash for long - term care : Policy debates, visions, and designs on the move. *Social Policy & Administration 53,* 519–536. https://doi.org/10.1111/spol.12506

De Waardt, D. A., Van Der Heijden, F. M. M. A., Rugkåsa, J., & Mulder, C. L. (2020). Compulsory treatment in patients' homes in the Netherlands: What do mental health professionals think of this? *BMC Psychiatry, 20*(1), 1–5. https://doi.org/10.1186/s12888-020-02501-7

Driessen, A. (2017). Sociomaterial will-work: Aligning daily wanting in Dutch dementia care. In J. Boldt & F. Krauze (Eds.), *Care in healthcare: reflections on theory and Practice* (pp. 111–133). Palgrave Macmillan.

Foot, J. (2014). Franco Basaglia and the radical psychiatry movement in Italy, 1961–78. Critical and *Radical Social Work 2*(2),235–249. https://doi.org/doi.org/10.1332/204986014X14002292074708

Glas. G. (2019). *Person-Centered Care in Psychiatry. Self-relational, Contextual and Normative Perspectives*. Routledge

Hautamäki, L. (2018). Uncertainty work and temporality in psychiatry: how clinicians and patients experience and manage risk in practice? *Health, Risk and Society, 20*(1–2), 43–62. https://doi.org/10.1080/13698575.2018.1442918

Hutschemaekers, G., Londen, J., Duyvendak, J., Schabel, P., Visser, A. S. C., & Winter, M. (2002). *Zorg van velen. Eindrapport van de Landelijke Commissie Geestelijke Volksgezondheid*. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport.

Jerak-Zuiderent, S. (2012). Certain uncertainties: Modes of patient safety in healthcare. *Social Studies of Science*, *42*(5), 732–752. https://doi.org/10.1177/0306312712448122

Jerak-Zuiderent, S. (2015). Accountability from Somewhere and for Someone: Relating with Care. *Science as Culture, 24*(4), 412–435. https://doi.org/10.1080/09505431.2015.1050368

Law, J. (1994). *Organizing Modernity*. Blackwell.

Law J. (2010). Care and Killing: Tensions in Veterinary Practice. In A. Mol, I. Moser, & J. Pols (eds.), *Care in Practice: On Tinkering in Clinics, Homes and Farms.* pp.57–93. Transcript Verlag. doi: 10.14361/transcript.9783839414477.57

Lester, R. J. (2009). Brokering authenticity: Borderline Personality Disorder and the ethics of care in an American eating disorder clinic. *Current Anthropology, 50* (3), 281–302.

Mezzina, R. (2020). Basaglia after Basaglia: Recovery, human rights, and Trieste today. In M. Burns, & J. Foot

(eds.), *Basaglia's International Legacy: From Asylum to Community*. Oxford University Press.

Mol, A., (2002). *The Body Multiple: Ontology in Medical Practice.* Duke University Press.

Mol, A., (2006). Proving or improving: On health care research as a form of self-reflection. *Qualitative Health Research, 16*(3), 405–414

Mulder, C., Van Weeghel, J., Delespaul, P., Bovenberg, F., Berkvens, B., Leeman, E., Kroon, H., Van Mierlo, T., Kienhorst, G. (2020). Netwerkpsychiatrie, samenwerken aan herstel en gezondheid. Boom uitgevers.

Moser, I. (2005). On becoming disabled and articulating alternatives. The multiple modes of ordering disability and their interferences. *Cultural Studies, 19*(6), 667–700.

Mundt, A. P., Rozas Serri, E., Irarrázaval, M., O'Reilly, R., Allison, S., Bastiampillai, T., Musisi, S., Kagee, A., Golenkov, A., El-Khoury, J., Park, S. C., Chwastiak, L., & Priebe, S. (2022). Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. *Molecular Psychiatry, 27*(4), 1873–1879. https://doi.org/10.1038/s41380-021-01435-0

Muusse C, Van Rooijen S (2015). *Freedom First, Een onderzoek naar de ervaringen met wijkgerichte ggz-zorg in Triëst, Italië, en de betekenis hiervan voor Nederland*. Lister.

Nijdam, F, Diekman W., Dorland L. (2022). *Gewoon doen wat nodig is? een meervoudige casusstudie naar de meerwaarde van integrale optimaal leven teams voor mensen met een ernstige psychische aandoening.* www.optimaallevendrenthe.nl [accessed on 4-12-2022)

Ootes, S. T. C., Pols, A. J., Tonkens, E. H., & Willems, D. L. (2013). Where is the citizen? Comparing civic spaces in long-term mental healthcare. *Health and Place, 22*, 11–18. https://doi.org/10.1016/j.healthplace.2013.02.008

Pols, J. (2006). Accounting and Washing Good Care in Long-Term Psychiatry. *Science, Technology, & Human Values: 31* (4), 409–430.

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry, 30* (1), 77–104. https://doi.org/10.1007/s11013-006-9009-z

Pols, J. (2014). Towards an empirical ethics in care: relations with technologies in health care', *Medicine, Health Care and Philosophy, 18* (1), 81–90.

Pols, J. (2016). Analyzing Social Spaces: Relational Citizenship for Patients Leaving Mental Health Care Institutions. *Medical Anthropology: Cross Cultural Studies in Health and Illness, 35*(2), 177–192. https://doi.org/10.1080/01459740.2015.1101101

Portacolone, E., Segal, S. P., Mezzina, R., Scheper-Hughes, N., & Okin, R. L. (2015). A Tale of Two Cities: The Exploration of the Trieste Public Psychiatry Model in San Francisco. *Culture, Medicine, and Psychiatry, 39*(4), 680–697. https://doi.org/10.1007/s11013-015-9458-3

Sheridan Rains, L., Zenina, T., Dias, M.C., Jones, R., Jeffreys, S., Branthonne-Foster S,, Lloyd-Evans B., Johnson, S. (2019). Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study. *The lancet. Psychiatry,6*(5), 403–417. doi: 10.1016/S2215-0366(19)30090-2.

Ralston, A. S. G. (2013). The philosophies of psychiatry: Empirical perspectives. *Medicine, Health Care and Philosophy, 16*(3), 399–406.https://doi.org/10.1007/s1101 9-012-9420-x

Raad voor Volksgezondheid en Samenleving (2022). *Grenzeloos samenwerken? Adviezen voor het beter mogelijk maken van domeinoverstijgende samenwerking*. Raad voor volksgezondheid en samenleving.

Ridente, P., & Mezzina, R. (2016). From Residential Facilities to Supported Housing: The Personal Health

Budget Model as a Form of Coproduction. International *Journal of Mental Health, 45*(1), 59–70. https://doi.org/10.1080/00207411.2016.1146510

Tjaden, C. D. (2022). Better together: On meaning, effectiveness and costs of resource groups for people with severe mental illness. PHD-thesis. Tilburg University

Tronto, J. C. (1993). *Moral Boundaries: A Political Argument For An Ethic Of Care*. Routledge.

Van Melle A.L., van der Ham A.J., Widdershoven G.A.M., Voskes Y. (2021). Implementation of High and Intensive Care (HIC) in the Netherlands: a Process Evaluation. *Psychiatry Quaterly. 92*(4):1327-1339. doi: 10.1007/s11126-021-09906-x

Vektis. https://www.vektis.nl/intelligence/publicaties/factsheet-ambulantisering-in-de-ggz [Accessed may 21, 2021]

Voskes, Y. (2014). *No effect without ethics: Reduction of seclusion in psychiatry from a care ethics perspective*. PHD-thesis. VU University

Waibel, S., Henao, D., Aller, M. B., Vargas, I., & Ývzquez, M. L. (2012). What do we know about patients' perceptions of continuity of care? A meta-synthesis of qualitative studies. *International Journal for Quality in Health Care, 24*(1), 39–48. https://doi.org/10.1093/intqhc/mzr068

Vijselaar J, Van Hoof F, Kok, I. (2009). Van lappendeken naar regionale integratie.Trends in organisatie en beleid in de ggz, 1970–2000. *MGV. 64*, 223–38.