GOVERNING IDEALS OF GOOD CARE

QUALITY IMPROVEMENT IN MENTAL HEALTH CARE

Tineke Broer

Broer, T.
Governing Ideals of Good Care: Quality improvement in mental health care
Dissertation Erasmus University Rotterdam, The Netherlands

ISBN: 978-94-6169-160-6
Printed by Optima Grafische Communicatie, Rotterdam

Governing Ideals of Good Care:
Quality improvement in mental health care

Sturen van idealen van goede zorg:
Kwaliteitsverbetering in de Geestelijke Gezondheidszorg

Proefschrift

ter verkrijging van de graad van doctor aan de
Erasmus Universiteit Rotterdam

op gezag van de
rector magnificus Prof.dr. H.G. Schmidt
en volgens besluit van het College voor Promoties.

De openbare verdediging zal plaatsvinden op
donderdag 26 januari 2012 om 13.30

door

Tineke Broer
geboren te Steenwijk

ERASMUS UNIVERSITEIT ROTTERDAM

Promotiecommissie

Promotor: Prof.dr. R.A. Bal

Overige leden: Prof.dr. P.L. Meurs
Prof.dr. G.C.G. Dehue
Prof.dr. L.M. Huijer

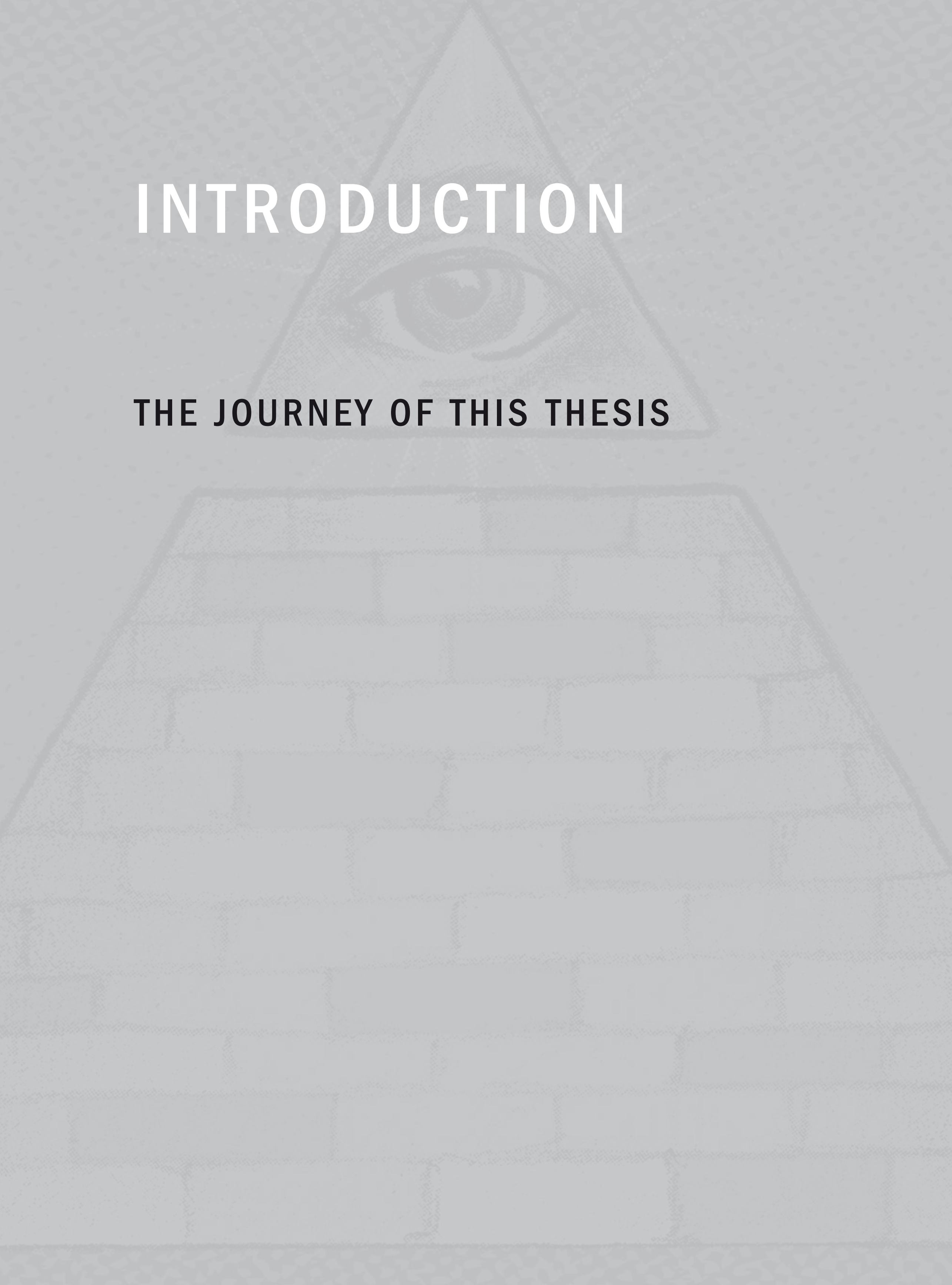
Copromotor: Dr. A.P. Nieboer

Table of contents

Introduction:

INTRODUCTION

THE JOURNEY OF THIS THESIS



How free are *you* actually?

In the spring of 2008 I attended a conference on the use of coercion in mental health care. A healthcare worker who was also a “practicing patient”, as the program told us, held an impressive lecture that captured the audience from the moment the woman walked to the front. She referred to herself as “difficult patient” and questioned certain care practices in her lecture, mainly those on the use of coercion within psychiatry. “How free are *you* actually?” she asked the audience. “Your life is made up of constraints.” But the difference is, she said, that in normal life constraints agreed upon by partners or created institutionally lead to bonds, whereas in care they often lead to marginalization.

The conference also featured some interactive workshops. One of the workshops was on the subject of how to deal (differently) with situations in which coercion is needed. It was mainly professionals who engaged in the discussion and one of them told about a client who maintained she would be able to live independently. Her care givers, however, were less convinced. “To what extent can we force her to live in the institution?” the care professional brought up. Eventually someone remarked: “if we continue with coercion [in this case] we win the war but loose the peace”. It became clear that coercion would endanger the (caring) relationship with this client.

This conference taught me how difficult it can be to provide and to receive mental health care. There are no easy solutions. At the end of this coercion workshop one of the organizers concluded that the discussion had rendered no tips that would help provide care in a better or less difficult way. Attending conferences like these therefore made me wonder: how do professionals go about providing good care? What is good care? What values are deemed important? How are these values defined and enacted? How do different actors decipher what is ‘best’ in a given situation? What do they see as (moral) problems in providing and improving care? These are the questions I explore in this thesis.

Diverging notions of freedom

Discussions on what constitutes good mental health care are nothing new. The most extreme position was probably taken by the anti-psychiatry movement, which claimed that mental illness did not exist and questioned the legitimacy and therapeutic value of putting people in psychiatric institutions as well as the specific techniques used within such institutions (Goffman, 1991; Rosenhan, 1973; Szasz, 1961). The “total institution” and its practices would make people hospitalized and passive (Goffman, 1991). In general, values like autonomy and freedom often come up in the discussions on mental health care, as the conference on the use of coercion once more demonstrated. But the way in which such values are enacted in practice may differ across different situations and across different times.

Introduced in The Netherlands in 1994, the BOPZ Act (Wet *Bijzondere Opnemingen in Psychiatrische Ziekenhuizen* – Psychiatric Hospitals Compulsory Admissions Act) offers a nice example. Its predecessor is the '*Krankzinnigenwet*' (Insanity Act of 1884). The BOPZ Act states the cases in which people can be forced to live in a psychiatric institution and the situations in which forced treatment, coercion and restraint are allowed within the institutions. The proposals for this Act have been discussed for 23 years before the BOPZ finally came into force (van de Klippe, 1997). One of the main amendments in comparison to the *Krankzinnigenwet* concerns the criteria under which forced institutionalizing was possible. In the *Krankzinnigenwet* this was possible on the ground of the argument of best interests ('*bestwil*'); in the BOPZ Act the criterion of danger is seen as a more objective ground for justifying forced institutionalizing (Ministerie van Volksgezondheid, Welzijn en Sport, 2007).

The transition from best interests to danger can also be seen as a contrast between negative and positive liberty, two common conceptualizations of liberty (Berlin, 1961). With danger as the criterion, people are seen as autonomous individuals, and interference is only justified when they threaten danger to themselves or to others. 'The best interests' however is a broader term, and interference in this case can also be justified when people are thought to benefit from professional help. In the first case there is no reason and no right to interfere in people's lives except when they limit the freedom of others (negative freedom); whereas in the second case it is allowed to help constitute the conditions under which people can live their lives to the full, under which they can become free (positive freedom). Hence whereas both in the *Krankzinnigenwet* and the BOPZ Act freedom is one of the dominant values, these two Acts define this value in diverging ways.

It is not only this transition from negative to positive liberty that illustrates that freedom can take different forms in different times and different practices. The use of constraints and coercive treatment within psychiatric institutions testifies to this as well. The discussion on coercion is as old as modern psychiatry itself (Steinert et al., 2009). Both nurses and patients are having a hard time with the restraint and coercion practices. Nurses consider them to be a necessary evil (Bigwood & Crowe, 2008). Furthermore, although seclusion may offer patients rest and could be helpful for therapeutic reasons (Mann, Wise, & Shay, 1993; Veltkamp et al., 2008), many patients have (also) negative experiences with coercion practices (Frueh et al., 2005; Mayers, Keet, Winkler, & Flisher, 2010; Paterson & Duxbury, 2007; Stubbs et al., 2009; Veltkamp et al., 2008). In general, the use of restraints and coercion is seen as limiting the patients' autonomy and freedom (Välimäki, Taipale, & Kaltiala-Heino, 2001).

Yet what is considered to be a restraint varies between different times and practices. For example, as early as the 1840s a so-called *non restraint* movement was active in England, arguing for the prohibition of restraints. Interestingly, however, this movement was only concerned with mechanical restraints; the use of seclusion was not seen as problematic (van de Klippe, 1997). Furthermore, countries may differ in opinion on which is most intrusive: either forced medication or seclusion (Jarrett, Bowers, & Simpson, 2008; Steinert et al., 2009; Veltkamp et al., 2008). So while the argument against restraint practices in all cases is the perceived 'deprivation' of clients' freedom, it differs from country to country and from time to time what is considered to be a restraint and which form of restraint is seen to have more impact on clients' freedom.

Even within countries opinions and practices may widely differ. In the Netherlands, Jeannette Pols (2003) undertook an ethnographic study of two psychiatric hospitals that responded differently to (changes in) the BOPZ Act. The BOPZ Act stipulated that each institution was to have a patient advocate. Pols found that in the one hospital the patient advocate supported the care practices, the nurses, and the patients. The advocate for example tried to team up with the nurses, convincing clients they would be better off taking their medications. In this case, the caring relationship between nurses and patients was not endangered by nurses having to force clients to take their medications. In the other hospital, however, consulting the patient advocate was seen as a potential breach in the caring relationship with professionals. It would transform an everyday argument into a juridical dispute. Thereby, the patient advocate was helpful neither to the nurses nor to the patients themselves. As a result, it became harder for the patients to actually preserve and defend their rights.

What this example shows is that legislation does not function (only) as an outside framing and legalization of an already existing situation. Rather it changes the care practices themselves, for better *or* worse (sometimes even contrary to the aims of the law). This also illustrates that the way in which good care is governed or legalized may have different consequences that cannot be (totally) predicted and that may be different for different care practices. Therefore, the impact of regulation and government initiatives on care practices should always (also) be investigated by following the actual changes.

These examples on the BOPZ Act and the use of constraints show that values can take different forms within different practices. Furthermore, they illustrate how difficult it can be to provide good mental health care and how many values at once need to be served within such practices. While it is easy to suggest that nurses should deliver “restraint with the maximum humanity possible” (Bigwood & Crowe, 2008 pp. 221) or even to argue that it “must surely be unacceptable” that this situation of restraints “continues to exist in an era of evidence-based practice” (Paterson & Duxbury, 2007 pp. 543), these kinds of prescriptions do no justice to the difficult practices nurses deal with everyday.

Studying good care

In order to get more insight into how good care is defined, how it is provided in different practices and in order to understand the moral complexities within these caring situations, I decided to observe how good care is provided and how care is improved. There are several ways in which this can be done. One is to undertake an ethnographical study within the (psychiatric) institutions. The work of Annemarie Mol, Ingunn Moser and, within mental health care, Jeannette Pols, shows that this can be productive (Mol, 2008; Mol, Moser, & Pols, 2010; Moser, 2000; Pols, 2003; Pols, 2004; Pols, 2006). By following day-to-day care practices, these researchers show how different ideals of good care are, what they call, enacted. Pols’ work, through following for example mundane care practices such as washing, shows the different enactments that ideals of citizenship can have in practice.

In this thesis however I adopted another approach. Rather than following care practices themselves, I decided to study places where care practices are explicitly reflected upon. In science studies but also in philosophy, ‘extreme’ or controversial situations are said to offer important insights also for ‘ordinary’ life. There are at least three reasons why this is so. First, these situations may work as a “magnifying glass” revealing ideas, ideals and moralities that are also at work (but less visibly and more blurry) in other situations (Todorov, 1997). Second, controversies and ambivalences hint at how the world and ideals on good care could have been otherwise or could become otherwise (Woolgar, 1991). They may for example illuminate ideals that are not as influential anymore as they used to be, or illuminate ideals that will be more influential in the future. Third, controversies show the world in the making rather than the world as made and as a result may help opening up the black box of knowledge or, in this case, ideals of care (cf. Latour, 1987).

Applying these arguments to good care, places where good care is explicitly discussed and thus problematized, may provide an interesting avenue for studying (ideals on) good care. Such places may thus work as ‘magnifying glasses’ revealing ideals on good care that also prevail in ‘normal’ care practices. They may magnify existing ideals but also other ideals that are not as prevailing anymore in current practices may come up in the discussions (cf. Pols, 2004). Such places show care and its subsequent ideals on good care in the (un)making.

Care for Better

Quality improvement programs are one of the situations in which good care is explicitly reflected upon and discussed. My involvement in the evaluation study of a large quality improvement collaborative (QIC) gave me the opportunity to study such a program. Within QICs, different improvement teams join forces to improve their care on a certain topic, in a set timeframe and in a structured way (Institute for Healthcare Improvement, 2003; Kilo, 1998). As policy instruments, they are increasingly used to improve health care in different settings (from hospital care to long term care) (Schouten, Hulscher, Everdingen, Huijsman, & Grol, 2008).

QICs have been run in the Netherlands as well. Initiated by the ministry of Health and commissioned by ZonMw, the Care for Better (CfB) program was mainly directed at elderly care but from 2007 also came to include improvement projects aimed at (long term) mental health care. Six projects have been executed in this setting, each devoted to a particular topic. The ‘recovery oriented care’ project aimed towards client autonomy and integration in society; the ‘social participation’ project was aimed to improve clients’ social networks and to make them feel less lonely; the ‘social psychiatric care’ project aimed to improve outreaching care; the projects ‘not (only) the mind but (also) the body’ and ‘health & medication safety’ set out to improve clients’ physical health; and the project ‘recovery oriented care & social participation’ aimed to improve clients’ autonomy and social networks. These six projects are the setting of this thesis.

Approximately 150 improvement teams from a wide range of organizations participated; predominantly (long term) mental health care teams, working in psychiatric institutions, sheltered housing, or working in ambulant mental health care. In many cases, their clients had lived in the institution for a long time. Several teams providing care to the intellectually disabled participated in the ‘social participation’ project. In the ‘social psychiatric care’ project, only outreaching care teams participated, working in public mental health care (*Openbare Geestelijke Gezondheidszorg*).

The projects were led by program managers mainly working at the Trimbos Institute. For each project of CfB, program management organized conferences in which improvement teams received advice from program management and from different experts on the specific domain. Furthermore, improvement teams could discuss their improvement practices at these conferences and could exchange information and experiences with each other. Thereby, discussions concerning good care were stimulated, discussions concerning what should be improved, how it should be improved and what that may mean for (ideals on) good care.

In order to study idea(l)s on good care, I mainly relied upon two methods. First, I observed conferences and meetings organized in the context of the different improvement projects. I attended 24 of these conferences, spread over the different projects, and observed five project leaders' meetings. By means of these ethnographic observations, I followed the discussions, the issues that the improvement actors struggled with, the way in which they set about improving care, the way in which improvement actions (were said to) work(ed) out, and improvement actors' ideas, ideals and motivations for providing and improving care in the way they did.

Second, I conducted interviews with different actors involved so as to make their ideas, ideals and motivations more explicit, i.e. creating places were ideals on good care are more explicit. I conducted seven interviews with program leaders of different improvement projects. Five were interviewed once; two were interviewed twice, i.e. halfway into the project and towards the end. Furthermore, I interviewed project leaders, team members and other actors involved in (the work of) the improvement teams. Sometimes informally during the conferences; at other times during visits to the care organizations. In total, I visited 13 improvement teams and interviewed 12 project leaders, 9 team members, 5 clients and 3 managers. Furthermore, I observed improvement teams' meetings in six teams, and the improvement or care practices themselves in seven teams. These allowed me to ask more situation-specific questions, so as to explore rationality behind certain improvement actions or care practices. By the combination of these methods I could follow how different actors went about providing, discussing and improving care.

Governing good care

So that was how I went about studying 'good' care in the CfB program: by observing and creating places where good care was explicitly reflected upon by different actors, i.e. where it was problematized. To do so, I relied upon two theoretical perspectives. The first is that of Actor Network Theory (ANT). One aspect of following this approach is that I did not define good care beforehand. Rather, by observing the conferences and asking after specific improvement and care practices I followed how the different actors defined good care, what values were deemed important, how they did define these values, how good care influenced the improvement processes and vice versa. From an ANT-perspective these values (about what good care is) get their meaning within a practice; they cannot be defined outside these practices. Researchers then should ‘follow the actors’ (Latour, 1987) and study the enactments of certain values (Mol, 1998; Mol, 2008; Pols, 2006). ANT, secondly, makes the observant aware of all the instruments and materialities used in and constituting care. From an ANT-perspective no a priori distinction is made between humans and non-humans or between society and technology (Latour, 1987). So ‘good care’ is defined (enacted) within a certain situation by both human and non-human actors. Drawing upon ANT, I thus studied how good care was defined and enacted in CfB.

But the improvement projects were not just concerned with discussing care practices and discussing good care. CfB was a policy instrument for the government and other actors to influence the care practices and thus to exert power. Therefore a second question emerged during my research: how is good care governed? To answer this question, I used the insights of Foucault on the (power) techniques used to govern and the consequences that these techniques produce (Foucault, 1977; Foucault, 1978; Foucault, 1988b; Foucault, 2006; Foucault, 2008). Foucault for example gave a detailed analysis of the asylum as it functioned since the nineteenth century. Observation, psychiatric questioning, but also the buildings and the way in which inhabitants were distributed within the asylum all helped to make the asylum function in the way it did and to shape a certain kind of patient like the hysteric patient (Foucault, 2008). Power, in Foucault’s analysis, is exerted through such governing techniques.

One important insight from Foucault is the term ‘governmentality’. Governmentality is broadly understood as ‘the techniques and procedures for directing human behaviour’ (Rose, O’Malley, & Valverde, 2006) and the concept combines a political rationality with technologies of power (Lemke, 2001). From a governmentality perspective, policy instruments like CfB reflect a particular political rationality and they contain certain technologies of power. Governmentality should not be analyzed only on state level but also on the level of the local practices in which governance is done, for example studying different improvement sites (conferences, organizations).

Foucault’s theory of power further states that governing techniques have consequences for the type of subject created. Foucault commented that his main question has always been how (by what techniques) people come to think of themselves as being subjects and consequently constitute themselves as subjects: “What I wanted to know was how the subject constituted himself, in such and such a determined form, as a mad subject or as a normal subject (…). I had to reject a certain *a priori* theory of the subject in order to make this analysis of the relationships which can exist between the constitution of the subject or different forms of the subjects and games of truth, practices of power and so forth”

(Foucault, 1988a pp. 10 italics in original). This constitution of the subject into a particular form is what Foucault referred to as subjectification (Papadopoulos, 2008).

Subjectification is achieved by certain power techniques. But this is not just a negative or restraining process. On the contrary, power can be positive or enabling at the same time as it is negative and restraining. It makes certain actions or feelings or ways of being more possible while restricting others (Foucault, 1978). Furthermore, people themselves play a profound role in how they are governed and in governing themselves, and also they may use certain techniques for becoming subjects of a certain kind (Foucault, 2010). Foucault further maintained that power is not stored in individuals. Rather it is produced in a relationship in which people always have the freedom to behave differently (Foucault, 1988a). In the example of the asylum, power is not seen as stored in individual psychiatrists but is seen as a function of the techniques and practices constituting the asylum (Foucault, 2008).

From Foucault's theory of power I deduced two questions for studying the governance of good care. First, what techniques with what different underlying rationalities do the different actors involved use to establish a certain performance of (good) care? And second, what consequences do these techniques have in terms of subjectification? The techniques will shape clients in certain ways but they will also have consequences for identities of professionals, organizations, and the mental health care field in general. In other words, governing good care also means governing identities within the mental health care field. For example, it may have consequences for the functioning of organizations or for the roles and tasks of professionals. In such an analysis, 'good care' is linked to certain power mechanisms. It is a way of shaping subjects in a particular way. In this thesis I will explore how good care is defined, performed, problematized and governed in the QIC Care for Better and the consequences of these processes for the kinds of subjects being created on different levels of the mental health care field.

Evaluating quality improvement of care

At the same time as CfB was developed, an evaluation study went ahead to investigate the processes and effects related to CfB (Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008; Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009). The evaluation study gave me access to the improvement projects, for example to the conferences. That also meant that I had to (or did) present my research as an evaluation, for example to program management or to improvement teams, if only to get access to the conferences and to be allowed to visit organizations and interview different actors. So although my thesis is not (a presentation of) an evaluation study, it does address some evaluation-type of questions.

Particular challenges or 'gaps' are pointed out in the literature on evaluations of quality improvement collaboratives. In my research I took up one of these challenges. Some authors describe QICs as 'black boxes', implying that descriptions of improvement processes are often lacking (Wilson, Berwick, & Cleary, 2003). Therefore, one of the aims of this thesis is to describe the QIC and its processes and consequences. The questions addressed are the following: How can we describe QICs? What are QICs? By what kinds of improvement processes are they constituted?

Some authors find such descriptions important for investigating 'the degree of implementation' (Robert, Hardacre, Locock, & Bate, 2002; Øvretveit & Gustafson, 2002 pp. 271). This idea is problematic from a constructivist perspective, however, because the truth is multiple and needs to be actively constructed. Based on this idea, different sorts of evaluation studies have been used since the (late) 1980s, such as fourth generation evaluation (Guba & Lincoln, 1989) and responsive evaluation (Abma, 2005; Abma, 2006). The evaluators are supposed to investigate what the intervention means for the people involved. The idea is for different actors to engage in a dialogue so as to negotiate about (the meaning of) the program that is to be evaluated. Thus, evaluators are not so much putting forward their own truths; rather they illuminate and uncover different perspectives by means of dialogue and negotiation (Abma, 2005; Abma, 2006; Guba & Lincoln, 1989; Mabry, 2002).

In line with such evaluation methods and also in line with ANT, I took up another approach than studying 'the degree of implementation'. I assumed that the QIC would be constructed *during* implementation and therefore, that I could not define it beforehand. One of the aims of this thesis is to follow how the collaborative and its different projects are constructed, and, therefore, how idea(l)s on good care are constructed. The description of the collaborative is then also a way of defining it, rather than starting from a definition beforehand and checking whether the criteria are met during implementation. Furthermore, I started from and with the idea that multiple perspectives would exist and would constitute the QIC. Quality improvement may mean different things to different people and its success and effects should not just be evaluated from one perspective (usually the organizers' perspectives) (Guba & Lincoln, 1989). Consequently, there is also no such a thing as 'degree of implementation'.

However, my aim was not only to solicit perspectives of different human actors. I also took into account acting capacities of non-human actors like the measurement instruments. Many evaluation studies including fourth generation evaluation and responsive evaluation place the human perspectives in the foreground. From an ANT-perspective, however, materialities are actors in and of themselves. So in this research rather than focusing on dialogue or negotiation only, I took into account the acting capacities of non-human actors as well.

Another characteristic of my (evaluation) research is the focus on (governance) techniques based on Foucault's theory of power. My aim was not only to investigate experiences of different people (as fourth generation evaluation and responsive evaluation do) but also to investigate how certain improvement processes affect how people think about, judge and act upon certain situations. The consequences of improvement are then not only framed in terms of experiences but also in techniques, and in how improvements change certain techniques – both techniques for governing others and techniques for governing oneself.

A final characteristic of this research is that I used the evaluation study as a data source in itself. Gradually I came to realize that the evaluation study also influenced the QIC, or, rather, that it was a policy instrument in itself, a technique by which mental health care could be governed. Whereas there is growing awareness of the evaluators' (non-neutral) roles, the rationality behind evaluations is often not taken into account (see for similar arguments: Mabry, 2002; Rose & Miller, 2008). However, there are several questions concerning evaluation studies that can be interesting. Why was it thought important to conduct an evaluation study, what aims does evaluation in a particular context serve, what rationale lies behind setting up an evaluation study (in a particular way)? In other words, how does evaluation contribute to (governance of) good care, what consequences does it have for a program and for identities on different levels?

To summarize, one aim of this research that might be categorized as evaluative is to give a description of the improvement processes and thus to open the black box of quality improvement collaboratives. I did so partly by using a constructivist perspective in which the collaborative is considered to be constructed during implementation and by different actors, both humans and non-humans. Therefore it cannot be predefined. Rather, I explored what techniques (including the evaluation itself) are used to establish the collaborative, the improvement projects and subsequent idea(l)s on good care.

Structure of the thesis

This thesis presents a description and analysis of some of the issues that are currently dealt with on the different levels of the mental health care field. However, this thesis is not to be seen as a set of answers constructed for various predefined questions. Because I started from the idea that the collaborative, the improvement topics and notions on good care could not be predefined, also the evaluation (questions) could not be predefined. Rather than *starting* with research questions, I constructed research questions while doing my research.

Therefore, this thesis presents a quest undertaken to find interesting questions to ask and answer.

Eventually, the following questions proved central to the thesis:

- *How is good care enacted (performed, discussed, improved) in contemporary mental health care practices?*
- *How is (good) care governed on the different levels of the mental health care field?*

All the chapters of this thesis thus deal with defining, discussing, performing, governing and evaluating good care. Care for Better serves as a case both for how good care can be governed and for how good care is made explicit. Every chapter addresses several techniques that are used to establish a certain performance of good care and, interrelated, of a good improvement process. Furthermore, in every chapter the consequences of these techniques are explored.

Chapter 1 "opens the black box" of quality improvement collaboratives. The topics of the improvement project are one way to determine what good care is. This chapter shows how these topics are constructed during the improvement processes. The way in which program management presents a topic and an improvement project in general has of course a profound influence on how the different improvement teams perform their projects. However, also improvement teams themselves play a role in defining and performing the topic, as was the case within the 'recovery oriented care' project. Teams can modify the topic, which also has consequences for the roles of clients and professionals. This definition work is not only done through language, but also through the instruments used. For example, the analysis shows how the measurement instruments used within the 'social participation' project influenced the way in which good care is defined and performed.

In *chapter 2* I also focus on the 'social participation' project. The mere existence of the project already indicates that 'social participation' is part of good care. It thus assumes that (at least some) clients want to become more social and it assumes that these clients want or need to do so with the help of professionals. Yet it is less clear from the outset what is meant by 'social participation'. Therefore, the main question of this chapter is how the social is defined and performed in this project. Rather than determining beforehand what this 'social' should be and thus establishing a norm as against which to judge if the program has improved sociality, I investigated how sociality is defined within the project. Thereby this chapter explores how social subjects are (attempted to be) created. In addition, this chapter also has a methodological aim, because it uses a mixed methods design in which the quantitative project results as well as the improvement processes are investigated. The quantitative data are first used as one productive way to conceptualize and investigate the results of the project. Secondly, I reflect upon the use of certain indicators and what they (may) mean for the enactment of sociality. These quantitative data and indicators are here considered to be (indicative for) a certain enactment of sociality in themselves.

After this exploration of how ‘social’ selves are created, the creation of ‘autonomous’ selves is explored in *chapter 3*. Autonomy proved to be a central concept within the different CfB projects. Some improvement teams struggled with the question how to improve care while not decreasing client autonomy, other teams aimed, as a predominant improvement goal, to increase client autonomy. Discussions at the national conferences were often devoted to this topic. Because it was such a relevant issue for improvement teams, I decided to investigate the autonomy concept in more detail. Also in this chapter, rather than defining autonomy upfront, I studied the improvement actors and processes as to explore the enactment of autonomy. I distinguish four different approaches to improve or maintain client autonomy. These approaches have consequences for what is considered to be a ‘good’ client (implying: which behaviours are (still) accepted and which are not). The approaches also have consequences for professionals, for example to decide when they are allowed (or allow themselves) to interfere and when not.

Clients in the CfB projects were expected to have a say over their own lives, and accordingly, over the care that they receive. Therefore, in many projects client participation in the improvement processes was also deemed important (next to, or in relation to, client autonomy). The aim of *chapter 4* consequently is to study how client participation is performed. How are practices of ‘good’ client participation shaped? What are the consequences for professionals and clients? And how does that change – or not change – the relation between professionals and clients? The second aim of this chapter is to study the role of power in this process, for two reasons. First, in the literature client participation is often associated and evaluated in terms of power, i.e. clients need to be em*power*ed. The (normative) question in such studies is often how much power clients actually have in the participation process. Second, within CfB the concept of power and the way in which it was conceptualized greatly influenced the shaping of participation.

Chapter 5 brings together the different lines of the former chapters and is more explicitly concerned with governing good care. I give an overview of the different governance techniques used within the CfB projects and their consequences, partly by conducting a meta-analysis of some of the former chapters of this thesis. I first of all reflect upon the rationale behind developing a QIC (in this particular way) and behind initiating an evaluation study (in this particular way). The QIC and the evaluation study are themselves ways of governing mental health care. Moreover, the within the different projects techniques were employed to govern mental health care. These techniques specified in more detail what should constitute good care and were thus used to make the actors uphold this way of defining and performing good care. The projects themselves, the measurement instruments, the presentation of the improvement project, the conferences, the autonomy concept, the concept of sociality among others were ways of governing good care and of governing identities on the different layers of the mental health care field, including, one could say, the mental health care field itself. In general, this chapter thus deals with the question how governing is done within and through the CfB program and what consequences these governance processes produce.

In the *conclusion* I come back to the question of the added value of this particular approach – both for studying good care and for evaluating a QIC in mental health care. Although studying improvement projects rather than care practices has its drawbacks, mainly in terms of what can be said about clients' experiences, I argue that this approach does provide opportunities for studying moral dilemmas within a mental health care setting. Policy instruments like quality improvement collaboratives thus provide insight both into the governance of care and into ideals on good care. Furthermore, they provide insight into the consequences of power mechanisms. In general, I argue that the discussion should not focus on whether there *is* power or not, but rather on what the consequences of specific power arrangements are.

References

Abma, T. A. (2005). Responsive evaluation in health promotion: Its value for ambiguous contexts. *Health Promotion International, 20*(4), 391-397.

Abma, T. A. (2006). The practice and politics of responsive evaluation. *American Journal of Evaluation, 27*(1), 31-43.

Berlin, I. (1961). *Two concepts of liberty: An inaugural lecture*. Oxford: Clarendon Press.

Bigwood, S., & Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing, 17*(3), 215-222.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* London: Penguin Books.

Foucault, M. (1978). *An introduction, the history of sexuality 1*. New York: Vintage Books.

Foucault, M. (1988a). The ethic of care for the self as a practice of freedom. an interview with michel foucault on january 20, 1984. In J. Bernauer, & D. Rasmussen (Eds.), *The final foucault* (pp. 1-20). Cambridge, Massachusetts: The MIT Press.

Foucault, M. (1988b). Technologies of the self. In L. H. Martin, H. Gutman & P. H. Hutton (Eds.), *Technologies of the self* (pp. 16-49). London: Tavistock.

Foucault, M. (2006). *History of madness*. London and New York: Routledge.

Foucault, M. (2008). *Psychiatric power: Lectures at the college de france, 1973--1974* Picador USA.

Foucault, M. (2010). *The government of self and others. lectures at the college de france, 1982-1983.*

Frueh, B. C., Knapp, R. G., Cusack, K. J., Grubaugh, A. L., Sauvageot, J. A., Cousins, V. C., et al. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, *56*(9), 1123-1133.

Goffman, E. (1991). *Asylums: Essays on the social situation of mental patients and other inmates*. New York: Penguin Books.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. California: Sage Publications.

Institute for Healthcare Improvement. (2003). *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement.* Cambridge MA: Institute for Healthcare Improvement.

Jarrett, M., Bowers, L., & Simpson, A. (2008). Coerced medication in psychiatric inpatient care: Literature review. *Journal of Advanced Nursing*, *64*(6), 538-548.

Kilo, C. M. (1998). A framework for collaborative improvement: Lessons from the institute for healthcare improvement's breakthrough series. *Quality Management in Healthcare, 6*(4), 1-13.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge, Massachusetts: Harvard University Press.

Lemke, T. (2001). 'The birth of bio-politics': Michel foucault's lecture at the collège de france on neo-liberal governmentality. *Economy and Society, 30*(2), 190-207.

Mabry, L. (2002). Postmodern Evaluation—or not? *American Journal of Evaluation, 23*(2), 141-157.

Mann, L. S., Wise, T. N., & Shay, L. (1993). A prospective study of psychiatry patients' attitudes toward the seclusion room experience. *General Hospital Psychiatry, 15*(3), 177-182.

Mayers, P., Keet, N., Winkler, G., & Flisher, A. J. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *International Journal of Social Psychiatry, 56*(1), 60-73.

Ministerie van Volksgezondheid, Welzijn en Sport. (2007). *Voortschrijdende inzichten. derde evaluatiecommissie van de wet BOPZ.*

Mol, A. (1998). Ontological politics. A word and some questions. *The Sociological Review, 46*(S), 74-89.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. London: Routledge.

Mol, A., Moser, I., & Pols, J. (Eds.). (2010). *Care in practice: On tinkering in clinics, homes and farms*. Bielefeld: Transcript.

Moser, I. (2000). Against normalisation: Subverting norms of ability and disability. *Science as Culture, 9*(2), 201-240.

Øvretveit, J., & Gustafson, D. (2002). Evaluation of quality improvement programmes. *British Medical Journal, 11*(3), 270.

Papadopoulos, D. (2008). In the ruins of representation: Identity, individuality, subjectification. *British Journal of Social Psychology, 47*(1), 139-165.

Paterson, B., & Duxbury, J. (2007). Restraint and the question of validity. *Nursing Ethics, 14*(4), 535-545.

Pols, J. (2003). Enforcing patient rights or improving care? the interference of two modes of doing good in mental health care. *Sociology of Health & Illness, 25*(4), 320-347.

Pols, J. (2004). Good care: Enacting a complex ideal in long-term psychiatry. Trimbos Instituut.

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry, 30*(1), 77-104.

Robert, G., Hardacre, J., Locock, L., & Bate, S. P. (2002). *Evaluating the effectiveness of the mental health collaborative as an approach to bringing about improvements to admission, stay and discharge on acute wards in the trent and northern & yorkshire regions: An action research project*. Birmingham: University of Birmingham.

Rose, N., O'Malley, P., & Valverde, M. (2006). Governmentality. *Annual Review of Law and Social Science, 2*, 83-104.

Rose, N. S., & Miller, P. (2008). *Governing the present: Administering economic, social and personal life*. Cambridge: Polity Press.

Rosenhan, D. L. (1973). On being sane in insane places. *Science, 179*(4070), 250-258.

Schouten, L. M. T., Hulscher, M. E. J. L., Everdingen, J. J. E., Huijsman, R., & Grol, R. P. T. M. (2008). Evidence for the impact of quality improvement collaboratives: Systematic review. *British Medical Journal, 336*(7659), 1491-1494.

Steinert, T., Lepping, P., Bernhardsgrütter, R., Conca, A., Hatling, T., Janssen, W., et al. (2009). Incidence of seclusion and restraint in psychiatric hospitals: A literature review and survey of international trends. *Social Psychiatry and Psychiatric Epidemiology, 45*, 889-897.

Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

Stubbs, B., Leadbetter, D., Paterson, B., Yorston, G., Knight, C., & Davis, S. (2009). Physical intervention: A review of the literature on its use, staff and patient views, and the impact of training. *Journal of Psychiatric and Mental Health Nursing, 16*(1), 99-105.

Szasz, T. (1961). *The myth of mental illness*. New York: Hoeber-Harper.

Todorov, T. (1997). *Facing the extreme: Moral life in the concentration camps.* Holt Paperbacks.

Välimäki, M., Taipale, J., & Kaltiala-Heino, R. (2001). Deprivation of liberty in psychiatric treatment: A finnish perspective. *Nursing Ethics, 8*(6), 522-532.

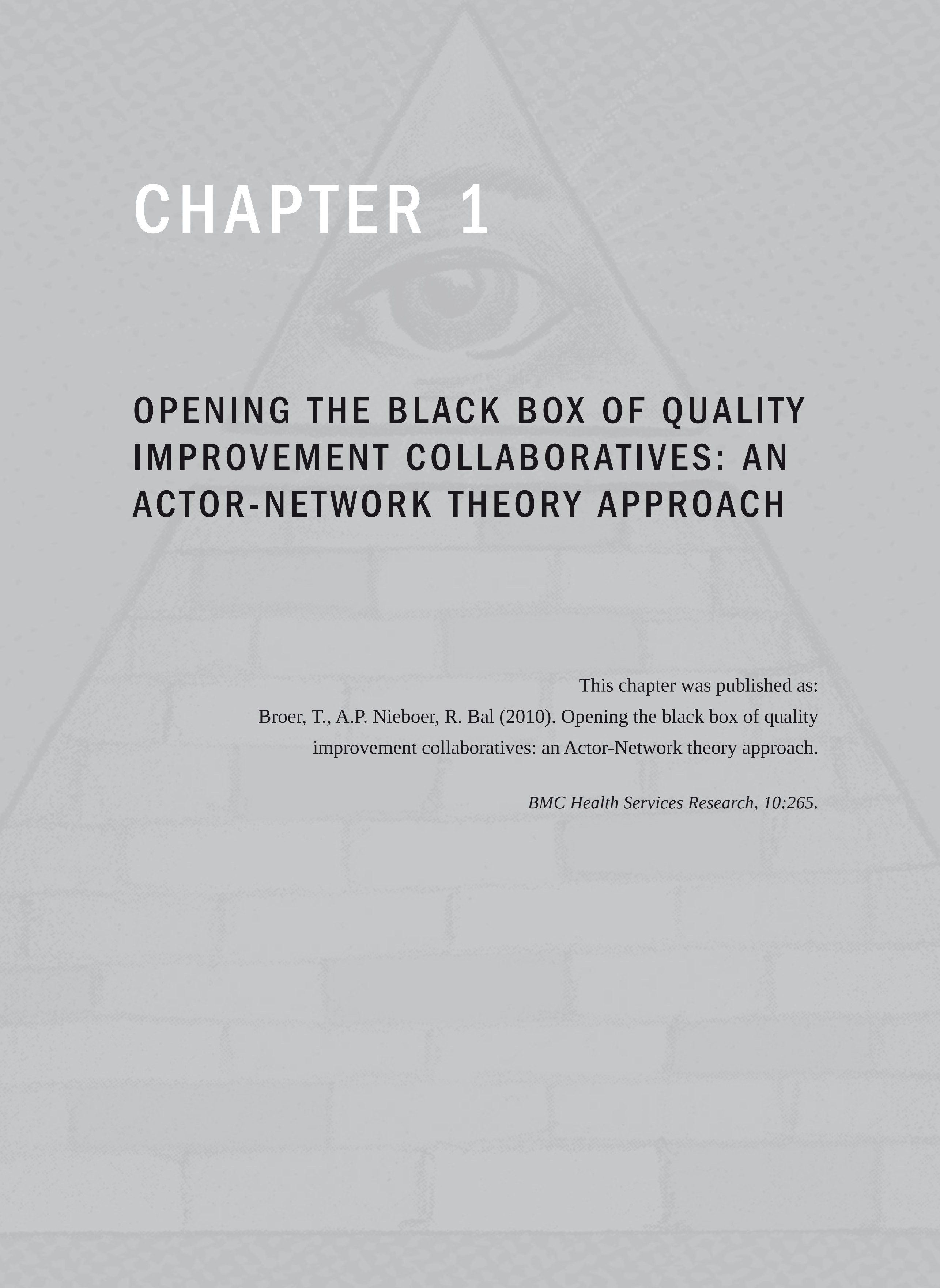
van de Klippe, H. (1997). *Dwangtoepassing na onvrijwillige psychiatrische opname. een juridische beschouwing (the enforcement of coercion after involuntary admission to a psychiatric hospital)*. Nijmegen: Ars Aequi Libri.

Veltkamp, E., Nijman, H., Stolker, J. J., Frigge, K., Dries, P., & Bowers, L. (2008). Patients' preferences for seclusion or forced medication in acute psychiatric emergency in the netherlands. *Psychiatric Services*, *59*(2), 209-211.

Wilson, T., Berwick, D. M., & Cleary, M. P. P. P. D. (2003). What do collaborative improvement projects do? Experience from Seven Countries. *Joint Commission Journal on Quality and Patient Safety, 29*, 85-93.

Woolgar, S. (1991). The turn to technology in social studies of science. *Science, Technology & Human Values, 16*(1), 20-50.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine, 69*(12), 1713-1721.



CHAPTER 1

OPENING THE BLACK BOX OF QUALITY IMPROVEMENT COLLABORATIVES: AN ACTOR-NETWORK THEORY APPROACH

This chapter was published as:
Broer, T., A.P. Nieboer, R. Bal (2010). Opening the black box of quality improvement collaboratives: an Actor-Network theory approach.

BMC Health Services Research, 10:265.

Abstract

Background: Quality improvement collaboratives are often labeled as black boxes because effect studies usually do not describe exactly how the results were obtained. In this study we propose a way of opening such a black box, by taking up a dynamic perspective based on Actor-Network Theory. We thereby analyze how the problematisation process and the measurement practices are constructed. Findings from this analysis may have consequences for future evaluation studies of collaboratives.

Methods: In an ethnographic design we probed two projects within a larger quality improvement collaborative on long term mental health care and care for the intellectually disabled. Ethnographic observations were made at nine national conferences. Furthermore we conducted six case studies involving participating teams. Additionally, we interviewed the two program leaders of the overall projects.

Results: In one project the problematisation seemed to undergo a shift of focus away from the one suggested by the project leaders. In the other we observed multiple roles of the measurement instrument used. The instrument did not only measure effects of the improvement actions but also changed these actions and affected the actors involved.

Conclusions: Effectiveness statistics ideally should be complemented with an analysis of the construction of the collaborative and the improvement practices. Effect studies of collaboratives could benefit from a mixed methods research design that combines quantitative and qualitative methods.

Background

Ever since the US Institute of Medicine described the so-called “quality chasm” in health care (Committee on Quality of Health Care in America & Institute of Medicine (US), 2001), quality improvement has become an important policy issue. A proposed solution for bridging the chasm is setting quality improvement collaboratives (QIC’s) to work. A nice example is the Breakthrough Series model that brings together teams from different hospitals or clinics with the aim to attain improvements on a certain theme (Institute for Healthcare Improvement, 2003). The QIC model in general and BTS in particular are widely adopted in Western countries (Schouten, Hulscher, Everdingen, Huijsman, & Grol, 2008). So far, there is little evidence, however, on the effectiveness of QIC’s (Mittman, 2004; Schouten et al., 2008).

Despite the lack of evidence concerning effectiveness of QIC’s, most studies evaluating QIC’s are investigating their effectiveness rather than follow the collaborative as it gets formed. Bate and Robert argue that many evaluation studies take up an approach they describe as “summative, noninterventionist, and heavily reliant on quantitative assessments of “success””, which is “outcome-oriented” (Bate & Robert, 2002). They contrast this approach to an action-oriented or formative approach that is mainly qualitative and that is devised to improve the method along the way by giving feedback to leaders of improvement projects. As (qualitative) process descriptions are lacking, QIC’s are often described as “black boxes” (Schouten et al., 2008; Wilson, Berwick, & Cleary, 2003). Knowing what actually occurs in setting up and carrying out collaboratives would seem crucial for interpreting the effectiveness results (Schouten et al., 2008; Wilson et al., 2003; Øvretveit & Gustafson, 2002).

Several suggestions for opening up the black box have been made. For example, Wilson et al asked collaborative leaders what they thought were crucial aspects of QIC’s (Wilson et al., 2003). On the basis of the information retrieved they proposed a framework of core elements that have to be described in order to meaningfully link effectiveness data to the workings of the collaborative. This framework is limited, however, in that the set topic and main elements are considered to stay fixed during the project, as if it is just a matter of implementing the elements rather than the elements changing themselves as a result of implementation. By assuming that the topic of a QIC can be predefined, the authors for example do not focus on the construction of the QIC and also do not explore whether the topic may change during the collaborative process.

Bate and Robert and colleagues (Bate, Robert, & McLeod, 2002; Robert, Hardacre, Locock, & Bate, 2002) took up a more dynamic approach by providing process descriptions of two collaboratives and detailing the extent to which the collaborative method was implemented. Yet also they did not analyze the way the features can be created or constructed within collaboratives. For example, they described the difficulties that measuring could pose for improvement teams, but they did not analyze how measurability was constructed or what different functions measuring could have within such projects (cf. van den Berg, Frenken, & Bal, 2009). They mainly looked at the success of implementation. In this sense, even Bate and Robert in their more dynamic approach still assume to know what collaboratives are before they even start opening the black box of collaboratives.

One of the reasons why this black box should be opened is to gain insight into the construction of effectiveness data within collaboratives, i.e. the relation between the topic and the outcomes of a QIC. As effectiveness is based both on the interventions carried out and on the way improvements are measured, two interrelated questions must be addressed. First, as summative research investigates the predefined effectiveness of a collaborative derived from the topic, it should be analyzed how this topic is created. Leading questions then concern possible changes in the topic during the project and the possible consequences of these changes for the predefined effectiveness. By focusing on the construction of the topic rather than on predefined elements, more insight is gained in what is actually done within the collaborative.

Secondly, the effectiveness measurement practices themselves should be analyzed. Within Breakthrough projects, measuring is assumed to play an important role. First, it helps in investigating a project's overall effectiveness. Second, teams themselves often use measurement instruments to investigate their own effectiveness and to adjust their improvement actions based on the results. But what roles do these measurement practices exactly play within QIC's and what is the relation between the topic and its measurability? Do the measurement instruments merely describe the topic and the improvements attained or do they affect the improvement practices as well?

In this study we will propose a way of opening the black box of collaboratives by using a dynamic perspective, though different from that of Bate and Robert. We study how the collaborative gets formed rather than taking fixed elements or the extent to which the elements are implemented as a starting point. To do so, we draw upon empirical material of two projects aimed at improving mental health care and care for the intellectually disabled. We studied these projects in the context of a larger evaluation study of the QIC they are part of.

The aim of our approach is threefold. First, we would like to propose a way for opening the black box of QIC's by focusing on their construction. Our second aim is to provide more insight into the dynamics of the collaborative process. So whereas the first question is more methodological, the second is an empirical question. Thirdly, we will study possible consequences of findings from this analysis for future evaluation studies.

The chapter is structured as follows. First we will describe a theoretical framework based on Actor-Network Theory (ANT). Then we will describe the two improvement projects and the way we gathered data for this study. In the next sections we explore empirically what opening the black box of QIC's may mean from an ANT perspective. We do so by focusing on the way the topic and its measurability get constructed within the collaborative. In the conclusion we come back to the question what our analysis can add to (discussions on) evaluation studies of QIC's.

Theoretical framework

As a methodology for opening the black box of QIC's, we draw on Actor-Network Theory. From an ANT perspective, none of a collaborative's elements is fixed before start of a project. Seen from this perspective a collaborative is a dynamic process in which its elements get constructed (cf. McMaster, Vidgen, & Wastell, 1997). In drawing on ANT, researchers need to "follow the actors" and to analyze how these actors themselves define what is going on (Latour, 1987; Latour, 2005). Therefore, we will not predefine the concept of 'collaborative' and its elements. Rather we look at the way the collaborative is formed during the project and what consequences this process has for the actors involved.

To analyze the dynamics within the topic of a collaborative, we use the ANT-notion of problematisation (Callon, 1986), which involves a dynamic way of defining and constructing the problem. Hence, seen from this perspective a problem is not given and already out there, but is constructed in a process in which actors can always (implicitly or explicitly) oppose the problematisation process. We use the term 'problematisation' instead of problem definition for it offers two advantages. First, it means that the problem definition emerges from a performance and not just from a perspective (Mol, 1998). Secondly, it implies that the problematisation is not a singular event but is done over and over again, because (dynamic) practices make up a problematisation. Thereby, the term 'problematisation' allows us to follow how the different actors involved construct the topic of a QIC. The term suggests to investigate the way leaders of improvement projects present the topic, the way improvement teams participating in the project discuss the topic and the way teams perform it within the care organizations.

Looking at the problematisation process within improvement projects has already proven to be relevant. For example, Zuiderent-Jerak et al (Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009) showed that different problematisations can co-exist within a medication safety improvement project. In this project some teams focused on client autonomy whereas others sought to reduce medication errors. So the authors showed that teams may differ in doing a problematisation process, but they did not analyze the construction of the problematisation over the course of an improvement project, which will be our focus.

Next to studying the problematisation process, we investigate the measurement practices. From an ANT-perspective it is suggested not to make an a priori distinction between human and non-human actors (Latour, 1987). The measurement instruments used within the projects can be perceived as non-human actors possibly contributing to the collaborative and the way the topic is performed. As said, measuring is assumed to play a dominant role in QIC's, notably regarding rapid cycle improvements. This means that improvement teams are to carry out small scale actions, measuring if the actions led to the expected outcomes, and, if not, adjusting the actions (Institute for Healthcare Improvement, 2003). Furthermore, measuring is often used to estimate a project's overall effectiveness.

Yet ANT-scholars and other scholars have pointed at the performative effect of measurement instruments, meaning that instruments not only measure a situation but also affect this situation in foreseen and unforeseen ways. Perhaps the most famous example of performativity is that of opinion polls, which are aimed to investigate the expected election result but at the same time these polls influence actual voting behaviour and thus possibly change the election result. Furthermore, in social sciences measuring plays a profound role in shaping identities of persons and groups (P. Miller, 2004; P. Miller & O'Leary, 1987; Ward, 1996). For example, Hacking holds that classification, including classification based on measuring, produces so-called looping effects, in which people react to the classification and make it either more true by behaving in line with the classification or make it less true by opposing to it (Hacking, 1999). So also here it is said that classification and measuring "interact" (Hacking, 1999) with the world they refer to; they do not just represent this world but change it. As a last example, in organizational sciences Power (Power, 2004; Power, 2007) illustrated the performativity of measurements used within and between organizations. The data do not only represent practices in the organization but co-construct the organization and involved actors in foreseen and unforeseen ways. People sometimes start to focus mainly on the measures and attaining high results, thereby focusing less on other issues not captured in the measures (Power, 2004; Sauder & Espeland, 2009).

Given that measurement practices can have a performative effect, their exact role(s) should be analyzed if we want to study the construction of a collaborative, because the measurement practices possibly affect the improvement practices and thereby also the performance of the topic – i.e. the problematisation – in foreseen and unforeseen ways.

Consequently, if we want to address the question what effectiveness in improvement projects may mean, we should look at the way in which the problematisation process and the measurement practices are interlinked.

Methods

The collaborative approach

In this study we focus on two improvement projects that were part of a larger collaborative performed in the Netherlands: Care for Better. These projects were named ‘recovery-oriented care’ and ‘social participation’. They aimed at improving long term mental health care and care for the intellectually disabled. Both projects started in 2007 and consisted of two rounds each lasting one year.

From twelve to fifteen improvement teams collaborated in each round of each project. Headed by a project leader, each team generally consisted of four to nine members. The two faculty teams of the projects consisted of an expert team and a core team made up of the program leader of the overall project and two or three ‘process counsellors’. So in this study leaders of improvement teams are called project leaders, and the leaders of the overall project are called the program leaders. In the project ‘recovery oriented care’ only teams from mental health care participated. In the project ‘social participation’ a mixture of teams participated, some delivering care to intellectually disabled clients and others to psychiatric clients. The clients involved usually lived in a form of sheltered housing or at a ward of the institution.

For each round of each project, four national working conferences were organized at which faculty provided recommendations on the improvement actions and the method for improving. The starting conferences were mainly intended to familiarize teams with the proposed problem and improvement method. In the first and second working conferences the improvement practices were discussed in a mix of plenary sessions and workshops. The closing conference mostly served to sum up the results attained and to focus on sustaining and spreading the findings.

Despite the organizational similarities, the projects had different goals. The ‘recovery-oriented care’ project was devised to give clients more control over their lives, while the ‘social participation’ project aimed at enlarging and enriching the clients’ social networks, supposedly making them feel less lonely. The exact interventions of improvement teams participating in these projects are part of our analysis and will be discussed in the results section.

Research methods

We evaluated these projects within the context of our larger evaluation study of the Care for Better collaborative (Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008; Zuiderent-Jerak et al., 2009). We carried out ethnographic observations at nine of the sixteen conferences, distributed over the two rounds of the two projects. Most data gathered at these conferences comprise lectures of the faculty team, reactions of improvement teams to these lectures, and discussions concerning the improvement practices. Furthermore, we separately interviewed the two program leaders. In addition, we studied six improvement teams in depth. These teams were selected on the grounds of observations of the conferences. In all cases we interviewed the project leaders of these improvement teams. Sometimes additional interviews with team members were conducted. These case studies usually lasted one day or one-half day.

We focus on only these two projects as it gives us the opportunity to analyze them more in depth, but other projects could be used as example as well. We draw on the 'recovery-oriented care' project to illustrate the problematisation process as suggested by faculty and actually performed by participating teams. In zooming in at the problematisation process, we first analyze the way faculty of the 'recovery-oriented care' project presented the problem and, interrelated, proposed solutions. Secondly, we analyze how teams discussed things and set improvement projects going (Zuiderent-Jerak et al., 2009), as well as whether and how they adopted the proposed problematisation of faculty. Measurement practices on the other hand are illustrated by observations from the 'social participation' project. We investigate the relation between the measurement practices and the initial problematisation of faculty, and furthermore explore the consequences of the measurement practices for the project and for the actors involved.

Results

The problematisation process

The initial problematisation: a lack of future perspective

The topic of the 'recovery-oriented care' project had been defined before the project went ahead. We entered stage at the starting conferences of the first round of the project, at which faculty introduced their ideas concerning problematisation. Their problematisation owed much to the recovery movement as initiated by former mental health care clients who described their recovery as a process of regaining control over their own lives, often leading to reintegration in society (Anthony, 1993; Deegan, 1988).

In line with the goals of the recovery movement, the main aim of the project was giving clients more space to govern their own lives and to make their own decisions. Many clients living in mental health care institutions were facing a bleak future, as faculty said. “The lives of clients within long term mental health care are characterized by routine, boredom, marginalization, and a lack of perspective,” a former client who was part of the expert team said. As faculty saw it, one of the reasons for this situation was the “mental health care regime” in which clients are approached in a “stigmatizing” way or receive scant attention. This speaker added that many care givers do not have faith in the possibility of change in clients’ conditions and skeptically asked “if this perception has changed now that mental health care has discovered the concept of recovery”. “Do they [mental health care professionals] really believe that clients can […] live a complete life?”

The proposed solution: reducing the role of professionals

Hence faculty defined the problem as follows: mental health care clients lack perspective owing to the way in which professionals approach them. Inherent to a problem definition is the question who should tackle the problem and what roles these actors should take up (Hilgartner, 1992). Interestingly, many teams in this project mainly consisted of professionals. However, through its focus on clients’ recovery, the recovery movement does not define a very clear role for professionals (Anthony, 1993; Deegan, 1988).

Even faculty of this project struggled with this discrepancy. “It is an illusion to think that mental health care professionals can recover their clients,” said one of the experts. The program leader moreover said that an improvement project is “a tricky thing” because it suggests that under certain conditions clear advances could be made within a year. The truth is we had no clear interventions available beforehand that would directly lead to clients’ recovery, she said in an interview.

Still the faculty team had ideas for improvement. In order to support the clients’ recovery process, professionals should be less dominantly involved in their lives. Ideally, as faculty said, professionals should restrict themselves to creating the essential preconditions for recovery to occur. For example, by removing those elements that are thought to be in the way of recovery, such as “restraining” home rules.

So this was how the faculty team saw the problem: many clients in mental health care institutions lack perspective because professionals do not show faith in their clients and do not give them much room for their wishes and plans. The improvement teams were therefore advised to step back.

The improvement actions: different ways of performing the project

Following faculty's problematisation process allowed us to analyze if and how the teams adopted this problematisation. Many teams recognized the picture sketched of clients lacking a future perspective. Also, they agreed they were too dominantly present in clients' lives. "Nurses often want to know everything, want to control everything, want to be in the lead," one project leader said. In an informal talk at a conference a team member said that while clients were often institutionalized, professionals were institutionalized as well.

So the teams seemed to adopt faculty's problematisation in the first instance. But how did they go ahead? As the recovery concept itself was seen as quite "abstract", many teams first set out to create a vision on what constituted recovery-oriented care. Furthermore, some teams discussed their approach to clients in line with the problematisation of faculty. One example concerned a client who changed clothes three times a day. Her bedroom door used to be locked to prevent her from doing so. The discussants wondered whether it was actually a problem that she changed clothes that often. They concluded it was not, unless this client was in "a manic period" and locking her door would calm her down. So this discussion indeed led to a proposal for reducing the professional role.

Another improvement action involved asking clients what hindered them in the way professionals approached them. One team invited clients to write down the home rules they disliked. This resulted in "a wall full" of post-its, said this team's project leader. One by one the post-its were taken from the wall and discussed. One client for example wanted a better arrangement for use of the washing machine. Another client disagreed with the lock on the refrigerator. This approach of asking clients what hinders them, in fact, is quite the reverse of the one in which professionals think up what might be hindering clients. It also has consequences for clients' role in their own recovery process; being either recipients or co-inventors of this new approach.

As another improvement action, clients were offered choice options in meals and snacks. "Despite being very psychotic, he is fully aware that he likes treacle wafers best," a team member said about a client who now chose treacle wafers every day. Yet many clients "do not know anymore what choosing means," a project leader said. One client, for example, even did not know what she would like to eat, although she expected the meals to be the best part of her holiday trip.

Many teams struggled with the question how to get clients to know and to state their wishes and how to get them into the recovery process, seeing that they “are often not easily mobilized and cannot mobilize and motivate themselves either”, as a project leader told. “Some of my clients still think they are Napoleon,” said another project leader to illustrate that clients may lack sense of reality. For these reasons, some team members told that recovery was not a suitable concept for their client group.

A change in problematisation: stimulating clients

These questions led to a change in problematisation. Improvement teams focused more on stimulating clients than on reducing their own roles in the lives of clients. The dilemma many team members faced was that they wanted to create a future perspective for clients but that clients themselves did not even have ideas about what they would like to eat, let alone what activities they wanted to undertake during their days or what life goals they had. Therefore some teams decided not to wait until clients could mobilize themselves, and to invent a program of activities themselves.

One team said that in the beginning of the project recovery looked like a figment to them. Clients could have been living for fourteen years within the institution and yet never have come up with the idea of breakfasting earlier than the set time, although they sometimes woke up at six o’clock. So the team proposed alternative meal times to clients. By the time of the closing conference these clients could have meals at variable times like in a hotel.

So during this project some teams shifted their focus from reducing their own role to stimulating clients. As faculty proposed it, the teams should strive for taking up as small a role as possible. However, some teams said that then nothing would happen and adopted a more active role in order to make clients more active as well.

Analysis of the problematisation process

To summarize, the ‘recovery-oriented care’ project was characterized by different problematisations. Faculty defined the main problem to be a lack of perspective for clients, and thought this was partly caused by a ‘negative’ approach from professionals. Faculty therefore advised teams to step back and to support the recovery process mainly by not hindering it. Some teams nevertheless took up a more dominant role in stimulating clients to become more active so as to improve their future perspective. This shift in the problematisation process also had consequences for “who has the right and who has the obligation” to do something about the problem (Hilgartner, 1992), for example which actions from professionals were allowed and which actions were not.

So the problem on which an improvement project focuses may change during the course of the project. The exact problematisation depends on both the expert knowledge and the local knowledge of improvement teams. The improvement actions could not be directly deduced from the topic of the collaborative or from the way faculty proposed the problem, but had to be analyzed by following the actors.

The changes in problematisation were clearly notable in this improvement project because improvement teams were given much leeway. They had to state their own goals as a means to endorse the actions undertaken by them. At the same time faculty of the projects still tried to control the improvement actions by their own presentation of specific solutions. Another way of directing teams, intertwined with the problematisation process, is found in the measurement practice(s), illustrated in the next section by focusing on the 'social participation' project.

The measurement practices

The 'social participation' improvement project

The two purposes of the 'social participation' project were to strengthen clients' social networks and, interrelated, to make them feel less lonely. Many clients have unfulfilled needs on the social domain, said the program leader at the starting conference. While he did some suggestions for improvement, he urged teams especially to adjust the improvement actions to the wishes and needs of clients themselves and to ask clients what they would like. The problematisation therefore was the following: although clients have many unfulfilled needs on the social domain, professionals do not always know and/or do not inform after these needs.

Consequently, many of the teams first set out to map the needs of clients, in order to see what improvements were possible in this regard. They often did so by using the network circle, which was an obligatory measurement instrument in this project and was meant to map all the contacts of clients. Options for improvement actions included contacting the persons important to clients or directing clients' attention to new contacts. For example, one client started to go to church; another regularly visited the sauna and there they met (new) people.

This project's central indicators for success were decided somewhere between the starting conference and the first working conference. The program leader proposed that social participation had "a subjective and an objective side", and teams were advised to direct their attention to either one of these pillars, or, ideally, to both. Teams were asked to measure both the subjective and the objective side at the beginning and the end of the project. The subjective side was measured in terms of the degree of loneliness clients experienced. The objective side was measured by the aforementioned network circle instrument, which is discussed in the next sections.

Shaping the actors: the assumptions within the instrument

The network circle is an instrument consisting of five concentric circles. The innermost represents the client himself or herself. The client's so-called anchors are placed in the next ring: "One can hardly imagine living without these people," one of the experts typified this circle. The third ring includes friends, "who enable you to do things you normally would not be doing". Then there are the acquaintances, "with whom you share one thing such as being part of the same tennis club". The outermost circle represents the professionals, who are getting paid to help clients. Professionals completed the network circle together with the client by informing after clients' contacts and where to place them. This approach was thought to bring up many unfulfilled needs and thus to open avenues for improvements aligned with clients' needs.

In making the network circle an obligatory measurement instrument, faculty assured that teams asked after clients' needs in this respect. The network circle in that sense was both an indicator of what faculty thought the problem and the solution were. The problem was, among other things, not enough information about clients' needs and/or the needs not being point of discussion. The solution accordingly was informing after these needs. Faculty could use the measurement instrument then to (subtly) steer the teams towards the proposed problematisation and solution.

Also in another way the measurement instrument supported the problematisation of faculty. Faculty said that professionals were often too dominantly present in a client's social life. Completing the network circle would tell them who else they could mobilize in order to improve the networks of clients. The instrument then would directly point at possibilities for reducing their role. Indeed, at the closing conference one of the experts said that this project was successful in that professionals had learned to abandon the notion that they were the ones who should manage everything for clients. So here again the measurement instrument had its function in strengthening the problematisation of faculty.

The instrument does not only carry assumptions about the professional role; it also "co-defined and co-produced" (Miller & O'Leary, 1987) the clients involved by assuming a typical client. Thereby, the instrument also stimulated professionals to assume this typical client and to approach clients in a certain way. For example, one of the assumptions in the instrument is that clients are able and interested to discuss their social network. Yet this was not always the case in this project. Some clients were reported to stay in bed the whole day, and their world accordingly was very restricted, as a project leader said.

Furthermore, clients were expected to be able to distinguish between professionals, friends and acquaintances. Yet many of the clients placed professionals in the friends ring. “From whose perspective do we fill this in?” a project leaders asked. “I have clients who designate my colleagues as their friends, is that allowed or not?” Faculty responded that clients should become aware that professionals cannot be their friends. Furthermore, professionals themselves also ought to realize they were clients’ caregivers and not their friends, faculty said. So here again the instrument strengthened the problematisation, and led to a situation that faculty of the project liked to see: clients placing professionals where they belong.

So although clients’ wishes had to be leading in the improvement actions, their perspective was not taken for granted. Perceiving professionals to be friends was thought to be problematic. Some teams, therefore, were struggling with adapting improvement actions to their clients’ wishes but at the same time had to confront clients with a picture of reality that was not the way clients perceived it. In this sense, the problematisation of faculty both strengthened and denied the perspective and wishes of some clients.

The effects of the instrument

Apart from strengthening faculty’s problematisation, the instrument may have other effects. For one, it could heighten clients’ awareness of their social networks. One client reported forty contacts at the start of the project, a number reduced to no more than twenty at the end. Faculty thought this might be due to more awareness of what really could be regarded as friends, and mentioned this awareness in general to be one of the successes of the project. For that matter, a project leader pointed out that the visual nature of the instrument makes the social situation of clients clear at a glance. Therefore clients could easily replace and relocate contacts. One client for example found out that a perceived friend was actually not a friend, and vice versa.

In some cases clients’ heightened awareness of their social networks made improvement actions superfluous. For example, a client who always said he was very lonely was astonished to see how big his network was and how active he was. “Why complain about being lonely at all”, he was reported to say. So the use of the network circle instrument led clients “to redefine the concept of loneliness”, as this project leader said. Apart from its positive effects, however, the instrument could evoke more negative feelings when clients were confronted with their small networks.

In the above examples the instrument transformed the way in which the actors involved thought about and enacted the improvement situation, and their social life in general. These transformations may have been foreseen. Still, as a possible unforeseen side-effect, use of the instrument often improved relations between professionals and clients as well. Even clients who did not gain any new contacts enjoyed talking about their social networks, a project leader said. All this, however, was rather not in line with faculty's policy of strengthening the inner network circles instead of the outer ring consisting of professionals.

Analysis of the measurement practices

To summarize, in the 'social participation' project the measurement instrument selected by faculty had several roles. It not only measured results, but also steered improvement actions in the desired direction. Faculty's problematisation was that professionals tended to be unaware of what clients would like and also did not ask them. Moreover, clients themselves sometimes lacked awareness of their social situation. Having them to 'objectively' classify their relations was thought to be a solution for this shortcoming.

Furthermore, the instrument assumed a typical client, one willing and able to discuss social relations with professionals who could not be conceived as friends anymore. Faculty assured that clients had an active role; they needed to think about what they would like and discuss this with care givers. The instrument thus had a performative effect; i.e. it shaped reality as well (Power, 2004). As this example illustrated, measurement practices in improvement projects not only endorse faculty's problematisation but also carry (subtle) assumptions about who should be able and who has the obligation to do something about the problem. Measurement practices may change the improvement practices in foreseen and unforeseen ways.

Conclusion

In this study we proposed a way for opening the black box of QIC's, going beyond a mere description of the elements or the extent to which they are implemented. We studied a collaborative in action and analyzed how it was formed over the course of one-year-long improvement projects. To illustrate our method and to actually open the black box we zoomed in at the problematisation process and the related measurement practices. Our empirical material came from two projects in a larger collaborative aimed at improving mental health care and care for the intellectually disabled.

The problematisation process in the ‘recovery-oriented care’ project proved to have undergone a transformation. At baseline professionals mainly sought to support clients’ recovery process by not hindering it. Later on many teams were trying to stimulate clients. This problematisation process also had consequences for the different roles proposed for the actors involved; it had consequences for “who has the right and who has the obligation” to do something about the problem (Hilgartner, 1992). So by using an ANT-perspective we showed that the topic is not fixed and given prior to the collaborative, but instead is formed within the collaborative, both by the expert knowledge of faculty and the local knowledge of improvement teams.

This change in problematisation may have been more pronounced in the projects we studied because the improvement teams were free to come up with their own targets, to ‘do’ their own problematisation. This may be different for other improvement projects. When improvement teams have that much leeway, a dynamic perspective is even more needed if only to see what the improvement project is all about.

To further open up the black box, we studied the role of the measurement practices within the ‘social participation’ project. As effectiveness studies often assume a direct relation between a topic and its measurability, researchers should unravel this relation, as we suggested. Our analysis showed that the measurement instrument is linked to the problematisation in more than one way. First, it measures the effectiveness of the collaborative in reaching the predefined goal(s). Secondly, it may strengthen the problematisation, supporting both the problem and the solution that faculty proposed. The instruments then may make it more likely that the teams will adopt the problematisation. But moreover, there were effects on the improvement practices as well. Measurement instruments inevitably carry assumptions, for example that clients are willing and able to have conversations about their network, and would do well not to count professionals among their friends. Therefore measurement instruments also co-define and co-produce the actors involved, and thus have a performative effect on the practices they measure (Power, 2004).

Both human and non-human actors play a role in constructing the collaborative, as we showed by using an ANT-perspective. However, by using this perspective, we were less concerned with the “why” or the intentionality question (Greenhalgh & Stones, 2010), for example with the question why the project was framed in a certain way or why the faculty team of the ‘social participation’ project urged professionals and clients alike not to classify professionals as clients’ friends. Instead we focused on the performance of a project and what consequences this performance has for the actors involved.

By focusing on these questions, we showed that the problem cannot be assumed to stay fixed over the course of the project. Yet these changes in problematisation do not automatically have consequences for measuring the effectiveness of the collaborative. In the 'recovery-oriented care' project, the solution changed, but teams were still trying to solve the same problem that faculty pointed at: the lack of future perspective. It depends on the actual goal of the program and on the indicators for success if changes imply a change in effectiveness as well.

But as much "summative" research assumes that goals do not change during the project, it is important to test this assumption. Otherwise, it is hard to ascribe the effectiveness – or lack of effectiveness – to the improvement actions and the collaborative method. So it would seem crucial not only to report on outcomes but also to analyze what happened in the collaborative. Therefore, our analysis can be seen as a plea for a mixed methods approach. This mixed methods approach is part of an ongoing debate and although some scholars argue for such an approach, the extent to which it is actually done leaves much to desire (Mittman, 2004; Schouten et al., 2008).

Bate and Robert in contrast argue that a summative evaluation (mainly quantitatively) and a formative evaluation (mainly qualitatively) will not mix at the end of the day: "Although there are some overlaps and similarities, they are, in our view, ultimately incompatible and incommensurable research paradigms (…)" (Bate & Robert, 2002). A formative approach implies intervening in the object one studies, which affects the outcomes, they say. This creates "impossible and, largely, unmanageable tensions" between intervention and experiment for no valid statements can be made about the method itself affecting certain results (Bate & Robert, 2002).

Yet our analysis can be read as a contradiction of, or at least as a critical note to, their argument. We have seen that measuring practices indeed can have a performative function. These measurement practices of improvement teams themselves are often used by evaluation researchers to examine effectiveness of QIC's. Therefore, this type of evaluation research has to deal with the same performativity of the measurement practices, which has consequences for the proposed distinction between intervention and experiment. But even if measurement instruments are used that are not owned by improvement teams themselves, one could question if these are free from performative effects. Even the fact that measuring takes place already influences its outcomes and thus can be seen as an intervention in itself (Power, 2004; Power, 2007; Zuiderent-Jerak et al., 2009).

When accepting that measuring can have (per)formative elements as well, there will be no unmanageable tensions, no incommensurable paradigms between intervention and experiment. Measuring is based on an interpretative and supposedly also a performative process which is thus a formative instrument in itself. If there are always tensions between intervention and experiment, this tension is no valid reason for not combining the more formative and the more summative research. Besides, as collaboratives are governmental instruments to improve certain aspects of care, they deserve confirmation of the expected outcomes. Thus there is every reason to explore ways to intelligently combine qualitative and quantitative methods, gaining insight both into the outcomes and in the (dynamic) construction of the collaborative. This then is the next challenge for evaluation researchers of quality improvement collaboratives.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*, 11-23.

Bate, P., & Robert, G. (2002). Studying health care "quality" qualitatively: The dilemmas and tensions between different forms of evaluation research within the U.K. National health service. *Qualitative Health Research*, *12*(7), 966-981.

Bate, P., Robert, G., & McLeod, H. (2002). *Report on the 'breakthrough' collaborative approach to quality and service improvement within four regions of the NHS: A research based investigation of the orthopaedic services collaborative within the eastern, south and west, south east and trent regions.* University of Birmingham, Health Services Management Centre.

Callon, M. (1986). Some elements of a sociology of translation: Domestication of the scallops and the fishermen of st brieuc bay. *Power, Action and Belief: A New Sociology of Knowledge*, *32*, 196–233.

Committee on Quality of Health Care in America, & Institute of Medicine (US). (2001). *Crossing the quality chasm: A new health system for the 21st century.* Washington DC: National Academy Press.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Greenhalgh, T., & Stones, R. (2010). Theorising big IT programmes in healthcare: Strong structuration theory meets actor-network theory. *Social Science & Medicine*, , 1285-1294.

Hacking, I. (1999). *The social construction of what?* Harvard: Harvard University Press.

Hilgartner, S. (1992). The social construction of risk objects: Or, how to pry open networks of risk. In J. F. Short, & L. Clarke (Eds.), *Organizations, uncertainties, and risk* (pp. 39–53). Boulder: Westview Press.

Institute for Healthcare Improvement. (2003). *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement.* Cambridge MA: Institute for Healthcare Improvement.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge, Massachusetts: Harvard University Press.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network-theory*. Oxford: Oxford University Press, USA.

McMaster, T., Vidgen, R. T., & Wastell, D. G. (1997). Technology transfer: Diffusion or translation? In McMaster T. (Ed.), *Facilitating technology transfer trough partnership: Learning from practice and research* (pp. 64-75). London: Chapman & Hall, Ltd.

Miller, P. (2004). Governing by numbers: Why calculative practices matter. *The Blackwell Cultural Economy Reader,* 179–190.

Miller, P., & O'Leary, T. (1987). Accounting and the construction of the governable person. *Accounting, Organizations and Society, 12*(3), 235-265.

Mittman, B. S. (2004). Creating the evidence base for quality improvement collaboratives. *Annals of Internal Medicine*, *140*(11), 897-901.

Mol, A. (1998). Ontological politics. A word and some questions. *The Sociological Review, 46*(S), 74-89.

Øvretveit, J., & Gustafson, D. (2002). Evaluation of quality improvement programmes. *British Medical Journal, 11*(3), 270.

Power, M. (2004). Counting, control and calculation: Reflections on measuring and management. *Human Relations, 57*(6), 765-783.

Power, M. (2007). *Organized uncertainty*. Oxford: Oxford University Press.

Robert, G., Hardacre, J., Locock, L., & Bate, S. P. (2002). *Evaluating the effectiveness of the mental health collaborative as an approach to bringing about improvements to admission, stay and discharge on acute wards in the trent and northern & yorkshire regions: An action research project*. Birmingham: University of Birmingham.

Sauder, M., & Espeland, W. N. (2009). The discipline of rankings: Tight coupling and organizational change. *American Sociological Review, 74*(1), 63-82.

Schouten, L. M. T., Hulscher, M. E. J. L., Everdingen, J. J. E., Huijsman, R., & Grol, R. P. T. M. (2008). Evidence for the impact of quality improvement collaboratives: Systematic review. *British Medical Journal, 336*(7659), 1491-1494.

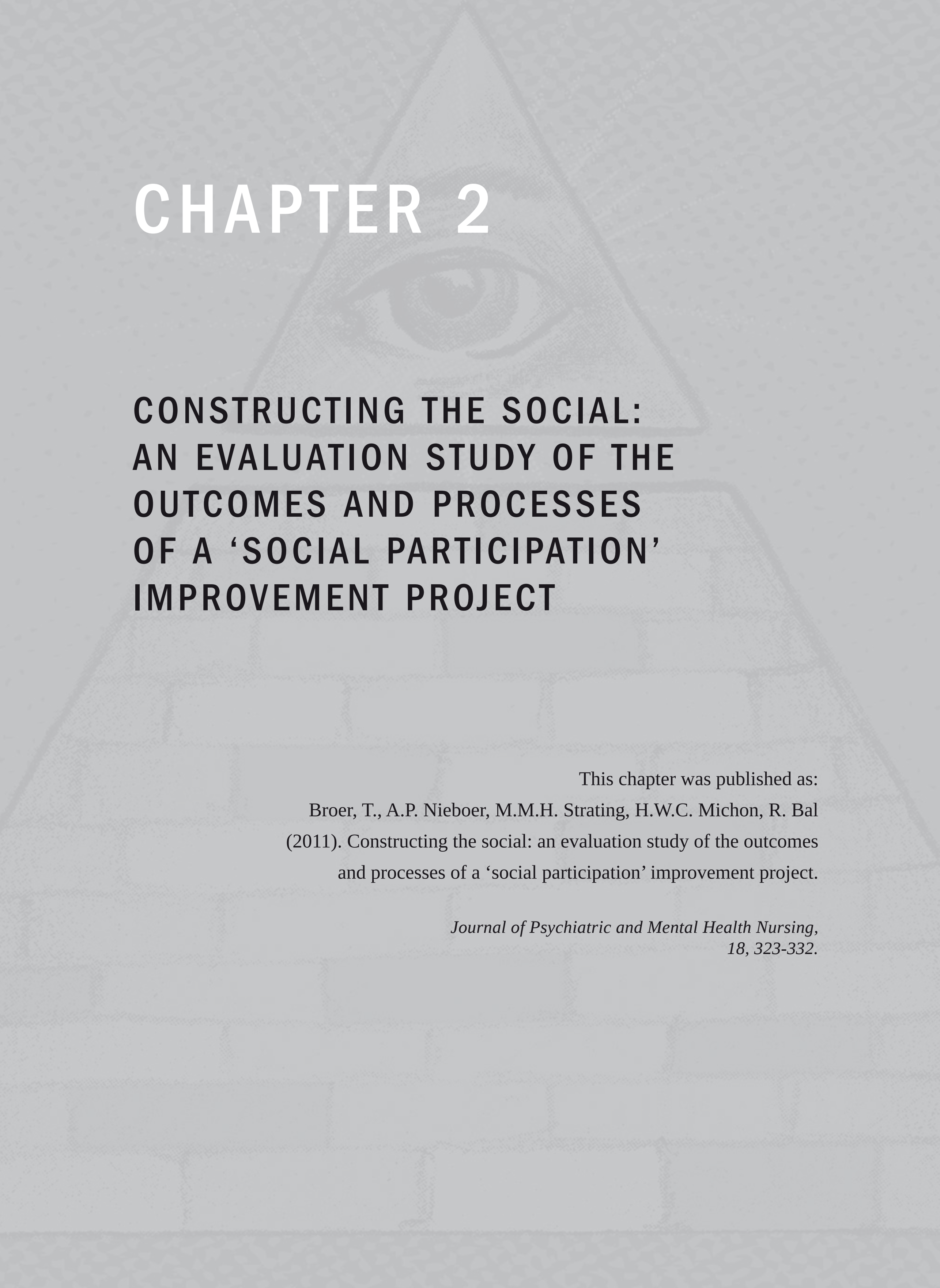
Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

van den Berg, M., Frenken, R., & Bal, R. (2009). Quantitative data management in quality improvement collaboratives. *BMC Health Services Research, 9*, 175.

Ward, S. (1996). Filling the world with self-esteem: A social history of truth-making. *Canadian Journal of Sociology,* 1-23.

Wilson, T., Berwick, D. M., & Cleary, M. P. P. P. D. (2003). What do collaborative improvement projects do? Experience from Seven Countries. *Joint Commission Journal on Quality and Patient Safety, 29*, 85-93.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and ‘acting with’ quality collaboratives in healthcare. *Social Science & Medicine, 69*(12), 1713-1721.



CHAPTER 2

CONSTRUCTING THE SOCIAL: AN EVALUATION STUDY OF THE OUTCOMES AND PROCESSES OF A ‘SOCIAL PARTICIPATION’ IMPROVEMENT PROJECT

This chapter was published as:
Broer, T., A.P. Nieboer, M.M.H. Strating, H.W.C. Michon, R. Bal (2011). Constructing the social: an evaluation study of the outcomes and processes of a ‘social participation’ improvement project.

Journal of Psychiatric and Mental Health Nursing,
18, 323-332.

Abstract

This study reports on an evaluation of a 'social participation' improvement project in a mental health care and care for the intellectually disabled setting. The main research question is how sociality (i.e. clients' social lives) was constructed and what consequences this had for the project and for the clients. We undertook a dual approach: investigating the predefined outcomes and analyzing the improvement processes in terms of how these processes construct sociality. As to the predefined outcomes, clients' social networks were not widened, but clients felt significantly less lonely at the end of the project. In a bottom-up analysis of data gathered on the improvement processes we articulated two ways of constructing sociality: individualization, in which clients had to verbalize their wishes (verbalization) and to act upon them more actively (enterprising); and normalization, in which a good social life was one embedded in 'normal' community. We argue that this (explorative) way of conceptualizing change corresponds with some of the quantitative findings but also brings to light aspects that would have gone unnoticed by using only the predefined outcomes. Therefore, a mixed methods approach in studying effectiveness is a fruitful addition to the quality improvement literature.

Introduction

Quality improvement is often investigated only in terms of predefined outcomes, like health (behaviours) or quality of life, but other perspectives are possible as well. In this study on a quality improvement initiative we indeed use the predefined outcomes but also explore changes in clients' lives by focusing on the improvement processes themselves.

We evaluated a Breakthrough quality improvement collaborative (QIC). In Breakthrough QICs, teams from different organizations join forces to improve care on a certain topic within a set time-frame, steered and supported by a faculty team (Institute for Healthcare Improvement, 2003; Mittman, 2004). These teams will develop and implement improvement actions geared to their own organizations and client groups. Best practices or evidence based interventions are the usual starting points and teams will learn about these at national conferences organized to this purpose. Furthermore, measuring is essential in Breakthrough QICs. It serves several purposes. First, it helps in investigating a project's overall effectiveness. Second, teams themselves may measure their own effectiveness and adjust strategies if needed. Third, evaluation studies of QICs benefit from data that teams themselves have collected (Schouten, Hulscher, Everdingen, Huijsman, & Grol, 2008).

The QIC reported on in this study sought to improve 'social participation' in a mental health care and care for the intellectually disabled setting. We employed a dual approach to evaluate the QIC's effectiveness. First, we investigated the collaborative goal of the project, i.e. improvements with respect to clients' social networks and loneliness. We start with the analysis of the predefined outcomes as this is the more 'regular' way of evaluating effectiveness of QICs.

Second, we explore the improvement actions themselves, to open up the "black box" (Wilson, Berwick, & Cleary, 2003) of the collaborative project in a way not limited to merely summing up the improvement actions. As social participation does not speak for itself and the definition of social life can differ across different settings (e.g. with whom, in what situations, based on what interactions) (cf. Foucault, 1977; Hacking, 1986; Hacking, 1999; Latour, 2005; Mackenzie & Stoljar, 2000; Rose, 1998), we address the question what conceptualizations of the social could be observed – notably in terms of 'sociality', i.e. a particular framing and performance of the social. Furthermore, we investigate the consequences of the different conceptualizations for clients' social lives.

Rather than analyzing the improvement actions in terms of a mentality or an ideological point of view, we perceive them as a heterogeneous assemblage of practices – techniques, language practices, actions, measurement instruments – that may contribute to the construction of sociality (cf. Mol, 2008). So instead of predefining what social should be and of what situations it is made up, we look at the formation of the social (Latour, 2005) in the course of the improvement project. Leading questions were: how is the social framed in the project? What situations are called 'social' and what situations are not? How do different practices and instruments influence the conceptualization and performance of social life? What were the (proposed and actual) roles of clients within the improvement processes? And what are the consequences of the different ways of constructing sociality for the improvement project and for clients?

Combining the analyses of the predefined outcomes and the improvement processes will give insight both in what happened during the project and to what outcomes it led. The main research question of this study is: how is sociality constructed and what are the consequences for the improvement processes and for the clients involved?

Methods

Setting and design

The 'social participation' QIC is part of a larger quality improvement program for the long-term mental health care sector in the Netherlands: Care for Better. Management of this collaborative was in the hands of the Netherlands Institute of Mental Health and Addiction (Trimbos), a knowledge institute for the mental health care sector, and it was commissioned by ZonMw, the main funding agency of health research in the Netherlands. As a research team we were asked to describe the effects of the collaboratives for clients and participating teams and to describe which interventions were actually carried out. The research design, therefore, consisted of a mixed methods approach including quantitative as well as qualitative data collection (Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008; Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009).

Set up of the quality improvement project

The project aimed to increase social networks of intellectually disabled and psychiatric clients and to make them feel less lonely. It was led by a faculty team consisting of a program leader and other experts on social participation of clients in (long term) care settings. The faculty team was assisted by experts on various domains and/or interventions.

The improvement teams from the participating organizations were invited to attend four national conferences offering workshops and sessions in which questions could be posed to other teams or to experts. The improvement teams developed and executed their interventions under the guidance of process counselors. They used the PDSA cycle: carrying out small scale actions, measuring if the actions led to the expected outcomes, and, if not, adjusting the actions (Institute for Healthcare Improvement, 2003; Langley et al., 2009).

At the conferences, the program leader suggested some topics that might need improvement, like recruitment of volunteers providing activities for clients or more attention to intimate relationships and sexuality. However, the teams were largely invited to decide on the interventions themselves dependent on their type of clients, local context and local targets. Thus, clear-cut interventions from which teams could choose were not offered, in contrast to the Breakthrough philosophy that uses the notion of best practices to give more detailed instructions. The exact interventions are part of our analysis and some of them will be described in more detail in the results section.

Participating improvement teams and client population

Twenty-nine teams all from different organizations participated, 14 in a first round (November 2007 till November 2008) and 15 in a second round (March 2008 till March 2009). Each team was headed by a project leader and consisted of four to nine other team members.

As part of the Breakthrough philosophy of small scale testing, each team was asked to select and involve a small sample of clients from one ward or department, between 20 and 30 clients. Many of the teams came from organizations that delivered long term care to intellectually disabled or psychiatric clients. The clients involved usually lived in a form of sheltered housing or at a ward of the institution.

Data collection as part of the quality improvement project

As an essential element of the Breakthrough method, the faculty team chose outcomes indicators (clients' social network and level of loneliness) and set up a monitoring system for teams to assess their own progress. The teams themselves collected quantitative data on these outcomes indicators at two time points: at three months (baseline) and at 12 months (end measurement) after start of the improvement project.

Social network

Professionals and clients together had a conversation concerning clients' networks, targeted at drawing up a so-called network circle. This yielded the client's total number of social contacts. Furthermore, for a maximum of ten network members additional information was collected on category of contact (partner, family member, friend, acquaintance, colleague, neighbor, care giver, fellow client, other category) and frequency of meeting (daily, weekly, monthly, once a year or less, never).

Social loneliness

Level of loneliness was measured by the 11-item De Jong-Gierveld Loneliness Scale (de Jong Gierveld, Van Tilburg, & Dykstra, 2006; de Jong-Gierveld & Kamphuls, 1985). This scale has proved to be a valid and reliable measurement instrument for both emotional and social loneliness. The reliability of the scale in this sample at baseline was .86.

It appeared that two teams had not measured at all and that four teams had performed baseline measurements only: One team dropped out during the project, the others had other priorities or did not see the added value of an end measurement. The baseline loneliness scores of the clients of the latter four teams were not significantly different from those of the clients for whom both measurements were available (p=0.718). The total number of social contacts at baseline, however, significantly differed between these groups (mean 8.17 vs. 12.70; p=0.019).

Furthermore, 40% of all clients, relatively equally distributed over the teams, participated in the baseline measurement only and were not willing or able to participate in the end measurement. These clients tended to be less lonely, but not significantly, than those who participated in both measurements (mean 5.14 vs. 5.84; p=0.094). On the other hand, they had significantly fewer contacts at baseline (mean 10.52 vs. 13.67; p=0.009).

Quantitative data collection of the evaluation study

Effectiveness of the improvement project was estimated from the individual client data on the loneliness scale and on the network circle. For all clients for whom baseline and end-measurement data were available, mean changes from baseline to end-measurement were established by paired samples t-tests.

Apart from these data collected by the improvement teams, we ourselves collected additional quantitative data. All 29 project leaders received a postal questionnaire right after the closing conference (end-measurement T1). Seventeen (58.6%) completed and returned this questionnaire. Among other things, project leaders were asked to report on a selected set of improvement actions which we had compiled on the basis of our observations of the national conferences (see below for a description of these observations) and on the plans of actions and monthly reports of teams themselves. The QIC program leader confirmed that the set was complete. There were four response categories: we do not do this; we already did this; we do this better since Care for Better (CfB); this is new since the start of CfB.

Qualitative data collection

Also as part of our evaluation study, one of us made ethnographic observations at four of the eight national conferences, spread out over both rounds of the project (for each round, four conferences were organized). In addition, the program leader was interviewed face to face. Furthermore, one of us performed case studies on four improvement teams, selected on the grounds of observations at the conferences and on diversity in setting and client population (the precise interviews and observations done for these case studies are reported below). Two of the invited teams refused participation because they had other priorities. In the case studies, we focused on improvement actions rather than opinions, because it is the constellation of practices that leads to the construction of sociality (cf. Mol, 2008). All clients and professionals participating in the observations and interviews gave their consent.

Setting of the case studies

A: This organization managed psychiatric clients living in a form of sheltered housing, and clients living on their own but receiving support from care givers. Many of the clients had psychotic episodes or were diagnosed with schizophrenia. The project was directed at 25 clients. One of us interviewed the project leader, a head of a department and a team member.

B: This organization offered both ambulant care and sheltered housing for psychiatric clients. This team had two project leaders – an exception with the 'social participation' project. The project leaders were both involved in ambulant care but for this project had joined forces with care givers in the sheltered housing facilities. The project was directed at 28 clients from sheltered houses. The case study consisted of observing the 'network table' this team organized and of interviewing the project leaders.

C: This organization was a small organization offering ambulant care to children and young persons, often intellectually disabled and/or with a psychiatric diagnosis. Social participation was already the main aim of their work. The project involved 30 clients. The case study consisted of an interview with the project leader, an observation of a care meeting of several professionals, and an interview with the entire improvement team.

D: This organization delivered care to intellectually disabled clients, some of whom were also physically disabled. The clients lived either on the grounds of the institution or in houses spread over the town. The project involved 30 clients. The case study consisted of an interview with the project leader and an observation of a team meeting.

Qualitative data analysis

Usually the interviews could not be audiotaped because they took place in an informal setting (for example when walking around the institution). However, we took detailed field notes of the observations and the interviews. We used Atlas.ti to analyze the different approaches of constructing sociality. In an iterative process, the gathered material was coded. The emerging themes were refined several times by comparing them to the original text in a constant comparative method. Further refinement resulted from the writing process of the qualitative analysis and from discussions among the authors.

Results

Here, we first investigate whether the predefined goals of the 'social participation' improvement project were attained. Then, we explore what has been done to attain these changes by using both the improvement activities as reported in the survey and our qualitative data. As to the latter, we discuss two ways of constructing sociality: an individualizing approach and a normalization approach.

Results on predefined outcomes

The mean number of clients' contacts at baseline was 13.52 (sd 9.829); at the end measurement it was 13.95 (sd 10.049). The t-test revealed that the difference was not significant: t (180) = -1.078, .282. Hence, clients overall did not gain more contacts during the project.

Table 1 gives the categories of contacts at baseline and end measurement. In Table 1, the figures in the columns headed 'Mean' represent the mean number of times clients assigned a contact to the categories listed in the left-hand column. For example, the baseline figure

Table 1: Categories of clients' network contacts

Contact category	T0- baseline measurement N= 186			T1- end measurement N=186		
	Mean	St.d.	Perc.	Mean	St.d	Perc.
Partner	0.1505	0.35856	1.86%	0.1452	0.35321	1.84%
Family	3.1720	1.88378	39.12%	3.0215	1.84525	38.26%
Friend	1.4032	1.38868	17.31%	1.3871	1.38355	17.56%
Colleague	0.2796	0.63867	3.45%	0.3226	0.65200	4.08%
Acquaintance	0.6935	1.09429	8.55%	0.7527	1.04655	9.53%
Neighbor	0.2419	0.54083	2.98%	0.2634	0.48819	3.34%
Professional	1.6075	1.35237	19.83%	1.4247	1.34656	18.04%
Fellow client	0.2312	0.71682	2.85%	0.2204	0.64917	2.79%
Other	0.3280	0.66979	4.05%	0.3602	0.69308	4.56%

Legend: Categories of clients' network contacts: mean number of contacts per category, its standard deviation, and the percentages of each category of contact for family is 3.17, and accordingly clients assigned their network members on average 3.17 times to the category of family member. Both at baseline and end measurement family members formed the largest proportion of contacts (respectively 39.12% and 38.26%), followed by professionals and friends.

Table 2 shows the mean numbers of contacts with whom clients had daily or weekly contact. Clients had most contact with family members: a mean of 1.47 at baseline measurement, which decreased somewhat to 1.43 at the end measurement. Next came professionals and friends. For none of the categories there was a significant difference in frequency of contact between baseline and end measurement.

At baseline measurement the mean loneliness score on a scale from 1 to 11 was 5.81 (sd 3.21); at the end measurement it was 4.85 (sd 3.18). The t-test revealed that the decrease was significant: t (187) = 5.264, < .001. Hence, clients overall reported to be less lonely at the end of the project.

Table 2: Mean numbers of network contacts with whom clients have daily or weekly contact, per category

Contact category	T0		T1		T-test
	Mean	St.d	Mean	St.d	
Partner	0.1183	0.32381	0.1452	0.35321	t (185)= -1.675; p=0.096
Family	1.4731	1.53582	1.4301	1.42865	t (185)= 0.573; p=0.567
Friend	0.8387	1.01652	0.9409	1.17715	t (185)= -1.241; p=0.216
Colleague	0.2097	0.53435	0.2742	0.59282	t (185)= -1.672; p=0.096
Acquaintance	0.4355	0.88142	0.4731	0.88947	t (185)= -0.601; p=0.548
Neighbor	0.1720	0.45616	0.1613	0.39702	t (185)= 0.353; p=0.725
Professional	1.0484	1.14506	1.0860	1.15927	t (185)= -0.534; p=0.594
Fellow client	0.2043	0.63347	0.2151	0.63840	t (185)= -0.294; p=0.769
Other	0.1882	0.48998	0.2634	0.59770	t (185)= -1.571; p=0.118

Legend: Mean numbers of network contacts with whom clients have daily or weekly contact, per category; their standard deviation, and the t-test testing the differences between end and baseline measurement

We also tested the relation between the social network and the degree of loneliness, as an extension or deepening of the social network could be one possible explanation of the decrease in loneliness. For baseline measurement, there was a significant relation between the total number of contacts and experienced loneliness (r = -0.144, p=0.016). For the end measurement this relation disappeared (r = -0.118, p=0.126), possibly because the forty percent of clients for whom no end measurement was available had significantly smaller networks. Also the change scores for the loneliness scale and the total number of contacts were not significantly correlated (*r* =-0.98; p=0.202), so a change in the number of contacts did not correlate with changes in loneliness.

We then checked whether the frequency of contact was related to experienced loneliness. Indeed, a weak significant relation existed between the change score on the loneliness scale and the change score on the number of network members with whom clients had daily or weekly contact (*r* = -0.133, two-tailed p-value = 0.069). Hence, having more (daily or weekly) contact with network members was related to reduced loneliness.

Furthermore, we checked which categories of contacts contributed most to this relation between frequency in contact and degree of loneliness. For partners and friends an increase in frequency of contact showed the highest (but still a small) relation with the experienced loneliness. The correlation between the change score in having daily or weekly contact with partner and the change score on the loneliness scale was -.130 (two-tailed p-value=0.092); the correlation between change score on the number of friends with whom clients had daily or weekly contact and the change score on the loneliness scale was -.129 (two-tailed p-value=0.096). Hence, the frequency of contact, mainly with partners and friends, was associated with a reduction in loneliness.

In summary, this project was successful with regard to one of the proposed indicators for success, i.e. clients' loneliness, and this reduction in loneliness was associated with increased frequency of contact with partner and friends. We will now describe what has been done to attain these results and analyze what approaches to sociality were present in this project.

The improvement actions: different ways of constructing sociality

Table 3 gives an overview of the improvement actions that were carried out. A relatively large proportion of the 'new' interventions (reported in the last column) seemed to concern the neighborhood or community. Clients were encouraged to participate in community activities or the community was invited to participate in activities organized by the health care organization. Furthermore, the improvement actions more often than not were actions many teams already performed, rather than new activities learnt during the QIC.

In the next sections, we explore these improvement actions more in depth by studying how the improvement processes construct clients' social lives, i.e. sociality. Two different ways of constructing sociality emerged: individualization and normalization. The first approach brought with it two interrelated techniques, verbalization and enterprising.

Table 3: Improvement actions

Specific interventions:	We don't do this	We already did this	We do this better since CfB	New since CfB
Mapping clients' needs and wishes		13	4	
Improving clients' contact with friends/ family		11	6	
Deploy volunteers	2	11	4	
Deploy experts by experience	2	10	4	
Developing or adjusting an activities program	1	10	4	
Encouraging clients to take part in activities in the neighborhood		9	7	1
Offering activities for the community oneself	3	7	5	2
Finding clients a mate		13	4	
Getting (more) clients at the labor market	2	12	3	
Offering clients a training	2	8	6	1

Legend: Descriptives of project leaders who reported on the executed improvement actions; CfB = Care for Better (the name of the overall collaborative in which teams participated)

Individualization

Individualization refers to a way of conceptualizing and practicing the social that starts with individual clients and their wishes. In this project, it speaks from the performance indicators selected and from the measurements in individual clients. It also speaks from the way in which the program leader presented the project and the possible interventions at the starting conference. Suggestions ranged from improving contacts among clients living in the institution to having more attention for clients' intimate relationships and sexuality. However, the major recommendation was to ask for clients' wishes and to use these to develop an improvement plan, and not, for example to focus on sociability on the ward straightaway without first asking individual clients after their wishes.

The network circle was often used as a means to inform after clients' wishes and had to result in improvement actions aligned with those. In case study D, for example, a client had a hard time making and keeping friends. He and his care givers developed a strategy in which he was to stay for a drink after playing soccer, instead of going home immediately after the match was over. And so he did. Unfortunately the plan fell through, as his team mates all left after the match. Yet through the network circle interview, his care givers had realized he was not happy with his social network. This awareness led to other improvement actions –with positive outcome. In the end, this client was seeing friends more often and even celebrated New Year's Eve among friends.

In such improvement actions, the individual is the starting point for the social. "Everyone decides for him/herself what he/she wants with his/her social life," as the program leader strikingly articulated this way of constructing sociality. That is not to say that wishes cannot be co-constructed or that clients may not influence one another. In case study A, for example, some clients had gone on holiday and told the others enthusiastic stories, upon which the others wanted to go on holiday as well. But although in general clients could exchange wishes and ideas, the starting point for interventions was an individual client and an individual wish.

The individualization approach brought with it two different techniques, verbalization and enterprising, which together construct clients' social lives in a particular way. We refer to these concepts as 'techniques' because both professionals and clients may use them, whether or not explicitly or consciously, to construct clients' lives (and professionals' work).

Verbalization

Gathering knowledge in this project was an intervention in clients' lives at the same time as it enabled further intervention. The network circle interview for example could make clients realize that they had only few social contacts or that professionals were over-represented among the contacts. Being confronted with their "empty" social lives, as project leader A qualified the lives of some of his clients, might stimulate clients to do something about it. Thus, wishes can be constructed by talking about clients' social lives, as project leader D said. On the other hand, verbalization through the network circle interview sometimes led to less loneliness. One client was surprised to find out how big his network was and reportedly said: "why complain about being lonely at all?" Project leader A therefore said that the technique of verbalization made clients "redefine the concept of loneliness".

Likewise, one client of team A said he did not need any social contacts. Nevertheless he joined the special client meetings set up for the project and started wondering what lives his old school friends lived. Then, coming across the death announcement of one of those friends, he decided to go to the funeral. There he met some other old school friends with whom he re-established contact. The project leader said this was a good example of "the effect of talking about", as the client would never have gone to the funeral if he had not attended the meetings.

Social life thus became debatable. The technique of verbalization changed the way clients thought about and enacted their social lives. It spawned wishes and changed their repertoire of behaviour, sometimes without professionals having to formulate further improvement actions. Verbalization then, whether or not supported by measuring, was an intervention in itself: it changed the ways in which clients conceptualized their social lives and sometimes stimulated actions towards extending and deepening their social networks.

Enterprising

As another technique of individualization, clients were expected to become more responsible for their own social lives. In many cases they were also expected to take an active role themselves. This is what we refer to as a technique of enterprising.

An example of an improvement action in which the technique of enterprising was dominant was organizing a full day program for clients, for instance stimulating clients to find a job or volunteer work. However, not all teams considered this day program as 'social'. Two members of team D said that some of their clients were not willing to become social. These clients had a day program at the institution where they lived, but in the evenings only wanted to watch soaps and drink coffee. One team member said the daily program did not add much weight to the social lives of clients, because it was always the same group of clients they were doing their day program with. So because clients "are fixed to one place", as this team member said, and their activity level in that sense was not (conceived of as) very high, their social participation was also not perceived of as high. As they were not enterprising, they could not be social.

Conclusion of the individualization approach

Many improvement actions had individual clients as their primary focus. This individualization approach brought with it two interrelated techniques that professionals and clients used to construct clients' social lives in a particular way. These two techniques did not necessarily turn clients into verbalizing or enterprising subjects. Clients always are free to resist initiatives to construct their social lives. Indeed, some clients were not willing to participate in the network circle interview or in the project in general. Yet resistance was not the only way in which clients contributed to the way their social lives were constructed, it was not the only 'agency' clients had. For instance, they were often involved in deciding on the improvement actions. Moreover, through the network circle, professionals provided possibilities for clients to be agents themselves, instead of passive recipients of the improvement actions, as clients could tell about their wishes and the way they perceived and performed their social lives. By gaining more information about clients' networks and their perceptions, professionals also perceived clients in a different way, as they repeatedly said, and consequently found new ways of providing care. Hence, the individualization approach also ensured the conditions for clients to participate in the construction of their social lives and thus the conditions for clients to be agents themselves (cf. Moser, 2010).

Normalization

Next to individualization, normalization was a vividly present approach of constructing sociality. A good social life is one embedded in the 'normal community'. To illustrate this, we first turn to case study B. This improvement team organized seven 'network tables' in the first year of the project. One session was observed and is reported below:

The session is held in a community centre and attended by some fifteen people. There are four clients, professionals, a volunteer worker, a representative of a volunteer association, and a person offering Individual Placement and Support (IPS, getting clients (back) at the labour market).

A client who has joined the network table before is invited to tell what she would like to do. She says she would love to be a postman because "I'd like to have some more day activities." The professionals then ask her: "Do you want to deliver 'real mail' or are advertising brochures an option?" "Would you like to join the supported labour market or the real one?"

When it is clear what she wants, a brainstorming session starts. People come up with all options they can think of and in the end there are five options for the client to become a postman. She smiles and says she wants to join the real labour market, also because the person offering IPS says that joining the supported labour market is always an option later on. Her own care giver – who has joined today – and the IPS-person together make an appointment to really get this client to work. The client is also invited for this meeting.

According to the project leaders, these network table sessions have a definite advantage over a single care giver investigating clients' needs of clients: ideas come from different perspectives. This approach indeed met one of the main goals of this team: clients should have the same choices as other citizens, as one of the project leaders said.

Furthermore, participating in 'normal' activities was set as the ideal. In this light, it is telling that the participants represented society at large; not all of them were working in mental health care. Moreover, this client was encouraged to join the real labour market rather than the supported one that offers employees an adapted program.

Wishes put forward at the network table need not be directly related to clients' networks. Proposals ranged from singing in a band to taking a computer course. In teams using the network circle, such as team D, such wishes hypothetically could have been mentioned as well, but their clients' eye was drawn to the personal network instead of for example to activities. Thus, improvement actions can rest on the same principle – asking after clients' wishes – but may construct sociality in different ways. Although the network table also focused on individual wishes, the approach was still one of normalization rather than individualization.

Normalization also was concerned with clients having contact with the 'right' people. In case study A, some clients befriended fellow clients or joined an ice skating club for clients only. "This could well be a somewhat surrogate form of participation," the project leader said, implying there was a community out there that was more real and more valued than the community within. In this sense, clients were not seen as members of the community themselves because they did not count as real contacts for fellow clients.

The ideal then seems to be that clients should *become* 'normal' citizens and therefore are entitled to the same things – the same choices, the same possibilities for their social network – 'normal' citizens are entitled to. Every client is seen as a 'citizen in the make' and not as a full-fledged citizen (cf. Pols, 2006). 'Social' is understood as clients participating in (activities within) the general society, with 'normal' people.

Discussion

The aim of this chapter was to study the construction of sociality within a 'social participation' project and to interpret the consequences of the different ways of constructing sociality for the improvement project and for clients. We took a dual approach. The first was to investigate whether clients widened their social networks and became less lonely. It appeared that clients did not establish significantly more personal contacts during the project. Nevertheless, their loneliness ratings decreased significantly, which means they came to feel less lonely during the project. As demonstrated in the Methods section, the decline in loneliness seems not to be attributable to a bias in the composition of groups at baseline and end measurements.

Second, we articulated two different ways of constructing sociality. One was individualization: developing improvement actions based on a client's individual social situation and needs on social domain. This approach spawned two interrelated techniques: verbalization and enterprising. The other way of constructing sociality was one of normalization. These ways of constructing sociality did not necessarily affect clients' lives in the proposed way. Clients always had the freedom to resist. For example, some clients were happy with their "fixed" day program, which professionals might not find enterprising at all. Other clients were not willing to discuss their social networks and claimed they did not need any social contacts.

The quantitative and qualitative findings sometimes pointed in the same direction. The finding that clients began to feel less lonely during the project might be partly explained by the fact that they appreciated talking about their social lives and needs. Verbalization sometimes made them "redefine the concept of loneliness", as a project leader said. So the decrease in loneliness might partially be explained by the mere use of the instruments. But it may also be due to improved quality of relationships as shown, for example, by clients having more frequent contact with network members.

A further way in which the quantitative and qualitative findings pointed in the same direction is that the individualization approach could partly be deduced from the indicators for success on individual client level. By encouraging improvement teams to measure on individual level, faculty contributed to the individualization approach. In so doing, faculty had already somehow conceptualized the social and social participation. Thereby, improvement teams may have been framed to conceptualize the social in no other manner than locating it within individual persons. This effect might have been more pronounced because the measurement instruments had much influence on the improvement processes, despite the fact (or because of the fact) that faculty did not provide a list of interventions teams could choose from. So although faculty provided much room for teams to develop their own improvement actions, steering took place by use of the measurement instruments (Broer, Nieboer, & Bal, 2010).

Other approaches and techniques could not be deduced from the indicators. For example, the function of the network circle – and of the interrelated technique of verbalization – as an intervention in itself is not directly revealed by studying the outcomes. Furthermore, the analysis showed that improvement actions seemingly based on the same underlying principle could be expressions of different approaches. Asking after clients' wishes could express an approach of either individualization or normalization, dependent on how it was performed.

Many teams reported that their improvement actions were the ones they already did before the start of the project, and which they now had intensified. New improvement actions were scarce. This does not mean that improvement teams have not been doing anything at all. In the analysis above we have shown that teams *did* do other things, or if not changed the ways in which they performed these activities. For example, the network table of team B was a new activity and so was the network circle interview. These activities provided professionals and clients with new information and also with a new way of thinking about and performing social life.

Another contribution of the study of the approaches to sociality is that it enables a critical reflection upon the changes attained in the improvement project. For example, the finding that some improvement teams valued the outside community more than the inside community is one we may want to reflect upon. Some clients might not be able to participate in ‘normal’ community; devaluing their living place by not counting it as a ‘real’ community may then contribute to feelings of being excluded from normality (cf. Moser, 2005; Star, 1991).

Combining different methods to evaluate an improvement project thus proved to be valuable. It revealed aspects that would have gone unnoticed if the study had been restricted to the outcomes of the ‘social participation’ project. Therefore, we argue that a mixed methods approach in studying effectiveness is a fruitful addition to the quality improvement literature and evaluation research of quality improvement collaboratives.

However, as actual changes in clients’ lives could not be directly deduced from the ways of constructing sociality – for instance because clients always have the freedom to resist these approaches –, an interesting focus for future evaluation studies would be to also conduct a process evaluation of changes in clients’ behaviour. This means, not just investigating clients’ opinions on the changes, but also exploring how they come to think about, judge and act upon themselves differently during an improvement project, and investigating how these changes relate to the ways of constructing sociality or constructing clients’ lives in general.

References

Broer, T., Nieboer, A. P., & Bal, R. A. (2010). Opening the black box of quality improvement collaboratives: An actor-network theory approach. *BMC Health Services Research, 10*, 265.

de Jong Gierveld, J., Van Tilburg, T., & Dykstra, P. A. (2006). Loneliness and social isolation. In P. D. Vangelisti A. (Ed.), *Cambridge handbook of personal relationships* (pp. 485-499). Cambridge: Cambridge University Press.

de Jong-Gierveld, J., & Kamphuls, F. (1985). The development of a rasch-type loneliness scale. *Applied Psychological Measurement, 9*(3), 289-299.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* London: Penguin Books.

Hacking, I. (1986). Making up people. In T.C. Heller, M. Sosna and D.E. Wellbery (Eds), *Reconstructing individualism: Autonomy, individuality, and the self in western thought* (pp. 222-236). Stanford, Stanford University Press.

Hacking, I. (1999). *The social construction of what?*. Harvard: Harvard University Press.

Institute for Healthcare Improvement. (2003). *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement.* Cambridge MA: Institute for Healthcare Improvement.

Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The improvement guide: A practical approach to enhancing organizational performance.* New York: Jossey-Bass.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network-theory*. Oxford: Oxford University Press, USA.

Mackenzie, C., & Stoljar, N. (2000). Introduction: Autonomy refigured. In C. Mackenzie, & N. Stoljar (Eds.), *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self* (pp. 3-31). Oxford: Oxford University Press.

Mittman, B. S. (2004). Creating the evidence base for quality improvement collaboratives. *Annals of Internal Medicine, 140*(11), 897-901.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. London: Routledge.

Moser, I. (2005). On becoming disabled and articulating alternatives. *Cultural Studies, 19*(6), 667-700.

Moser, I. (2010). Perhaps tears should not be counted but wiped away. On quality and improvement in dementia care. In A. Mol, I. Moser & J. Pols (Eds.), *Care in practice. on tinkering in clinics, homes and farms* (pp. 277-300). Bielefeld: Transcript Verlag.

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry, 30*(1), 77-104.

Rose, N. (1998). *Inventing our selves: Psychology, power, and personhood*. Cambridge: Cambridge University Press.

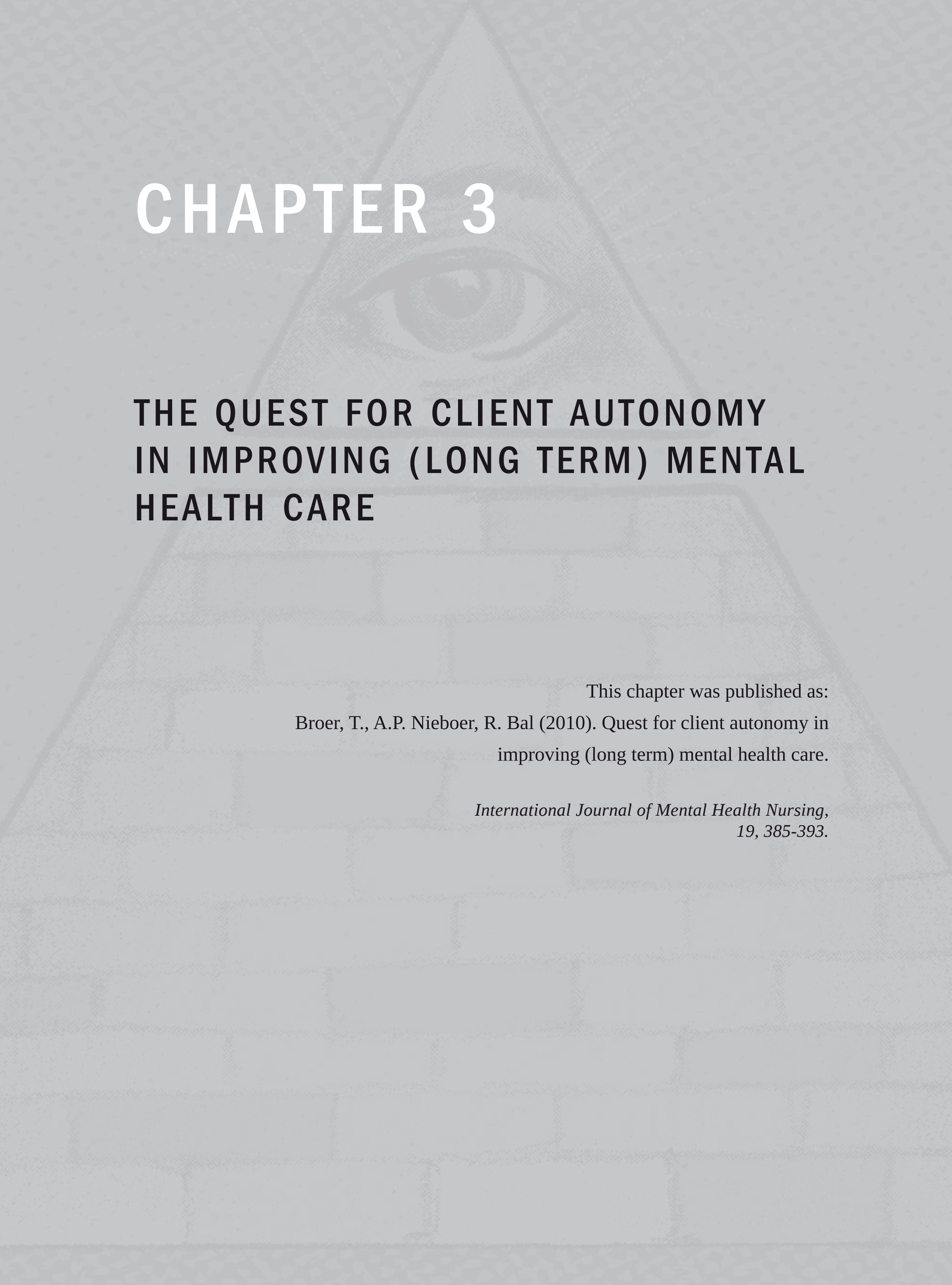
Schouten, L. M. T., Hulscher, M. E. J. L., Everdingen, J. J. E., Huijsman, R., & Grol, R. P. T. M. (2008). Evidence for the impact of quality improvement collaboratives: Systematic review. *British Medical Journal, 336*(7659), 1491-1494.

Star, S. L. (1991). Power, technologies and the phenomenology of standards: On being allergic to onions. In J. Law (Ed.), *A sociology of monsters: Essays on power, technology and domination* (pp. 26-56). London: Routledge.

Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

Wilson, T., Berwick, D. M., & Cleary, M. P. P. P. D. (2003). What do collaborative improvement projects do? Experience from Seven Countries. *Joint Commission Journal on Quality and Patient Safety*, *29*, 85-93.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine*, *69*(12), 1713-1721.



CHAPTER 3

THE QUEST FOR CLIENT AUTONOMY IN IMPROVING (LONG TERM) MENTAL HEALTH CARE

This chapter was published as:
Broer, T., A.P. Nieboer, R. Bal (2010). Quest for client autonomy in improving (long term) mental health care.

International Journal of Mental Health Nursing, 19, 385-393.

Abstract

The study's objective was to explore how mental health care professionals initiate, improve, and maintain client autonomy while improving other aspects of quality of care. We studied the (different) ways they approach autonomy and the dilemmas within them. As a methodology, we used the insights of Actor Network Theory that concepts cannot be predefined but are formed within specific situations and therefore should be studied by addressing the actors involved. Data was gathered by conducting ethnographic observations of national conferences of a quality improvement collaborative and by interviewing actors involved in the improvement practices. In a bottom-up analysis, four approaches to autonomy emerged: (1) professionals removed constraints to autonomy and passed initiative to clients; (2) professionals made an active effort to learn and support client preferences; (3) clients were given opportunities towards independent lifestyles; (4) professionals tried to 'normalize' their relationship with clients to encourage roles other than those of client. The study showed that autonomy is an important issue throughout the process of quality improvement. Articulating the different approaches to autonomy and the dilemmas in these approaches contributed to reflection on the concept and highlighted the limits of the concept within a mental health care setting.

Introduction

Within (mental) health care, autonomy has gained increasing attention (Harnett & Greaney, 2008; Tauber, 2001). Although an increasing body of literature describes the different forms autonomy can take – both as a theoretical concept (Tauber, 2001) and in the way it plays out in different practices (Pols, 2006; Schermer, 2001) – the dilemmas occurring within a particular conceptualization of autonomy remain relatively unexplored. Here we will follow professionals' endeavours to maintain or improve their clients' autonomy while improving other aspects of quality of care. We unravel different conceptualizations of autonomy and, when relevant, different dilemmas within these conceptualizations. Before exploring the approaches and dilemmas, we will briefly discuss the relevance of the autonomy concept and the way it is discussed in (mental) health care.

In general, researchers find that autonomy contributes to subjective well being (Diener, 1984; Nieboer, Koolman, & Stolk, 2010; Owusu-Ansah, 2008; Reis, Sheldon, Gable, Roscoe, & Ryan, 2000; Van Bruggen, 1998), although opinions vary on the universality of the need for autonomy (Diener, Oishi, & Lucas, 2003). In such studies, autonomy is usually defined in terms of 'perceived control' over one's life circumstances. In this definition, control is thus both attaining certain goals and attributing the outcomes to one's own actions instead of, for example, to luck (Grob, 2000; Schulz & Decker, 1985).

The importance of autonomy notwithstanding, many authors argue that maintaining or improving client autonomy poses problems within mental health care settings. First, it is often related to making one's own decisions and one of the 'problems' of many mental health care clients is exactly that they (are perceived to) have difficulty making decisions (Dekkers, 2001). Second, because some symptoms of mental illness do not tally with rational thinking and decision making, some choices clients make may not be deemed justified or beneficial and effort may then be put in creating 'choices' that correspond to caregivers' ideas (Velpry, 2008). Third, involuntary treatment is sometimes deemed necessary in mental health care settings (Harnett & Greaney, 2008; Sjöstrand & Helgesson, 2008).

However, what is seen as problematic – for example involuntary treatment – is also dependent upon the particular conceptualization of autonomy (Verkerk, 2001). The autonomy concept has been defined in diverging ways in different disciplines (Tauber, 2003). Within health care, for example, discussions prevail between justice ethics and care ethics, each of which defines autonomy differently. Justice ethics is based on a set of principles that includes respect for autonomy, defined as "respecting the decision-making capacities of autonomous persons" (Beauchamp & Childress, 1994 pp. 12). Care ethics on the other hand defines autonomy as a relational concept that may include interference from caregivers against clients' will. In care ethics, building a personal relationship with clients is more important than applying impersonal values to everyone (Verkerk, 2001). Whereas care ethics goes one step further than justice ethics by situating moral dilemmas within care practices themselves (Gremmen, Widdershoven, Beekman, Zuijderhoudt, & Sevenhuijsen, 2008), it generally still defines autonomy in a certain way, i.e., relationally.

Although we argue that such reflections on (the definition of) autonomy offer valuable insights, here we do not predefine the concept but follow how professionals perform the concept, whether there are differences in performance between different practices, and whether these differences lead to different dilemmas for professionals striving for client autonomy. As a methodology, we draw on Actor-Network Theory (ANT). An ANT-perspective suggests not to talk about concepts as detached from the practices in which they are used but rather to investigate how the actors involved form the concepts within these practices (Latour, 1987; Latour, 2005; McMaster, Vidgen, & Wastell, 1997; Mol, 2008). In drawing on ANT, researchers "follow the actors" and analyze their performance and how they define what is going on (Latour, 1987).

For example, Pols (2006) drew partly on ANT in studying citizenship – specifically, participation in community – within long term mental health care. By focusing on different ways of washing clients – for example, trying to make clients wash themselves or asking what clients prefer in the washing process – she articulated four different ways of washing that were expressions of four different forms of citizenship. Three of these repertoires were related to a conceptualization of autonomy, be it autonomy as privacy, as independence, or as self-actualization. A fourth repertoire defined citizenship not in terms of autonomy but rather in a social way. Hence, different ways of 'doing' something as 'simple' as washing may indicate different conceptualizations of a complex notion, such as citizenship.

By drawing on an ANT perspective, we formulated several assumptions for studying autonomy. First, autonomy cannot be defined without addressing actors involved in shaping the concept. Second, autonomy can be conceptualized in different ways by looking at different practices. Even if all agree on a particular definition of autonomy, the way it is performed in different practices may still be different. Furthermore, we assume that a particular conceptualization of autonomy also leads to specific dilemmas; hence what professionals see as problematic is partly defined by the particular conceptualization of autonomy they uphold and act out.

We use these assumptions as a starting point to explore the concept of autonomy within a quality improvement collaborative (QIC) (see below). In quality improvement practices, professionals set out to improve care in certain areas but at the same time may feel the need to avoid interfering in clients' lives, for interfering, as Verkerk (2001) argues, is often seen as the opposite of client autonomy. We explore how professionals approach client autonomy and frame the relevant discussions, and what dilemmas they encounter in striving for or maintaining client autonomy while improving other aspects of quality of care. The main research question is: how is client autonomy conceptualized and approached within a (long term) mental health care QIC, and to what dilemmas does the conceptualization lead?

In the following, we first outline the study's setting and methodology. Then we describe four approaches to autonomy articulated by studying the QIC, respectively: removing constraints, learning individual preferences, enhancing independence, and creating different social roles. Last, we reflect upon implications of the study and how discussions surrounding autonomy are often framed.

Methods

Participants and setting

QICs are increasingly used as means to improve health care. Within QICs, improvement teams from different organizations work together to improve care within a certain area and timeframe (Kilo, 1998). Typically, a structured way of improving is outlined with elements such as national conferences, Plan-Do-Study-Act (PDSA) cycles, and expert knowledge input (Institute for Healthcare Improvement, 2003).

Recently, a large QIC called 'Care for Better' was carried out in the Netherlands. One component of this collaborative consisted of four improvement projects set up for (long term) mental health care (i.e., institutions or sheltered housing) and these projects were the focus of our study.

The first improvement project, 'social participation', aimed at making clients feel less lonely by enlarging and enriching their social networks. Improvement teams investigated the social networks of individual clients and, often based on wishes of clients themselves, tried to improve them by, for example, supporting clients in visiting old friends. A project called 'not only the mind but also the body' set out to improve the clients' physical health by monitoring blood pressure and weight and encouraging healthy diets. The project entitled 'recovery-oriented care' was devised to give clients more control over their lives, in relation to the recovery movement that aims toward empowerment and participation in the community of mental health care clients (Anthony, 1993; Deegan, 1988). Improvement teams tried, for example, to give clients the opportunity to exercise more control over their living space. The last project, 'social psychiatric care', was to improve outreaching care, which aims at establishing contact with those who avoid care but are thought to need it. Here improvement teams primarily tried to improve organizational collaborations (housing associations, for example) to support clients in attaining better life conditions.

Every project comprised two rounds. In every round, seven to fifteen improvement teams participated, each of which had four to nine members and a project leader. Each project also had a faculty team consisting of a group of experts, the program leader, and usually one or more ‘process counsellors’. Four national working conferences were organized during each round where the teams received recommendations about project content and improvement processes.

Data collection

We observed the proceedings of eighteen conferences of the mental health care projects, within the context of the larger evaluation study of the QIC (Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008; Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009). During the first observations, autonomy emerged as an important theme in the quality improvement process in all projects. Some improvement teams formulated improving client autonomy as their first improvement goal. Other improvement teams wanted other improvement goals, like a healthier lifestyle of clients, not to go against clients’ autonomy and preferences. In all the projects, what needed improving, how that should happen, who performs the projects and who determines if they have worked were generally decided by improvement teams or the health services and these decisions were thus not normally structured around the preferences and priorities of clients, except in instances where professionals have deliberately sought clients’ advice and the development of the plan and improvement actions have flowed from this. This is one reason why autonomy posed a problem for professionals participating in the projects. One of the strengths of doing observations is that researchers are able to explore concepts and situations that the actors themselves defined – implicitly or explicitly – as important so that, instead of superimposing an autonomy framework on existing projects, we could try to stay close to the issues improvement teams were struggling with in their respective practices.

Because autonomy emerged as an important theme, we decided to explore the concept further by attending the remainder of the conferences (of the eighteen that were observed) and observing a selection of improvement teams in-depth. One author initiated six case studies of one or one-half day, with six teams distributed over the four projects. She observed the teams’ processes and carried out five interviews with project leaders, two with team members and two with middle managers. Autonomy was always a topic although not the only one. The interviews were recorded and transcribed verbatim where possible; where not possible or even desirable (strolling on-site interviews, for example), they were captured by detailed field notes. A disadvantage of the note-taking approach was that not all remarks were saved for analysis, but walking around the site had the strong advantage of giving the researcher the opportunity to ask more situation-specific questions. Apart from the interviews, process observations included one team meeting, two care meetings concerning care plans and treatment, and five on-site care or improvement practices. All respondents consented to the interviews and observations.

Data analysis

Hence, the data gathered in large part represented discussions among professionals at national conferences or at team meetings, and descriptions of situations from a professional perspective. We used the observations and interviews to study different approaches to autonomy and the dilemmas involved in these approaches. The gathered material was coded iteratively. Emerging themes were refined several times by comparing them with the original text in a constant comparative method. The themes were incidentally refined by the writing process of the qualitative analysis. In the following sections, we describe the four approaches to (improve) autonomy revealed by this bottom-up analysis. There is no hierarchical order in the presentation, and no approach is a priori (morally) privileged.

Results

The approaches emerging from the bottom-up analysis of observations and interviews were (1) removing constraints, in which ‘constraining’ elements within mental health care were eliminated to give clients the opportunity to take initiatives themselves; (2) an active effort to discover and support clients’ individual preferences, wishes, and choices; (3) encouraging more independent lifestyles; and (4) creating different social roles, in which professionals initiated more informal contact with clients to elicit more repertoires of behaviour than the one of being a mental health patient.

1. Removing constraints

One conceptualization of autonomy within the mental health care improvement projects presented itself mainly in the ‘recovery-oriented care’ project and concerned clients’ initiatives. Professionals wanted to give clients opportunities to control their own lives, but this goal was often (perceived as) paradoxical, because the wish to have more control and become more autonomous was not necessarily shared by clients themselves. The paradox was highlighted by the project's faculty. Within the recovery movement on which the project was partly based the professionals' role was not very clear because recovery – and becoming more autonomous – is something clients must do for themselves. Ideally professionals only create the preconditions for recovery to occur.

When faculty expressed these ideas at a national conference, professionals reacted in diverging ways. One project leader said she was in a dilemma. On one hand she wanted to help see her clients recover; on the other she felt that the project required her to be removed from the recovery process. In a different session a project leader said smilingly: "For me that's the most intriguing part of this project: the challenge to leave the initiative to clients." His team had invented various interventions to 'recover' their clients, but then realised it would be a form of forced rehabilitation. (Rehabilitation is sometimes perceived as a precursor of the recovery movement and aims at clients participating in community and attaining their life goals, but in the rehabilitation movement professionals are expected to take the lead in the process (Anthony, 1993)). The team thus changed their course and studied the negative impact professionals could have on clients and investigated which ward rules were perceived as restraining by clients.

Rules were criticised at many of the conferences by other teams as well, and classified as 'restraining elements' within mental health care. Examples were the locked refrigerator, no visitors after 10 PM, and waking all clients in the morning at the same time. Here autonomy was conceptualized as being free from restraining elements and thereby giving people control over their own lives and initiatives.

The nurses' office was another restraining element that was criticised by both professionals and clients. Clients at one institution often reproached nurses for not being available, said a project leader. Nurses could close their doors and ask calling clients to come back later. In one institution, clients came up with the idea of breaking down the office, and indeed this was eventually done by professionals and clients together. One client reportedly said, "You've been sitting there [in the office] for an hour talking about us, and you haven't come to see me all day. How come?" The sight of caregivers laughing and talking behind the glass wall made clients suspicious; they often thought caregivers were laughing at them. Breaking down the nurses' office aimed to ensure a more natural presence of caregivers at the ward, which improvement teams thought would function as an invitation for clients to talk with professionals and thus give initiative back to clients. The 'open office' (the one that had been broken down) had different effects. As reported by the project leader, for some clients it worked well, and they were happy to walk into the former office and join the professionals having coffee. Others came no nearer than where the door used to be. Still others disliked the new situation because they were accustomed to the door being closed.

Changing ward rules and opening the office were two examples of removing constraints within mental health care. This form of autonomy gave clients more space and opportunity to live as they preferred not to be controlled by nurses and/or a strict regime. Clients could act out their preferences and were allowed to do so at will. The only actions of professionals in this process were to assure that nothing would stand in the clients' way and that they were available if clients wanted to talk with them.

2. Learning individual preferences

A second way of approaching client autonomy was to increase choices by asking about clients' preferences or by offering them options to choose among. Although the elimination of constraints as discussed above was partly meant as an invitation for clients to talk about their wishes, they were often reluctant to respond. In many cases, affording space was not enough to make clients use it. As one project leader said, "If we don't shake the tree, nothing will happen". Therefore, teams made an active effort to learn clients' preferences.

The preferences could be at the daily living level by, for example, offering clients a choice in meals or furnishings. Long-term preferences were also considered, like swimming with dolphins in Florida, getting a job, or enrolling in a computer course. Sometimes a domain was specified, like when one team wanted to give clients opportunities to influence their living space. An expert, however, objected to this because clients might opt not to live at the institution, and then the colour of the wallpaper does not matter to them at all. Choices, as was often mentioned, had to be relevant for clients.

In the process of asking about preferences or giving clients more choices, professionals faced dilemmas like, for example, when some clients maintained not to have any wishes. "How long will you go on pushing them?" one team member asked. Another dilemma was that professionals sometimes thought the choices clients made were not beneficial. For example, what to do if clients aspired for something outside their reach as defined by caregivers? Did clients have to state only goals they could surely attain or were all goals welcome?

One way of actively shaping the preferences of clients to a way deemed beneficial for their well-being was pointing to clients' responsibility for their own lives. A nurse stated that forced injections were not necessarily required if clients refused to take their medication. Perhaps by pointing out the benefits of the drugs, clients could be made responsible for their own well being, the nurse suggested. This would also help, another nurse added, to keep a good relationship as forced injections can endanger the caring relationship.

Another way of proposing direction for clients was “acting the curious caregiver”, as a team member of the ‘not only the mind but also the body’ project brought forward. She was trying to get clients to exercise regularly and eat healthfully, but did not want to force them. One client for example was a former military man known to have been extremely healthy. The team member thus asked him about his earlier lifestyle, hoping he would realise its value and remember that he used to value it as well. The client was not interested in participating, however, partly because he was convinced that a healthy life style would lead to his death. The nurse attributed this to schizophrenia.

Therefore, while learning client preferences, professionals had to ascertain if a client’s view was genuine or rather a symptom of mental illness (cf. Velpry, 2008 for a similar analysis). The paradox was that only after a choice was made and its outcome revealed could anyone judge whether a choice was really a choice. If the client had been convinced that consuming less fatty food was healthy, for example, professionals would not have used schizophrenia to explain his stance and they would perceive it as a ‘real’ choice.

In sum, the initiative to learn clients’ preferences was taken up by professionals and not, as in the first form of autonomy, given to clients. Dilemmas and discussions concerned situations in which clients had no preferences or when the preferences were not deemed good for the clients’ well-being. In these situations, professionals often played a more active role in shaping the wishes or their outcome.

3. Enhancing independence

A third approach toward improving autonomy was to enhance clients’ independence by, for example, making them organise their own social lives in the ‘social participation’ project or making them more independent in eating healthy food in the ‘not only the mind but also the body’ project. Dilemmas arose within this approach, too. We will illustrate the approach and some of its dilemmas by an improvement action of a team participating in the ‘recovery-oriented care’ project.

As one team action toward independence, clients were encouraged to move from the ward to private apartments on the grounds of the institution. One dilemma toward autonomy however was encountered when giving medications. At first, when caregivers rang their doorbells, clients came to the door promptly and took their medication. After a while, some clients became reluctant to come to the door. Some did not even open it altogether. The professionals, waiting outdoors, sometimes in bad weather, were tempted to let themselves in with a master key, but realised that clients, seeing that it made no difference, would then not be motivated to open the door at all the next time.

The improvement team questioned this situation. Clients had to be proud of their own domain and to regard it as theirs. The professionals therefore were instructed to be patient, especially when clients were quite capable of responding to the bell. Clients who refused to open the door were instructed that it is normal to open it when someone rings the bell. Professionals were thus always able to access clients by using their master key, however, they wanted their clients to open their doors independently and to behave 'normal'. In this example autonomy was thus having one's own domain and regarding it as such, and being independent even if residing on the grounds of an institution.

To sum up, in this approach to autonomy professionals tried to improve clients' independence, but clients did not always behave independently. Thereby, clients' actions and preferences were sometimes overridden. Independence was thus seen as more important than clients' preferences, and as such this approach was different from removing constraints or seeing to individual preferences.

4. Creating different social roles

The last approach to autonomy manifested mostly in the 'social participation' and 'recovery-oriented care' projects. Professionals focused on their relationship with clients and actively changed their own roles to elicit repertoires of behaviour other than the 'mental health care patient'. The idea was for professionals to take an equal position in the relationship with clients. "Clients have difficulty acting normally," a team member said, "and we are busy contributing to that." For example, even on a beautiful day many clients stay glued to the couch. "Take them out to a terrace in town, and you'll see a remarkable change in behaviour," a team member stated. But often we do not realise, he continued, that our behaviour in this situation is different as well, because the usual contact takes place within the institution. The project leader said that clients appreciated contact that was more informal.

It was argued that by approaching clients as patients and positioning themselves as caregivers, the role of 'client' would be confirmed; the ideal here was to get them out of this limited role. Within the 'social psychiatric care' project this approach was sometimes referred to as engaging in a "professional friendship". The social psychiatric care professionals said they needed to establish such a professional friendship because most of their clients would not at all be willing to talk with them should they position themselves as professionals.

It was also frequently mentioned that mental health care focused on problems rather than possibilities. Even clients themselves sometimes had a “problem-oriented” focus, according to some professionals. By taking into account only sickness and difficulties, many possibilities remain closed. For example, a client’s history does not always come up in conversation: “Treatment usually focuses on the here and now,” a project leader explained. Therefore, the Electronic Client Record (ECR) posed a dilemma for professionals performing this approach to autonomy, because the ECR in many institutions reportedly only asked for clients’ problems and not for their possibilities. The problem-oriented focus was thought to contribute to the ‘sick’ role and close down other roles and identities clients might have or develop. Autonomy here was conceptualized as being able to be more than just a client, and professionals tried to elicit different roles by acting in a less ‘professional’ way.

Another dilemma for team members was that they began to realise that their enthusiasm could prevent clients from undertaking activities. For example, when clients involved in the ‘social participation’ project identified a person who was important to them – thereby giving professionals an opening to improve a client’s social network – immediate action could be devastating. Many clients are afraid of obligations, a project leader explained, and they usually see all kinds of disadvantages related to activities. So the approach seemed to require a delicate balance between creating different social roles for clients and not overwhelming clients by becoming too enthusiastic.

To create more roles for clients, some teams actively attempted to create an informal client network, sometimes against the will of clients. For example, a leader in the ‘social participation’ project explained that sometimes clients insisted they did not want contact with family and vice versa. He said that nurses used to take their statements for granted and did not make further attempts to establish contact. After the start of the project, however, the teams’ professionals became more assertive in contacting family, and clients were ultimately happy with the regained contact, as the project leader reported.

To summarize, the focus of this approach to autonomy was to create roles for clients outside of a ‘mental health care patient’, thereby encouraging them to explore their potential. This was related to autonomy because professional behaviour was perceived as constraining clients in their repertoires of behaviour. Professionals changed their behaviour to ‘free’ clients from their client role. Therefore, this approach to autonomy is related to the one of removing constraints. Yet in producing autonomy by removing the constraints, no direct activity of professionals was allowed, whereas in focusing on social roles professionals had to take up an active role.

Discussion

In the mental health care projects of the Care for Better QIC, four approaches to autonomy came to the fore. In the first, clients were encouraged to take initiatives while professionals stepped to the side, removing elements that might prevent clients from acting on their preferences. This was a solution to the dilemma of wanting but not forcing their clients to take initiatives.

In the second, professionals took a more active role and asked about clients' preferences or offered them options such as when and what to eat. Dilemmas and discussions concerned situations in which clients had no wishes at all or when the preferences were deemed harmful to the clients' well being. In these situations, professionals often took up a more active role in shaping the wish or its outcome.

In the third, independence was improved by, for example, clients moving into private apartments on the grounds of the institution. Clients had to learn to become independent and to live in a 'normal' way on their own, even when this led to situations in which clients' preferences had to be overridden.

The last approach involved equalising the relationship between caregivers and clients. The ideal was for clients to have roles other than those of a mental health care patient. Although autonomy is not always framed in terms of relationships (as some of the other approaches in this study demonstrated), improvement teams regarded this approach – explicitly or implicitly – as a way of making room for individuality and eliciting different repertoires of behaviour, and they perceived their usual way of working as restraining clients in this process.

In all the four projects autonomy was mentioned to greater or lesser extent. However, in the 'social psychiatric care' project it was hardly mentioned, except when professionals described their work as 'engaging in a professional friendship' with clients, which can be seen as creating other roles for clients than just the one of client. That autonomy came up only infrequently in 'social psychiatric care' may be ascribed to the fact that many improvement teams in this project established goals not directly on the client level but on the level of collaboration with other organizations. Alternatively, the social psychiatric care professionals might be in a frame of mind in which the good of interference is not questioned at all, for the very nature of their work is interfering in the lives of people who do not welcome it.

Many teams in the various projects were opting for more than one form of autonomy depending on the client or improvement action. Opting for different forms is probably advisable when the aim is to improve client autonomy because one particular form may be ineffective in certain circumstances or with certain clients. For example, focusing only on removing constraints could well lead to a situation in which clients fail to use the space that is created. Having more approaches at hand allows applying the one most suitable to the client, improvement action, or situation.

Another reflection upon the different approaches is that every approach asks for professionals to interfere in the lives of clients. Stepping aside, in this respect, does not work as non-interference, but constitutes a different way of interfering. Our analysis furthermore showed that improving or changing the relationship with clients can also be a goal within an autonomy framework. This finding may enrich discussions on autonomy, which often do not take into account relational approaches (Verkerk, 2001). More attention to relational approaches may transform or reconceptualise the dilemmas professionals within mental health care face; the discussion does not necessarily have to focus on interfering or not interfering.

Furthermore, by articulating the dilemmas professionals encountered within the different approaches, the limits of the autonomy concept became more visible, at least within the mental health care setting. For whatever reason, clients had sometimes difficulty performing the behaviour that professionals deemed ‘autonomous’ in the various approaches. The study thereby contributes to a reflection on the desirability of the widespread use of the autonomy concept, without aiming to disregard the concept altogether.

Conclusion

Our study showed that autonomy is an important issue throughout the process of quality improvement in mental health care and may bring about different (moral) dilemmas. It also revealed that autonomy cannot be conceived of as a purely prescriptive concept. While the concept hints at how to behave as a professional, the actual performance of autonomy cannot be deduced directly from a particular conceptualization or the concept in general. Therefore, an empirical approach in studying autonomy allows us to follow how professionals conceptualize autonomy and to identify moral dilemmas in specific care situations. Articulating the different dilemmas that arise in striving for client autonomy – especially in a mental health care setting – also highlights the limits of the concept. Our study thus contributes to a (different) reflection of autonomy and the widespread use of the concept.

The aim of the study was to describe the approaches to autonomy and the dilemmas professionals faced within these approaches. In the study, however, we rarely consulted clients and rarely observed actual care practices; we have instead discussed many practices as seen from a professional perspective and moral dilemmas as framed by the actors themselves. The effects of the various ways of approaching autonomy on care practices and clients’ lives would be an interesting focus for future research.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*, 11-23.

Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics*. Oxford: Oxford University Press.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Dekkers, W. J. M. (2001). Autonomy and dependence: Chronic physical illness and decision-making capacity. *Medicine, Health Care and Philosophy, 4*(2), 185-192.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, *95*, 542-575.

Diener, E., Oishi, S., & Lucas, R. E. (2003). Personality, culture, and subjective well-being: Emotional and cognitive evaluations of life. *Annual Review of Psychology, 54*(1), 403-425.

Gremmen, I., Widdershoven, G., Beekman, A., Zuijderhoudt, R., & Sevenhuijsen, S. (2008). Ulysses arrangements in psychiatry: A matter of good care? *Journal of Medical Ethics*, *34*(2), 77-80.

Grob, A. (2000). Perceived control and subjective well-being across nations and across the life span. In E. Diener, & E. M. Suh (Eds.), *Culture and subjective well-being.* (pp. 319-339). Cambridge, Mass.: MIT Press.

Harnett, P. J., & Greaney, A. M. (2008). Operationalizing autonomy: Solutions for mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing, 15*(1), 2-9.

Institute for Healthcare Improvement. (2003). *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement.* Cambridge MA: Institute for Healthcare Improvement.

Kilo, C. M. (1998). A framework for collaborative improvement: Lessons from the institute for healthcare improvement's breakthrough series. *Quality Management in Healthcare, 6*(4), 1-13.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge, Massachusetts: Harvard University Press.

Latour, B. (2005). *Reassembling the social: An introduction to actor-network-theory*. Oxford: Oxford University Press, USA.

McMaster, T., Vidgen, R. T., & Wastell, D. G. (1997). Technology transfer: Diffusion or translation? In McMaster T. (Ed.), *Facilitating technology transfer trough partnership: Learning from practice and research* (pp. 64-75). London: Chapman & Hall, Ltd.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice*. London: Routledge.

Nieboer, A. P., Koolman, X., & Stolk, E. A. (2010). Preferences for long-term care services: Willingness to pay estimates derived from a discrete choice experiment. *Social Science & Medicine, 70*(9), 1317-1325.

Owusu-Ansah, F. E. (2008). Control perceptions and control appraisal: Relation to measures of subjective well-being. *Ghana Medical Journal, 42*(2), 61-67.

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry, 30*(1), 77-104.

Reis, H. T., Sheldon, K. M., Gable, S. L., Roscoe, J., & Ryan, R. M. (2000). Daily well-being: The role of autonomy, competence, and relatedness. *Personality and Social Psychology Bulletin, 26*(4), 419-435.

Schermer, M. (2001). The different faces of autonomy. A study on patient autonomy in ethical theory and hospital practice. *Ridderkerk: Ridderprint BV.*

Schulz, R., & Decker, S. (1985). Long-term adjustment to physical disability: The role of social support, perceived control, and self-blame. *Journal of Personality and Social Psychology, 48*(5), 1162-1172.

Sjöstrand, M., & Helgesson, G. (2008). Coercive treatment and autonomy in psychiatry. *Bioethics, 22*(2), 113-120.

Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

Tauber, A. I. (2001). Historical and philosophical reflections on patient autonomy. *Health Care Analysis, 9*(3), 299-319.

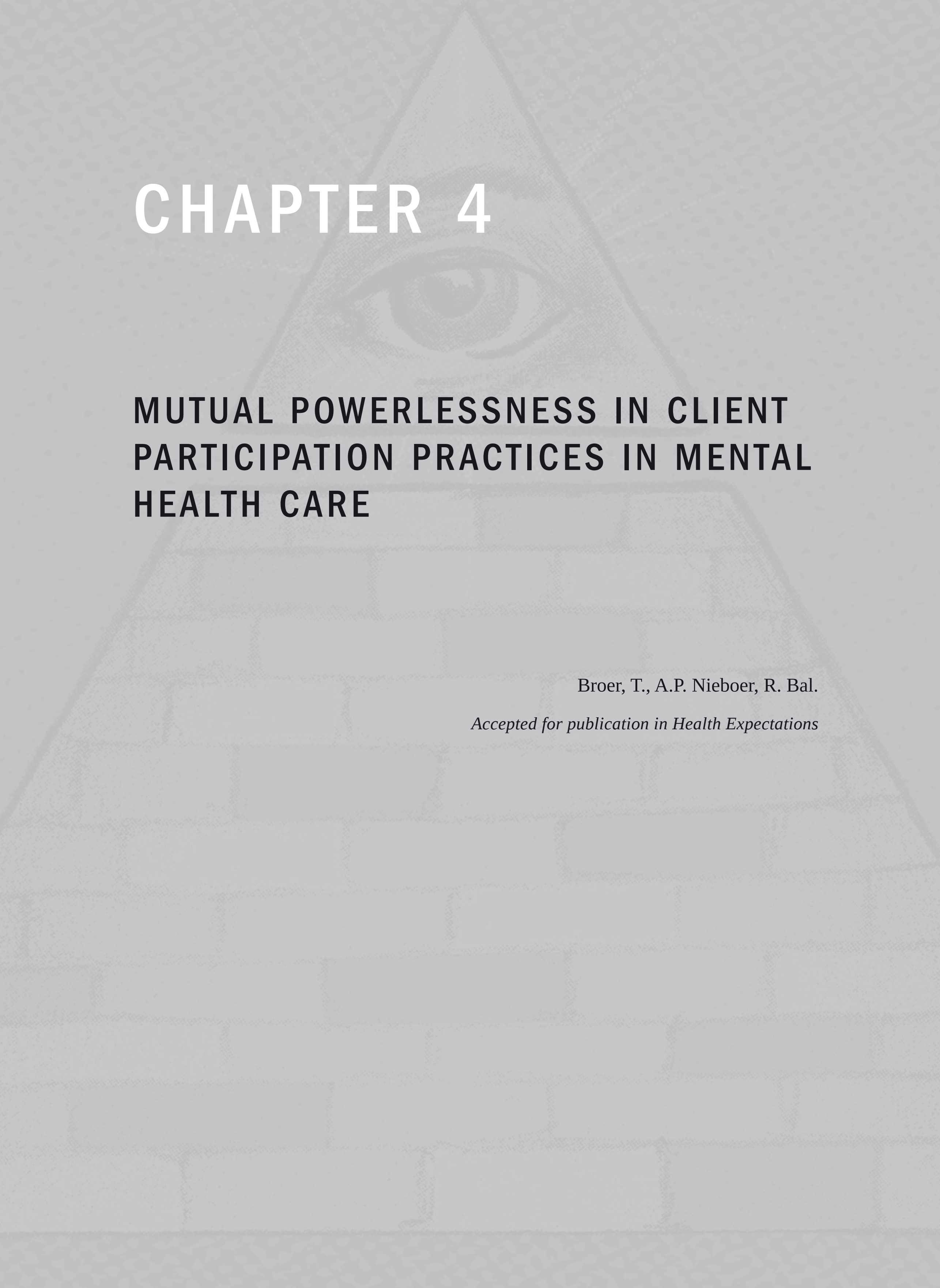
Tauber, A. I. (2003). Sick autonomy. *Perspectives in Biology and Medicine, 46*(4), 484-495.

Van Bruggen, A. C. (1998). *Individual production of social well-being: An exploratory study.* Groningen: Interuniversity Center for Social Science Theory and Methodology.

Velpry, L. (2008). The Patient's view: Issues of theory and practice. *Culture, Medicine and Psychiatry, 32*(2), 238-258.

Verkerk, M. A. (2001). The care perspective and autonomy. *Medicine, Health Care and Philosophy, 4*(3), 289-294.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine, 69*(12), 1713-1721.



CHAPTER 4

MUTUAL POWERLESSNESS IN CLIENT PARTICIPATION PRACTICES IN MENTAL HEALTH CARE

Broer, T., A.P. Nieboer, R. Bal.

Accepted for publication in Health Expectations

Abstract

Background: Client participation has become a dominant policy goal in many countries including the Netherlands and is a topic much discussed in the literature. The success of client participation is usually measured in terms of the extent to which clients have a say in the participation process. Many articles have concluded that client participation is limited; professionals often still control the participation process and outcomes.

Objective: The objective of this study is to gain insight into (1) the practice of client participation within a quality improvement collaborative in mental health care and (2) the consequences of using Foucault's conceptualization of power in analysing practices of client participation.

Design: We used an ethnographic design consisting of observations of national events and improvement team meetings, and interviews with the collaborative's team members and program managers.

Results: Contrary to many studies on client participation, we found both clients *and* service providers frequently felt powerless in its practice. Professionals and clients alike struggled with the contributions clients could make to the improvement processes and what functions they should fulfil. Moreover, professionals did not want to exert power upon clients, but ironically just for that reason sometimes struggled with shaping practices of client participation. This mutual powerlessness (partly) disappeared when clients helped to determine and execute specific improvement actions instead of participating in improvement teams.

Conclusion: Recognizing that power is inescapable might allow for a more substantive discussion concerning the consequences that power arrangements produce, rather than looking at who is exerting how much power.

Introduction

Client participation has become a dominant policy goal in many countries including the Netherlands (Van de Bovenkamp, 2010) and is a topic much discussed in the literature (cf. P. Anthony & Crawford, 2001; Crawford et al., 2002; Pilgrim & Waldron, 1998; Robert, Hardacre, Locock, Bate, & Glasby, 2003; Rush, 2004; Rutter, Manley, Weaver, Crawford, & Fulop, 2004; Stickley, 2006; Van de Bovenkamp, Trappenburg, & Grit, 2009; Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009). The success of client participation is often measured in terms of the extent to which clients actually have a say in the participation process. Arnstein's participation ladder, for example, describes a continuum of participation ranging from being informed to complete control (Arnstein, 1969). Also discourse analyses often focus on the extent of power clients have within the participation process. A common finding is that service providers still control how client participation is performed and what topics clients can articulate, which limits the extent of client participation (Borg, Karlsson, & Kim, 2009; Carr, 2007; Fudge, Wolfe, & McKevitt, 2008; Harrison & Mort, 2003; Hodge, 2005; Milewa, Dowswell, & Harrison, 2003; Roberts, 2010; Rutter et al., 2004). As a consequence, clients are still often excluded from the participation process and their voices marginalized (Hodge, 2005; Martin, 2008).

Although studies that point to the limited extent of client participation are valuable in creating some healthy scepticism towards those who claim to have achieved it, there are at least two sets of critiques concerning these studies. The first is about conceptualizing participation as a continuum. One of the critiques is that participation can take many different forms that can and should not be compared to each other solely in terms of clients' influence (Schipaanboord, Delnoij, & Bal, 2011; Tritter & McCallum, 2006; Zuiderent-Jerak et al., 2009). Therefore it would seem crucial to investigate the participation process itself. What does it mean in what setting?

The second set of criticisms involves the concept of power. In many studies on client participation, power is thought of as negative and repressive, at least when exerted by professionals. Such a conceptualization is debatable. Foucault in particular argued that power is produced in a relationship in which people always have the freedom to behave differently (Foucault, 1988; Gordon, 1991). In Foucault's power theory, power is not a characteristic or a resource of a person but is produced in a relationship to which the material, social and normative elements of the situation contribute. Furthermore, from this point of view power can be positive *and* negative; it restrains certain repertoires of behaviour while enabling others (Foucault, 1978; Foucault, 1983; Hui & Stickley, 2007).

Moreover, researchers focusing on power in client participation often seem to start from the assumption that clients do not have any, thus focusing on discourses that impede the client's voice. By doing so, situations in which clients' voices are marginalized can become exaggerated, whereas examples of their inclusion are dismissed. Such studies run the risk of overvaluing other actors' power discourses as opposed to those of the clients and therefore tend to assume (and conclude) that clients are excluded due to one coherent discourse (Moser, 2005).

In light of these two sets of criticisms, this study addresses two interrelated questions. First, how is client participation performed? To do so, we will be (a priori) neutral to (i) the desirability of client participation and (ii) any assumption on how it should be done (Contandriopoulos, 2004). Rather we will follow the actors (Latour, 1987) to investigate how they perform participation. Second, we focus on what role(s) power plays within the participation process. We do so by using Foucault's conceptualization of power, by treating it as a repressive *and* productive mechanism. Furthermore, we do not start from the assumption that clients have no power and that they are rendered disabled due to a coherent discourse (cf. Moser, 2005; Moser, 2006). Rather, we focus on both exclusion and inclusion mechanisms.

We study the practice of client participation within a quality improvement collaborative (QIC) carried out in mental health care. Originally coming from industrial settings, the QIC-method is increasingly adopted within healthcare settings mainly in western countries. (Kilo, 1998; Wilson, Berwick, & Cleary, 2003) In the UK, US, Australia and also in the Netherlands many QICs have now been carried out (Dückers, Spreeuwenberg, Wagner, & Groenewegen, 2009; Kilo, 1998; Schouten, Hulscher, Everdingen, Huijsman, & Grol, 2008; Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008). Within QICs improvement teams from different health care organizations aim to improve care on a certain topic. Next to the improvement goals themselves, an objective of many QICs is that clients should be involved in the improvement process (Bate & Robert, 2006; Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008; Zuiderent-Jerak et al., 2009). Therefore, QICs are relevant to the study of client participation.

The aim of this study is twofold. First, we study the consequences of using Foucault's power theory in analysing practices of client participation. Second, we assign the concept empirical specificity by studying how power is *produced*. Focusing on client participation – a setting in which researchers often explicitly refer to power mechanisms – makes the study of power production especially interesting.

Methods

Care for Better

A large QIC called Care for Better (CfB) was developed in the Netherlands, initiated by the Ministry of health and commissioned by ZonMw (the Dutch Organization for Health Care Research and Development). The program comprised many different projects and initiatives, all intended to improve the long term care sector on specific topics that were aligned with nationally set quality goals. Seven of the improvement projects of CfB were launched with a primary focus on mental health care, and these projects are the setting for this study.

The first four, which ran for two rounds each, started in 2007. 'Not (only) the mind but (also) the body' aimed to improve the physical health of clients living in mental health care institutions. In this project for example blood pressure and weight were monitored and healthy diets encouraged. 'Social participation' aimed at making clients feel less lonely by enlarging and enriching their social networks. 'Recovery-oriented care' was devised to give clients more control over their lives. The project relied to a large extent upon the principles of the recovery movement which was initially a user-led movement but is now also increasingly adopted by mental health care professionals. The movement strives toward empowerment and participation of clients in the community (Anthony, 1993; Deegan, 1988). Finally, 'Social psychiatric care' was to improve outreach care. Outreach care teams aim to establish contact with those who avoid care but are thought to need it (by the professionals).

The next three projects were executed in 2008 and 2009. In a 2008 project called 'Medication safety', half the participating teams were from mental health care. Two additional projects set up in 2009 were a combination of subjects of the improvement projects mentioned above: 'Recovery-oriented care and social participation' and 'Health and medication safety'.

Each project of CfB was organized and led by a program management team. This team comprised a program leader and some 'process counsellors' who advised on the improvement processes. The program management team mainly consisted of employees of the Trimbos Institute (the Netherlands Institute of Mental Health and Addiction). Each project also had a team of domain-specific experts who acted as on- and off-site advisors. For example, an expert in the 'Not (only) the mind but (also) the body' project had developed a somatic screening tool. For each project four national conferences were organized. Improvement teams were invited to join the conferences and to learn from the program management team, experts and each other. Meetings with specific people from the improvement teams – like project leaders – were sometimes organized.

All projects were similarly structured and relied to a large extent on the Breakthrough Method (see for details on this method: Institute for Healthcare Improvement, 2003). The Breakthrough method, developed by the IHI in the USA, is one of the most popular QIC-methods, spread mainly to Western Europe and Australia (Kilo, 1998; Wilson et al., 2003). It prescribes a structured, collaborative improvement method, including Plan-Do-Study-Act cycles and measuring the extent to which the goals are attained. The method's collaboration of different improvement teams from different organizations is aimed at facilitating better quality improvement (processes) by sharing experiences.

Within each project of CfB, usually ten to fifteen improvement teams participated. The improvement teams of one project all worked on the same topic, but each within their own organization. Each team consisted of people working in the same care organization and therefore the teams could develop and execute improvement actions according to their client types, local context, and targets. The improvement actions varied with projects and, to a lesser extent, between improvement teams participating in the same project.

Improvement teams worked primarily in mental health care settings, often a form of sheltered housing or long-stay mental hospital (both open and closed wards). In many cases, their clients were long-term residents. In the 'Social psychiatric care' project only outreach care teams participated. Improvement teams were headed by a project leader and generally had four to nine team members, who were sometimes (former) clients. The teams largely comprised psychiatric nurses. Participating clients were recruited from the wards or institution of the team's project. Improvement teams decided how, why and when to involve clients and did so in various ways. The involvement process and how teams were encouraged to involve clients are part of our analysis.

Data collection

Our study was part of a larger evaluation study of CfB; in that context we had access to conferences and other activities (Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008). We relied upon two forms of data collection: observations and interviews (table 1).

First, we conducted participant observations at 26 of the 44 conferences. We also observed five project leader meetings. The aim of these observations was to investigate how the program management team instructed teams to shape client participation and to observe discussions surrounding the topic. We did not intend to give program management or improvement teams suggestions on how they were doing, although they sometimes asked

Table 1: Types of data collection and research questions

	What:	Research aims/ questions:
Observations:	26 one-day national conferences	- Whether and how clients participated at the conferences - How client participation was performed in team discussions during ‘team time’
	Five project leaders’ meetings	- How client participation was discussed and performed
	Six improvement team meetings	- How client participation was performed in the team meetings
Interviews:	Seven interviews with five program managers	- What their ideas were about client participation - How they viewed clients (not) participating in improvement teams
	12 improvement team project leaders	- Why they did (not) involve clients - What their ideas were about client participation - How the participation process went
	Nine improvement team members	- Why they did (not) involve clients - What their ideas were about client participation - How the participation process went
	Two clients participating in improvement teams	- Why they were involved - What their ideas were about client participation - How the participation process went
	Mini-interviews at conferences with project leaders, team members and participating clients	- Why teams did (not) involve clients - What their ideas were about client participation - How the participation process went

for our opinion. We also observed team discussions (sometimes with client participants) during the conferences and conducted many ‘mini’ interviews concerning client participation with team members (be they clients or not) at these conferences and meetings. These ‘mini’ interviews were non-planned and more or less informal conversations with team members, for example during breaks. Notes of these conversations have been made, either during the conversation or right after.

Second, we visited 13 improvement teams in their organizations to explore their improvement practices in-depth. In 12 of those instances, we interviewed the project leader. Sometimes additional interviews with team members were conducted. We observed team meetings during six visits, which were ‘official’ meetings to discuss and adjust the improvement practices. Clients participated in two of the meetings. In the other four, although clients were team members or were involved in specific improvement actions, they were not present at these particular meetings. We conducted interviews with two client-participants. In many cases interviews were not possible for diverse reasons: clients were otherwise occupied, were no longer participating in the project (e.g., because they found it difficult or became ill) or had not participated from the outset. In such cases, we collected data on client participation from project leaders and team members.

Third, we conducted seven interviews with program leaders. Two leaders were interviewed twice, once halfway into the project and once near the end. All respondents consented to the interviews and observations.

Data analysis

Most of the interviews were recorded and transcribed verbatim. For some it was not possible as they took place informally (for example, interviews conducted during walks through the healthcare organizations or the 'mini-interviews' at the national conferences). In such cases we took detailed notes. We also took detailed notes during the observations of conferences and meetings, which were transcribed as soon as possible. We used Atlas.ti for the data analysis, which consisted of two parts. The first concerned a bottom-up analysis to explore how client participation was discussed and performed. During this analysis, we identified two forms of client participation: within the improvement teams and within specific improvement actions. Furthermore, many of the 'codes' identified could be analyzed as either a specific power conceptualization or as an effect of power mechanisms, for example 'using words that clients were unfamiliar with' – pointing at the exclusion of clients through language use. So it became clear that the concept of power and how it was conceptualized by the different actors involved greatly influenced the procedure of client participation.The second part therefore involved a theoretically driven analysis on power, in which we used Foucault's power theory. We conducted a discourse analysis, believed to be a valuable approach for studying the concept of power in client participation (Hodge, 2005). There are several ways in which discourse analyses can be conducted. The close examination of language patterns is one way adopted by some scholars studying client participation. As a consequence, the language patterns are sometimes put to the foreground and other elements that also play a role in client participation practices are then pushed back into the background (Hodge, 2005). Another way is studying how certain practices, made up by discursive, material and social elements, constitute client participation, and thus how client participants are constructed (cf. Arribas-Ayllon & Walkerdine, 2008; Blommaert & Bulcaen, 2000). The latter approach, for example as outlined in critical discourse analysis, is what we apply in this study. We analyse how power relations are (re)produced within client participation practices and the consequences it has for the type (rather than extent) of participation.

Terminology. We are aware that any term used to refer to 'clients' has a performative effect: it may reproduce differences or express a certain view of what characteristics clients should have (McLaughlin, 2009; Moser, 2000). The term 'service user' is, for example, a reflection of a consumerist tradition and therefore carries a positive view on client participation (McLaughlin, 2009). We use the term 'client' because it was the one most used by the people involved (clients, professionals, program managers). When appropriate, we use the terminology itself for the analysis of client participation practices.

Results

Client participation in improvement teams

Client participation at the conferences

The extent to which client participation was highlighted by the program management team varied by project. The program leader of 'Social psychiatric care' said that the nature of the project made it impossible to ensure client participation, as social psychiatric care attempts to find clients unwilling to receive care; obviously they would not be likely to participate in a professional team. In other projects, client participation received more attention. During the intake procedure the topic of client participation was always addressed and teams were urged to involve clients.

In addition, client participation often came up during lectures and discussions at national conferences. For example, when the program leader of 'Not (only) the mind but (also) the body' discovered that only one client was present at the starting conference, she said that this should be "improvement action number one". "Clients should be members of the teams and should attend the conferences," she said firmly. Interestingly, however, she gave no reason for client participation, as if the practice and relevance were self-evident. This was repeated in many of the projects. During presentations, different people – from program managers to project leaders – summed up the factors contributing to success of their project, but rarely did they mention the participation of clients. Apparently client participation was not seen as a project success factor, despite the sometimes urgent attention to the topic.

Furthermore, the conferences seemed to be not adjusted to client participants. Some enjoyed the trips to the conferences and perceived them as an "outing", but for many clients the conferences were "long and exhausting" days, as both clients and professionals expressed, and were therefore often too demanding for clients. Other teams reported that, although clients were on their teams, they did not find the information and program interesting enough to join them at the conferences. In general, there was no well-developed structure for client participation in the programme.

Yet at the conferences team members were continually asking each other whether clients actually approved the improvement actions. For example, one team wanted clients to manage their own money, and another immediately asked: “Is that a wish of clients themselves?” This was one of the main comments from other improvement teams when a team presented its project and it shows how client involvement – or at least client approval – in developing improvement actions was set as the ideal. It sometimes also seemed to illustrate a fear of exerting power. Although professionals did not often use the term ‘power’, some of them seemed to be fully aware of professional power due to its presence in professional language, standards and attitude, and therefore tried to *avoid* all ways of exerting power.

Such a fear of exerting power could already be observed sometimes in program management. For instance, an expert team member of ‘Health and medication safety’ was asking what kinds of people, in terms of profession, were present at a conference. She did not mention clients, and a question from the audience consequently was: “And experts by experience?” “Oh, I’m sorry, I forgot the most important ones,” the expert said, apologizing a few times. The point here is not that she forgot clients – which may seem only logical given that clients were rarely present at conferences – the point is that she felt the need to apologize and call the clients “the most important ones”. The example illustrates the fear of exerting power. At the same time, it is also the ‘doing’ of power. She first does not refer to them, and when reminded of this, calls them “the most important ones” when, obviously, they are *not* the most important ones at the conference. Including clients so explicitly demonstrates and reproduces the fact that they are excluded.

The fear of exerting power was also present in some of the improvement teams, mostly in ‘Recovery-oriented care’. At almost every meeting of this project, professionals were cautious not to do anything that might be perceived as ‘coercive’ or ‘imposing’. They even accused each other of exerting power on clients. For example, in a project leaders’ meeting a leader said that in her organization an “expert and knowledge group” was established to ensure recovery-oriented care throughout the organization and “define the boundaries of this process for all departments of the organization”. Other project leaders immediately reacted, because recovery does not fit with words like “boundaries”, as such words seem to start from a professional or organizational perspective and thereby imply that recovery is not owned by clients themselves. Almost scrupulously, professionals investigated their own and other’s words and behaviour to reveal possible power exertion. Power then was seen as being negative, restrictive, and something that should be avoided in all cases.

The examples also show that, on the one hand, professionals struggle with ‘new’ concepts like recovery and client participation and therefore engage in ‘self-disciplining’ behaviour, and, on the other, work in a professional and organizational context that also brings with it a particular normative framework and professional values – for example recovery versus the need to establish a uniform organisational policy. The examples thus show the existence of powerful and sometimes competing normative frameworks of professional work. Furthermore, because client participation has become a dominant policy goal, professionals reflect upon their behaviour in a different manner, showing the ‘panoptic’ function of stressing these concepts. In the panopticon, subjects are both observed and aware of being observed, which makes them change their behaviour and internalize certain norms (Foucault, 1977; Simon, 2005), like the norm of client participation.

Inclusion and exclusion

In some cases clients did participate as team members. To explore the participation process, we start with an observation of a meeting of one improvement team. We focus on this meeting in detail as we want to explore if discourse analysis reveals only power discourses that render clients disabled or if we can find counter-examples within the same meeting. We first report on examples of exclusion and then give some counter-examples.

This team participated in ‘Recovery-oriented care and social participation’. It consisted of a quality employee, two managers, two care professionals, and one client. During the meeting of the team, there were some moments indicating the exclusion of the client. For example, the client raised the issue of whether the team would continue after the official project ended: “This will stop, won’t it, or have you no ideas about that?” The use of the “you” indicated that she did not perceive herself to be in the position of having the right or the role to contribute to discussions concerning the future of the team.

In addition, the client said that she had a hard time following the discussion, as she was unfamiliar with many of the terms. During the meeting, many terms of the organization and health care in general were used, like “the HKZ” (a Dutch accreditation system). Although the terms were probably not deliberately used to exert power, they decreased the opportunities for this client (and outsiders more generally) to participate in the discussions, and therefore these terms can still be seen as forms of power in which the client is thus (partly) excluded from the discussion.

Hence, if we were aiming to detect professional power and had not looked any further, we would have come to the conclusion that indeed professionals and managers set the agenda and determine what is being addressed. But let us first examine some other moments of the meeting.

At one point, the team members were discussing whether or not to allow program management of ‘Recovery-oriented care and social participation’ to take five anonymous care plans of clients with them to assess them in terms of client centeredness and recovery goals. The quality employee had already assented to their viewing the plans, but not to taking them out of the care institution. After discussing this point for a while, a care professional asked the client for her opinion. The client asked whether the team members knew where the plans were to be taken and, if not, then she would like the plans to stay within the care institution. The quality employee agreed and said she would formulate the answer in the proposed way to program management. So in this case the clients’ perspective was solicited and used to reply to program management. On the other hand, we could still say that professionals decided whether or not the clients’ perspective came to the fore. Furthermore, the decision eventually made was the one that professionals planned to make before they solicited the client’s opinion.

In another moment of the meeting, the question of who was to attend an upcoming national meeting of the project was raised. The client was not asked whether she would like to attend (although one of the care professionals was not asked either). Later in the meeting, however, the client spoke about the delicious lunches served at the meetings, after which she was asked to join the improvement team in attending. Either deliberately or unconsciously, the client was thus exerting power to join the conference. “Yes, I’d like you to join us,” the quality employee said to the client, “also for reasons of equality.” Yet this equality was not about the client-professional balance but, as it became clear, the balance of gender. The client’s attendance made the composition of the group two women and two men rather than one woman and two men. The gender equality sought by the quality employee had the effect of undoing the inequality that is usually implied in the client-professional relationship. By explicitly referring to the client in terms of her gender, other differences are temporarily undone (cf. Moser, 2006). Moreover, it emphasizes the similarities between them.

So examples of both exclusion and inclusion of the client were found during the meeting. By focusing only on how power excludes clients, other consequences of power that were also at work in the meeting might not have been taken into account.

Mutual powerlessness

Although there seemed to be not one coherent power discourse at work in the team meeting and the client claimed to feel equal to other members, the entire improvement team struggled with the specific role of the client. The client said that the idea was for her to think along with the improvement team and listen critically to the discussions. Furthermore, the idea was for the client to benefit from having a position in the team. And indeed it did her a tremendous service. She was asked to tell her story at one of the conferences, which, along with the positive reactions from the audience (often from professionals), increased her self-confidence. She became more convinced that at some point she would be able to write a book, fulfilling a long term wish.

On the other hand, she critically questioned her own function and the contributions she was able to make. She wanted to represent the client group, but it had not been formulated as her role nor did she find herself able to do so. “I do not have the idea that I have a particular contribution to make,” she said in an interview. “I think [being a team member] is very interesting for myself, but I think it is problematic when I’m sitting here representing the client. (…) I think the information is interesting, the conferences are fun, *but* if I am here as a representative of clients I think my task ... that I should be more active, and my role has to be clearer.”

In interviews, all team members remarked that the clients’ role was not clear. The quality employee for example confessed that she had “no answer” to the question concerning the client’s role. “To express it crudely, we could say ‘Hurrah, hurrah, we have a client participating’, while it would of course be great if she had a clearer role.” So both the client and the other team members were having a hard time creating a function through which the client could contribute to the improvement processes.

On the other hand, by always emphasizing the client’s ‘special’ role, the team members emphasized her separateness from the others. One of the managers, for example, wondered whether they had to emphasize the client’s background. However, by not acknowledging differences, it becomes less clear how clients can contribute to the improvements. If clients participate because of their experiences with mental health care but that background is explicitly de-emphasized, the value of client participation could decrease.

What speaks out of these fragments therefore is not (only) professional and managerial power and client powerlessness or exclusion. Rather, the various people seemed to be engaged in a situation that renders them *all* powerless in terms of client contribution. The client was unfamiliar with the terms used in the meetings and furthermore struggled to find a way to add value, all the while trying to represent other clients. The manager, caregiver, and quality employee admitted that the role of the client was not at all clear and that they were unsure how to make it clear without, as the manager added, emphasizing her background.

The function of clients was a struggle in other teams, too; there were many expressions of this mutual powerlessness. While some teams remarked that they began to “look with different eyes” due to the clients, these teams were the exception to the rule. A former client in the expert team of ‘Recovery-oriented care’ organized a meeting for all client team members in the project and the main complaint concerned role ambiguity. In reaction, a project leader expressed her powerlessness by saying that she, too, felt “thrown to the lions”. In different teams from different projects, clients questioned the value of their role and were often quiet during discussions, perhaps because these were often framed in medical and professional terms and hard to follow for ‘outsiders’. As these examples illustrate, encouraging the practice of client participation without devising a good structure for their involvement can lead to ‘mismatch’ practices that are not deliberately created, but that lead to costs on both the client and professional sides (cf. Anthony & Crawford, 2001; Zuiderent-Jerak et al., 2009).

Client participation in the improvement actions

All the above is not to say that clients were not involved in developing and executing improvement actions. Their opinions and perspectives were often collected in ways other than participating in improvement teams. For example, in ‘Social participation’ almost all improvement teams first asked about clients’ social needs before starting to think of improvement strategies. Most of the teams did so by using the network circle, a specific measurement instrument suggested by the program management team that allowed improvement teams to have a conversation with clients concerning their social networks (Broer et al., 2011).

Thus within specific situations that clients knew and recognized, their opinions, experiences, and ideas were solicited. In many cases, this seemed to work well. Much new information surfaced, as many team members said, such as that concerning medication side effects and which home rules clients saw as restraining. Professionals said they adjusted their improvement actions based on this information. In one project, the nurses’ office was removed entirely based on clients’ wishes. Such interviews were mostly developed by teams themselves since there was generally no system established as part of the projects – except for ‘social participation as already mentioned – for how consultation should be conducted.

Sometimes clients, instead of professionals, were asked to approach other clients to collect wishes and opinions because, according to the various people involved, clients found it easier to talk with (former) clients than with professionals. A client team member said that it helped to see that someone had been in the same position. Moreover, one professional said that clients had known them for so long that they anticipated what professionals wanted to hear and then formulated the answer they felt was expected from them instead of expressing their 'true' opinion. This hints at a second rationale that could have played a role in the decision to have clients approach other clients. Although not so framed, the approach also could have been a solution to the fear of exerting power. Professionals let the entire process be determined by clients.

Members of the 'Recovery-oriented care' project explicitly said that the strategy of clients approaching other clients was chosen partly to escape exerting power. Professionals wanted their clients to recover but did not want to take the lead (Broer, Nieboer, & Bal, 2010). Since the recovery movement itself is initiated by (former) clients, the role of professionals in such a recovery framework is often unclear and debatable. "It isn't legitimate for professionals to tell clients the story of recovery," one team member said. A project leader said, "In principle, recovery is owned by patients, we have to keep our hands off it." If professionals tell the story, clients often think it is a new kind of therapy, and again something they *have* to do, as was expressed. In many teams, (former) clients indeed told fellow clients and professionals about their recovery process and about their ideas on how to stimulate clients' recovery processes. Thereby, it was also a way to avoid exercising power: professionals did not have to lecture on recovery and on how clients might 'recover'.

Discussion

The aim of this study was to investigate how client participation was performed in a QIC aimed at mental health care and the consequences of using Foucault's theory of power to analyse client participation processes. Although many studies on client participation have pointed to a lack of genuine involvement because service providers still determine the participation process and outcomes, we found that many teams feared (being accused of) exerting power and did not want to do anything that might be categorized as 'power'. We found many situations characterized by mutual powerlessness. Professionals and clients alike did not know how to shape a good structure, what function clients should fulfil, how to facilitate so clients could be more participatory, and how all actors could benefit from the involvement process. This mutual powerlessness (partly) disappeared when clients helped to determine and execute specific improvement actions instead of participating in improvement teams, which was sometimes seen as a solution to or escape from exerting power.

Given that we were able to observe only some meetings in which a (former) client participated and given that interviews with client participants were often not possible, generalizing the findings is difficult. But next to being a limitation, it is a finding in itself, strengthening our conclusion that the practice of client participation was difficult for professionals and clients. These difficulties might in part be due to the fact that there was no well-developed structure for client participation within the programme; it was largely up to teams themselves to design the practice of client participation.

Despite these limitations, we believe our study may form an alternative approach to studying client participation. Some studies on client participation reflect an attitude that is cynical at the same time as it is idealistic. On one hand they reveal all the powers at work and point to a lack of “genuine forms of user involvement” (Borg et al., 2009) and of “genuinely open dialogue[s]” (Hodge, 2005); on the other hand the researchers thus believe that communication without (negative) power can or should be possible (see for a similar analysis: Contandriopoulos, 2004). Yet, like the fact that non-behaviour does not exist, non-power is also impossible. Every action can be perceived in terms of power. Even the escape from exercising power that improvement teams sought in the solution of clients approaching other clients can be framed in terms of power because the professionals then determined that they should not be the ones guiding the conversation.

The professionals in the QIC we were studying seemed to have become ‘disciplined’ by the need for client participation and by the need to problematize their power mechanisms. Sometimes they were captured between different, sometimes competing normative frameworks, like professional values, the organizational context and (policy) goals like client participation and recovery. Furthermore, they did not want to exert power upon clients, but ironically just for that reason sometimes struggled with shaping practices of client participation. Yet, as power is unavoidable, trying not to exert it might paralyze the actors involved instead of freeing (some of) them. By being more neutral in terms of the power concept (as professionals and as researchers), seeing it as positive and negative, and by not automatically assuming that professionals exercise (negative) power upon participating clients, a different picture of client participation might be sketched, as we showed in this study. Recognizing that power is inescapable might allow for a more substantive discussion concerning the consequences that power arrangements produce, rather than looking at who is exerting how much power.

References

Anthony, P., & Crawford, P. (2001). Service user involvement in care planning: The mental health nurse's perspective. *Journal of Psychiatric and Mental Health Nursing, 7*(5), 425-434.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*, 11-23.

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Planning Association, 35*(4), 216-224.

Arribas-Ayllon, M., & Walkerdine, V. (2008). Foucauldian discourse analysis. In C. Willig, & W. Stainton Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 91-108). Los Angeles: SAGE.

Bate, P., & Robert, G. (2006). Experience-based design: From redesigning the system around the patient to co-designing services with the patient. *British Medical Journal, 15*(5), 307-310.

Blommaert, J., & Bulcaen, C. (2000). Critical discourse analysis. *Annual Review of Anthropology, 29*, 447-466.

Borg, M., Karlsson, B., & Kim, H. S. (2009). User involvement in community mental health services – principles and practices. *Journal of Psychiatric and Mental Health Nursing, 16*, 285-292.

Broer, T., Nieboer, A.P., & Bal, R. (2010). Quest for client autonomy in improving (long term) mental health care. *International Journal of Mental Health Nursing, 19*(6), 385-393.

Broer, T., Nieboer, A.P., Strating, M.M.H., Michon, H.W.C., & Bal, R. (2011). Constructing the social: an evaluation study of the outcomes and processes of a 'social participation' improvement project. *Journal of Psychiatric and Mental Health Nursing, 18*(4), 323-332.

Carr, S. (2007). Participation, power, conflict and change: Theorizing dynamics of service user participation in the social care system of England and Wales. *Critical Social Policy, 27*(2), 266-276.

Contandriopoulos, D. (2004). A sociological perspective on public participation in health care. *Social Science & Medicine, 58*(2), 321-330.

Crawford, M. J., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N., et al. (2002). Systematic review of involving patients in the planning and development of health care. *British Medical Journal, 325*(7375), 1263-1267.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

Dückers, M. L. A., Spreeuwenberg, P., Wagner, C., & Groenewegen, P. P. (2009). Exploring the black box of quality improvement collaboratives: Modelling relations between conditions, applied changes and outcomes. *Implementation Science*, *4*(1), 74.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* London: Penguin Books.

Foucault, M. (1978). *An introduction, the history of sexuality 1*. New York: Vintage Books.

Foucault, M. (1983). Afterword: The subject and power. In H. Dreyfus, & P. Rabinow (Eds.), *Michel foucault: Beyond structuralism and hermeneutics* (pp. 208-226). Chicago: University of Chicago Press.

Foucault, M. (1988). The ethic of care for the self as a practice of freedom. an interview with michel foucault on january 20, 1984. In J. Bernauer, & D. Rasmussen (Eds.), *The final foucault* (pp. 1-20). Cambridge, Massachusetts: The MIT Press.

Fudge, N., Wolfe, C. D. A., & McKevitt, C. (2008). Assessing the promise of user involvement in health service development: Ethnographic study. *British Medical Journal, 336*, 313-317.

Gordon, C. (1991). Governmental rationality: An introduction. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 1-53). Chicago: Chicago University Press.

Harrison, S., & Mort, M. (2003). Which champions, which people? public and user involvement in health care as a technology of legitimation. *Social Policy & Administration, 32*(1), 60-70.

Hodge, S. (2005). Participation, discourse and power: A case study in service user involvement. *Critical Social Policy*, *25*(2), 164-179.

Hui, A., & Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: A discourse analysis. *Journal of Advanced Nursing, 59*(4), 416-426.

Institute for Healthcare Improvement. (2003). *The breakthrough series: IHI's collaborative model for achieving breakthrough improvement*, Institute for Healthcare Improvement.

Kilo, C. M. (1998). A framework for collaborative improvement: Lessons from the institute for healthcare improvement's breakthrough series. *Quality Management in Healthcare*, *6*(4), 1-13.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society*. Cambridge, Massachusetts: Harvard University Press.

Martin, G. P. (2008). "Ordinary people only": Knowledge, representativeness and the publics of public participation in healthcare. *Sociology of Health and Illness, 30*(1), 35-54.

McLaughlin, H. (2009). What's in a name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by experience', 'Service user' — what's next? *British Journal of Social Work, 39*(6), 1101-1117.

Milewa, T., Dowswell, G., & Harrison, S. (2003). Partnerships, power and the" new" politics of community participation in British health care. *Social Policy & Administration, 36*(7), 796-809.

Moser, I. (2000). Against normalisation: Subverting norms of ability and disability. *Science as Culture, 9*(2), 201-240.

Moser, I. (2005). On becoming disabled and articulating alternatives. *Cultural Studies, 19*(6), 667-700.

Moser, I. (2006). Sociotechnical practices and difference: On the interferences between disability, gender, and class. *Science, Technology & Human Values*, *31*(5), 537-564.

Pilgrim, D., & Waldron, L. (1998). User involvement in mental health service development: How far can it go? *Journal of Mental Health, 7*(1), 95-104.

Robert, G., Hardacre, J., Locock, L., Bate, P., & Glasby, J. (2003). Redesigning mental health services: Lessons on user involvement from the mental health collaborative. *Health Expectations, 6*(1), 60-71.

Roberts, M. (2010). Service user involvement and the restrictive sense of psychiatric categories: The challenge facing mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 17*, 289-294.

Rush, B. (2004). Mental health service user involvement in England: Lessons from history. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 313-318.

Rutter, D., Manley, C., Weaver, T., Crawford, M. J., & Fulop, N. (2004). Patients or partners? case studies of user involvement in the planning and delivery of adult mental health services in London. *Social Science & Medicine, 58*(10), 1973-1984.

Schipaanboord, A., Delnoij, D., & Bal, R. (2011). Patient empowerment in the netherlands. In E. de Leeuw, & H. Lofgren (Eds.), *Democratising health. consumer groups in the policy process.* London: Edward Elgar.

Schouten, L. M. T., Hulscher, M. E. J. L., Everdingen, J. J. E., Huijsman, R., & Grol, R. P. T. M. (2008). Evidence for the impact of quality improvement collaboratives: Systematic review. *British Medical Journal*, *336*(7659), 1491-1494.

Simon, B. (2005). The return of panopticism: Supervision, subjection and the new surveillance. *Surveillance & Society, 3*(1), 1-20.

Stickley, T. (2006). Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing, 13*(5), 570-577.

Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

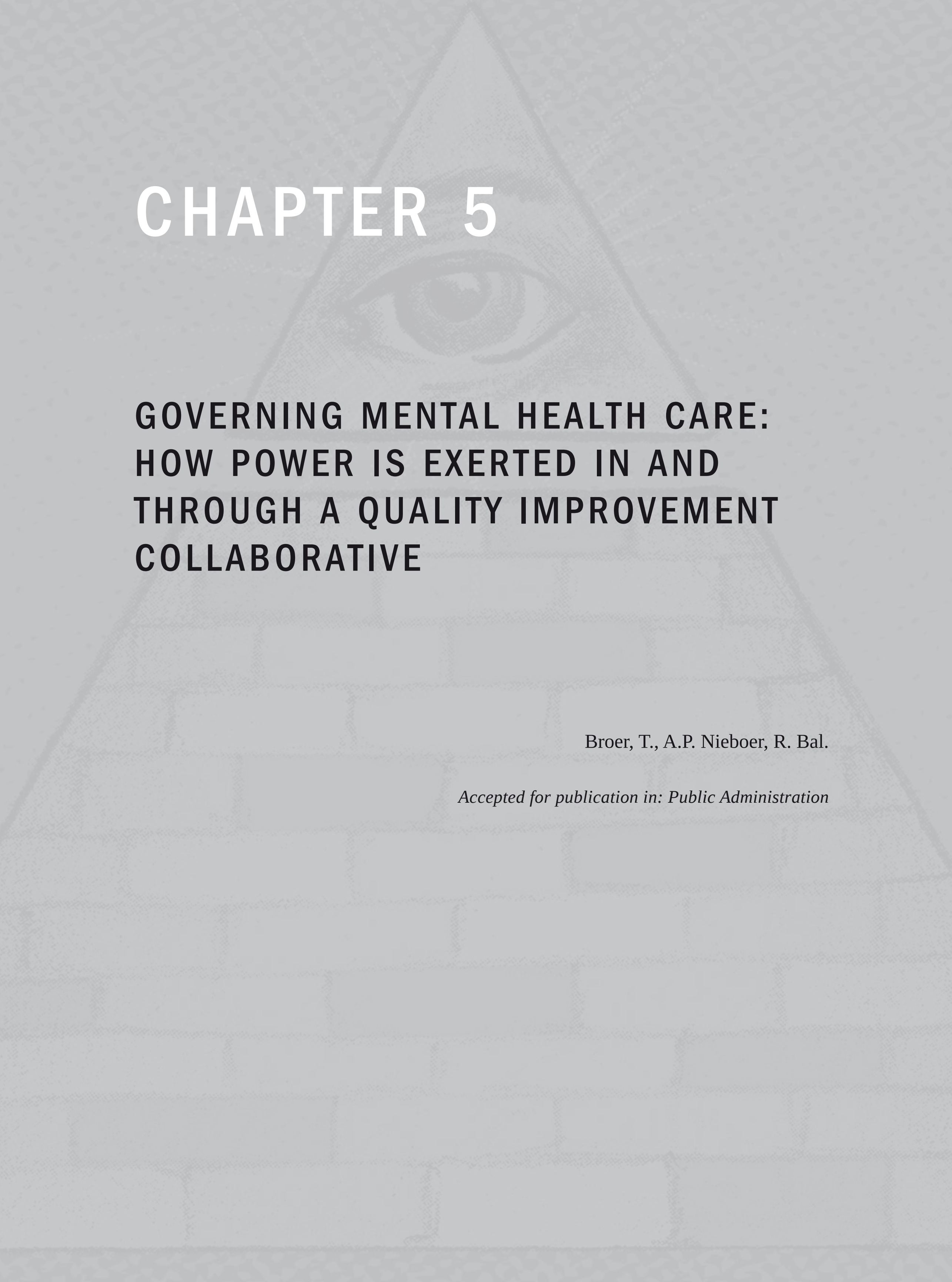
Tritter, J. Q., & McCallum, A. (2006). The snakes and ladders of user involvement: Moving beyond Arnstein. *Health Policy, 76*(2), 156-168.

Van de Bovenkamp, H. (2010). The limits of patient power: Examining active citizenship in dutch health care. Rotterdam: Erasmus University Rotterdam.

Van de Bovenkamp, H., Trappenburg, M. J., & Grit, K. J. (2009). Patient participation in collective healthcare decision making: The dutch model. *Health Expectations, 1369*, 6513-6526.

Wilson, T., Berwick, D. M., & Cleary, M. P. P. P. D. (2003). What do collaborative improvement projects do? Experience from Seven Countries. *Joint Commission Journal on Quality and Patient Safety, 29*, 85-93.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine, 69*(12), 1713-1721.



CHAPTER 5

GOVERNING MENTAL HEALTH CARE: HOW POWER IS EXERTED IN AND THROUGH A QUALITY IMPROVEMENT COLLABORATIVE

Broer, T., A.P. Nieboer, R. Bal.

Accepted for publication in: Public Administration

Abstract

We investigated the role of power in public governance using Foucault's conceptualization of power, i.e., power is produced by a range of techniques as diverse as language and measuring. We draw on an evaluation study of a quality improvement collaborative, in which different mental health care organizations were encouraged to improve their care in a structured way. We analyzed how the different actors involved in the collaborative were governed and came to govern themselves differently. Measurement instruments were an example of a dominant mechanism by which actors at different levels of the collaborative were governed: by accounting for improvements, introducing or strengthening a certain way of thinking about health care clients, and changing how clients thought about and acted upon themselves. We argue that the focus on consequences of governing techniques is fruitful for studying governmentality and leads to new research questions in the context of public policy analyses.

Introduction

The concept of power – a dominant theme within many governance analyses – is frequently perceived as a resource and, as such, an explanation of policymaking. Power 'stored' in individuals or organizations allows them to influence policymaking processes. Rhodes, for example, speaks of the 'power potential' of people and organizations, and argues to investigate 'who is in what position' to explain policymaking (Rhodes, 2007). Those having the most power and exerting it most effectively are also the ones to influence policy making most. Also studies on interactive policy making often focus on (power) resources and how and whether these are used by whom (Van Tatenhove *et al.* 2010).

The resource conceptualization of power has been useful in governance analyses. Another, less dominant aspect of power in such analyses however is to treat it as a function of the specific techniques and procedures used to 'do' government (Foucault, 2010). In such a view, power concerns the 'how' of government rather than the 'why' or 'who' (Miller and Rose 2008). Foucault has used this conceptualization of power to analyse governing in various sites, such as asylums and households (Foucault, 1985; Foucault, 1986; Foucault, 2006; Lemke, 2001). We believe this conceptualization has several things to offer public policy analyses. First, it shifts the perspective from a macro-level to a micro-level perspective: 'The dominant focus of regulation studies on macro-level epochal forms of rule tends to overlook the 'surfaces, practices, and routines' that give these forms of governing meaning' (Higgins, 2004 pp. 472). Second, an analysis in which power is not an explanatory factor but the topic of study itself allows for empirical specificity of the concept, by investigating how it is produced.

Such questions are central in what is now commonly referred to as governmentality studies (Miller and Rose 2008). Governmentality is broadly understood as 'the techniques and procedures for directing human behaviour' (Rose *et al.* 2006) and the concept combines a political rationality with technologies of power (Lemke 2001). Rather than focusing on state practices, governmentality studies usually focus on the 'mundane' and local practices in which governance is done. For example, Miller and Rose (2008, p. 51) argue 'that the analysis of "governmentality" needs to be accompanied by an investigation of the "technologies" which seek or claim to give effect to the aspirations of programmers'. So within governmentality studies, researchers study the political rationality of a program, the way in which authorities within this program seek to govern individuals and/or groups, and who exactly should be governed in what ways (Rose *et al.* 2006). In this study we sympathize with this approach but place more emphasis on the consequences that governing technologies produce. Since power is seen as produced in a relationship, the consequences of governing mechanisms will give the power concept more empirical specificity, i.e. they are part of the power concept.

We use Foucault's conceptualization of power to analyse how public governance takes place. We draw on an evaluation study of a large Dutch quality improvement collaborative (QIC) aimed at improving quality of mental health care. Within QICs, improvement teams from different health care organizations join forces to improve care on a certain topic within a set timeframe (Kilo, 1998; Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008). The notion of 'collaborative' here is interesting, as it suggests the mechanism is about collaboration and not about governing. By giving it such a 'positive' connotation, the aim of governing health services is not explicitly mentioned. The same holds for evaluations of collaboratives, which frequently focus on the goals formulated by the actors involved or on factors that constitute success. In doing so, the policy goals and political rationality of the program are less likely to be objects of reflection, because such evaluation studies usually do not take into account the reasons why particular goals are formulated in a specific way and why the improvement program itself is developed as it is. Furthermore, evaluation studies usually do not reflect upon their own role within the collaborative and within public policy in general but rather take an instrumental orientation (Bate & Robert, 2002; Walt et al., 2008).

Against such a dominant instrumental perception, studying the functioning of power mechanisms in relation to QICs is interesting. To do so, we propose an alternative evaluation of QICs. The main research question of this study is: what is the role of power within a QIC? In answering we explore questions related to the political rationality of the policy instrument by focusing on "the techniques, the practices, which give a concrete form to (…) political rationality" (Foucault, 1988b pp. 153). We thus focus on the techniques used to govern actors in the collaborative and the consequences they produce, conceptualizing power as a function of these techniques. We use an ethnographic study design as it is seen as a promising method for studying public policy and its consequences (Rhodes, 2007).

We begin with a theoretical framework based on the work of Foucault. We then describe the QIC and our data collection and analysis, followed by an analysis concerning the functioning of power in the QIC. Last, we discuss what our study adds to discussions on the concept of power in contemporary governance arrangements and to the concept of governmentality.

Theoretical framework: The governance of self and others

In Foucault’s power theory, power refers to the ‘how’ of government. It can also be conceptualized as a function of the techniques used to govern (Foucault, 2010). One of its specific forms, dominant since at least the nineteenth century, is disciplinary power. Although discipline often has a negative or repressive connotation, Foucault has analysed it as simultaneously restricting and enabling (Foucault, 1978). Another of its elements is that it is diffused: it cannot be ascribed to one or several persons and is found throughout society (Foucault, 1977), in disciplinary sites such as households (Foucault, 1985; Foucault, 1986), prisons (Foucault, 1977), and asylums (Foucault, 2006).

Disciplinary sites employ several techniques to govern inhabitants. The governance techniques can involve language as well as material practices, so they can be discursive at the same time as they are non-discursive. In Foucault’s power theory, all these techniques rely upon knowledge practices. Every form of knowledge is also a set of norms: norms for normal and thus also for deviant behaviour (Foucault, 2010). Since knowledge orders reality, it is itself an intervention just as it suggests how to further intervene. Foucault referred to this reciprocal constitution between forms of knowledge and power techniques as ‘governmentality’ (Foucault, 2010; Lemke, 2001). Public policy instruments, for example, carry knowledge (or rationality) concerning social control and how to exercise it (cf. Lascoumes & Le Gales, 2007).

Classification in particular is seen as an important way of governing people. Categorizing and thus approaching people in a certain way constructs different kinds of persons like the mad, the homosexual or the delinquent (Foucault, 1977; Foucault, 2006; Hacking, 1986; Hacking, 1999). For example, by confining the ‘mad’ person, reality is ordered according to the binary division mad/sane, an effect not just caused by the division as such but by the practices of confinement and by the way the ‘mad’ are approached (Foucault, 1988a). People thus become ‘mad’ subjects; they are approached as such and as a consequence perceive themselves differently.

Measuring, which is based on and adds to classification, is said to affect the practices that it only aims to investigate. It has a normalizing effect. As measuring is a form of knowledge and creates further forms of knowledge, it is thus also a set of norms by which phenomena of deviance can be described and norms for behaviour constituted (Foucault, 2010; Sauder & Espeland, 2009). By having knowledge, for example, about a mean score, it becomes a relative point that can transform people’s (thinking about their) behaviour (Foucault, 1977; Triantafillou, 2007). For example, Triantafillou (2007) analysed how hospital benchmarking produced normalizing effects. It created knowledge about the average productivity level, which made hospitals change the way they thought about their own productivity and thereby stimulated their self-regulating capacities.

Importantly, it is not only *others* who govern a person's behaviour. For Foucault, governing takes place both between and within individuals. People play a profound role in governing themselves, something Foucault referred to as 'technologies of the self' (Foucault, 1988c; Lemke, 2001), which can be conceptualized in two ways. First, technologies of the self relate to how people can govern themselves more or less independently of expert regimes (Foucault, 1988a). Second, the technologies of the self might be changed or stimulated such that people begin to self-govern differently as a consequence of being governed (Heyes, 2006). Government then takes place at the contact point between the governing of others and the governing of oneself (Foucault, 1988c).

Notwithstanding the effects governance may have on the construction of subjects, governance is not equal to repressing people, as Foucault argued. First, subjects always have the freedom to behave differently, which, indeed, is a precondition for power relations to exist (Foucault, 1988a; Gordon, 1991). Without such freedom, Foucault speaks of domination rather than power. Therefore, power techniques produce opportunities for subjects to resist or behave differently. Resistance then is not the opposite of power but the acknowledgement of the power relation; it is only possible within a power relation (Foucault, 1988a; Sauder & Espeland, 2009).

Secondly, most contemporary political instruments work through subjects' freedom and autonomy. Concepts like autonomy are used to govern behaviour at a distance, for example by making people responsible for their lives and their choices (Rose, 1998). That does not mean that autonomy is a mere extension of social control. In fact, power can be seen as a mechanism by which subjects are steered to become of a certain 'kind', while at the same time offering them possibilities for constructing their own identities, i.e., using power as a point of resistance or a starting point for new behaviours (Lacombe, 1996).

In sum, in Foucault's power theory, power is a function of the techniques used to govern people. The techniques often are or rely on knowledge practices like classification and measuring. Both discursive and non-discursive elements constitute specific governmentality practices and it is those practices we are interested in here. Therefore we do not make a distinction a priori between discursive and non-discursive methods for governing. We use this framework based on Foucault to analyse the role of power within a QIC by focusing on the techniques it uses to govern health care experts, organizations, professionals, and clients. We study their consequences, which included, for example, resistance, normalization, and changes in self-governance of organizations and individuals.

Methods

Care for Better

The QIC Care for Better (CfB) was initiated by the Dutch Ministry of Health. ZonMW (the Dutch Organization for Health Care Research and Development, a quasi-governmental organization) was appointed to steer the execution of the projects and the evaluation study of the collaborative. ZonMW appointed other organizations for organizing and evaluating CfB, and established a steering committee that made or delegated many decisions concerning CfB.

When CfB started in 2005, it was largely aimed at care for the elderly. In 2007 four improvement projects in mental health care were developed, each of which consisted of two rounds of collaborative projects. Two more mental health projects were developed in 2009. The six projects were executed by the Trimbos Institute (the Netherlands Institute of Mental Health and Addiction) and are the focus of this study. The project 'Social participation' aimed at reducing clients' loneliness and enlarging and enriching their social networks. Examples of improvement actions were to support clients in visiting old friends or getting a job. The 'Not (only) the mind but (also) the body' project set out to improve clients' physical health by monitoring blood pressure and weight and encouraging healthy living. 'Recovery-oriented care' was devised to give clients more control over their lives and was related to the recovery movement toward empowerment and reintegration in society (Anthony, 1993; Deegan, 1988). The goal of 'Social psychiatric care' was to improve outreaching care, i.e., to establish contact with those who avoided care but were thought to need it – the homeless, for example. The 2009 projects aimed for a larger impact upon care organizations by increasing the number of team-participants from the same care organization. The 2009 projects were a combination of old subjects: 'Recovery oriented care & social participation' and 'Health & medication safety'.

All six projects were more or less set up and structured in the same way. Each was led by a faculty team comprising a program leader and usually some other 'process counsellors'. Each project also had an expert team that gave input to both the faculty and improvement teams by lecturing at national conferences, answering improvement teams' questions, and making on-site visits. For each round of each project, four national conferences were organized. Improvement teams were invited to participate and learn from the faculty team, the experts, and each other. The faculty teams also organized project leaders' meetings. Each project used indicators and measurement instruments to determine its effectiveness and enable teams to monitor and adjust their improvement actions.

In each round of each project, usually ten to fifteen improvement teams participated. In total, about 150 improvement teams participated in the six projects. They were headed by a project leader and generally had four to nine other team members, usually mental health care professionals, although the exact composition of the team was up to organizations and varied between the projects.

Data collection

As part of a larger evaluation study of CfB (Strating et al., 2008; Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009), different sorts of data have been gathered. For this study, we used an ethnographic design (observations and interviews) because ethnographic methods are considered important to analyses on governance and power (Rhodes, 2007). All respondents consented to the interviews and observations.

First, we conducted ethnographic observations at 24 of the national conferences organized for the mental health care projects. Second, we conducted ethnographic observations of four project leader meetings. Third, we accompanied a member of the expert team of 'Recovery oriented care' during an assessment of a care institution in the context of this project. Fourth, we conducted observations of two meetings in which we presented our (preliminary) findings to ZonMw and discussed a follow-up of the evaluation study. During all these observations, we made detailed notes and wrote down as many direct speech quotations as possible. However, this was not always possible given time constraints and therefore most of the material gathered during the observations consists of indirect rather than direct speech quotations.

Fifth, we conducted seven face-to-face interviews with the program leaders. During these interviews, we mainly focused on how the projects were set up, on how program management presented the improvement project to improvement teams, how program management saw improvement teams reacting, and on how improvement teams developed and executed improvement actions. So mainly these interviews were meant to explore the different techniques used to govern improvement teams to develop and execute specific improvement actions and the consequences of these techniques. Sixth, we conducted observations and interviews on a selection of 13 improvement teams spread over the different projects to examine the improvement processes. These on-site visits usually lasted one-half to one day. At almost all sites, we conducted interviews with the project leader of the improvement team. At some sites we conducted additional interviews with team members or we walked around in the organization to observe the team's improvement practices and ask more situation-specific questions. The interviews with improvement teams and other actors in the mental health care organizations were very much descriptive in nature. We focused on the improvement actions developed and executed, on why teams chose their improvement actions so as to explore the rationality behind the improvement actions, and on how clients responded to the improvement actions. As well, we asked improvement teams how they perceived the faculty's supervision and ways of presenting the improvement project, what they thought about the measurement instruments chosen, whether they used the instruments and what the consequences of these instruments were, for example for clients. The interview questions were meant to explore the rationality behind (ways of directing) improvement actions, to explore the techniques used to govern both improvement teams and clients, and to explore the consequences of these techniques.

Both the interviews with program management and with improvement teams were also meant to discuss the conferences with them. Because we had observed many of the conferences, we could ask these actors how they perceived the conferences, why they behaved in the way they did (how program management for example decided on the workshops given during these conferences). In this way we came to know more about the rationality behind the way the conferences were organized, performed and reacted upon. This served as data triangulation; the interviews also clarified and deepened material gathered during observations.

Whereas evaluation often involves making judgments in relation to predefined criteria, the ethnographic design chosen for this particular study allowed us to follow how the actors were improving, why they decided to improve in a particular way, and what the consequences were. This is not to say that evaluation in the proper sense was not part of what was going on in the collaborative and we return to the role of evaluation in governing mental health care improvement in a later section.

Data analysis

Most of the interviews were recorded and transcribed verbatim. For those that took place informally (for example, when walking about the institution or at the national conferences), we took detailed notes. We also took notes during the observations of conferences and meetings, which were transcribed as soon as possible. Using Atlas.ti for the data analysis, we distinguished three empirical levels: program, organization/ team, and individual (clients and professionals). Concerning the first level, we focused on the CfB-program in general, including projects in other sectors than mental health care, as they were all steered and developed by the same committee and evaluated by the same team. For the second and third level we focused only on the mental health care projects of CfB. For all levels, we investigated the techniques that were used in the CfB program, how they were used and how the different actors responded.

The analysis for this study is based in part on the results of other articles within the mental health care projects of CfB (Broer *et al.* 2010a; Broer *et al.* 2010b; Broer *et al.* 2011).

Results

In the results section we distinguish three empirical levels: (1) the rationality of the CfB-program and the techniques used to steer it (including our evaluation study); (2) how improvement teams and their organizations were governed; and (3) how professionals and clients were governed and were expected to govern themselves differently.

The CfB-program

We analyse the CfB program as a policy instrument used as a strategy to achieve desirable states in mental health care organisations and clients. The name Care for Better itself already implies the intention to govern care practices. In Dutch CfB means ‘Zorg voor Beter’, which can be read in two ways. First, the name refers to a kind of movement within health care opting for better care: ‘health care opts to do better’. Second, the name connotes a warning, translating as ‘deliver better care in the future’. It can thus be interpreted as an encouragement or a critique.

Because CfB is a way of governing health care, it represents both particular knowledge of mental health care services and ways of intervening in the services and in clients’ lives. For example, the focus on particular topics involved assumptions about the services and clients. The ‘Social participation’ project for instance assumed that health care services did not adequately emphasize clients’ social lives and it should be the responsibility of professionals to do so, and assumed that clients wanted to have their social lives improved (with the help of professionals).

Also how changes were to be attained represented a particular political rationality. The program was executed such that improvement teams came together at an intermediate level. A different way might have been for teams to be more directly instructed on what and how to change. The rationale seemed to be that it was the responsibility of health care services to ensure better care, and as such the institutions were governed through their own autonomy and sense of responsibility.

On the other hand, improvements had to be made visible to account for the effort and money spent on developing the program. One way of doing so was by conducting an evaluation study, a task to which we were assigned. We analyse the evaluation study as a policy instrument itself, and here analyse the rationality behind setting it up, its functions, and its consequences mainly for program management of CfB.

According to the call for evaluation proposals the primary focus for the evaluation study had to be to investigate whether the program attained its goals and to report these results to the ministry, making the legitimization of the CfB program a predominant function. This was also illustrated by a meeting we had with two ZonMw employees to negotiate some of the tasks of the evaluation study. ZonMw urged us to present the lessons learned from the program to the steering committee, especially to justify money spent. One evaluator reacted: ‘We can present what has happened but they [the steering committee] themselves have to judge whether the money has been spent in the right way’.

The demand for accountability expressed through the requirements for and framing of the evaluation study showed that the program was intended to govern health services in accordance with certain aims like improving clients’ social lives or their physical health (the aims of the program itself). More importantly, it was a specific form of governmentality in which, on one hand, organizations were made responsible for improving care but on the other, improvements were made visible so the program could be accounted for in terms of effects (Power, 2003; Strathern, 2000).

This specific form of governmentality and framing of the evaluation study had consequences for how the evaluation study was perceived by project managers. The program management of the initial projects had referred to a note-taking evaluator as ‘the watchman’, thus framing the function of the evaluation study within an ‘effective/ non-effective paradigm’ (Zuiderent-Jerak et al., 2009 pp. 1718). One program leader of the mental health care projects said that he was pleased with our evaluation study and observations during an interview: ‘well, I think it is really great that you do this [the evaluation], because you are able to look at it in a more distant way’. On the other hand, he also confessed to being frightened of independent evaluators judging his work. We tried to make clear that judgment was neither our aim and nor was it scientifically interesting. The examples show that the evaluation study was sometimes framed in terms of judgment and accountability, making us actors in an accountability discourse, be that our intention or not. This has had consequences for access to conferences (Zuiderent-Jerak et al., 2009) and program management meetings because program management saw our evaluators’ jobs as fundamentally different from their own.

Hence, an evaluation study can be seen as a policy instrument. In a sense, assigning an evaluation study might be seen as an investigation of what happened, a signal that governmental bodies care about the ongoing projects, and a ‘warning’ to improve care.

The CfB projects

The employment of an accountability discourse in which the effects of the program were exposed was one way to govern the program as a whole. It was also present in the techniques used within the projects to govern organizations and improvement teams, to which we will now turn. One form of governing was having organizations responsible for improving their own care (autonomy); but on the other hand improvements were made visible by means of the ‘panoptic’ function of the projects and measurement instruments.

Autonomy of improvement teams

Although faculty of the different projects had suggestions for improvement actions, in general it was deemed important that improvement teams decide on them. The program leader of ‘Not (only) the mind but (also) the body’ articulated the rationale that the improvement teams ‘had to come up with their own preferences in order to really endorse the changes’. The chair of many of the conferences often said that the projects involved ‘bottom-up creativity’. How the actions were carried out was up to the care professionals. ‘Change we can believe in’ was his slogan, reminiscent of the Obama campaign. In this sense, improvement teams were governed through autonomy and their knowledge of the local situation.

Improvement teams, however, did not always immediately understand or practice the ideas of bottom-up creativity and target-setting. According to the program leader, a team within ‘Social psychiatric care’ assumed that the faculty team would instruct them on what and how to improve. Similarly, the program leaders of ‘Health and medication safety’ and ‘Social participation’ said that some teams were impressed by the faculty team and therefore expected their instruction. Others wanted their improvement plans to be perfect and spent much time on writing them. The faculty teams tried to change such attitudes by repeating that improvements were the responsibility of improvement teams and that ‘doing’ something with clients was more important than a perfect plan. Hence, although the idea was for improvement teams to have autonomy, some did not use it ‘appropriately’; i.e. according to the faculty team it would have been appropriate if improvement teams developed and executed improvement actions themselves, however some improvement teams used this leeway to wait for the faculty team to instruct them.

In contrast, many teams used the leeway to think about their care situation and disagree (implicitly or explicitly) with the faculty team about improvement goals. For example, faculty within 'Recovery-oriented care' advised teams to create only the essential preconditions for recovery to occur and to leave further initiative to clients. Some teams, however, took a more active role in the project because, according to them, their clients could not take initiative even though they were given opportunities to do so (Broer *et al.* 2010a). Many of the clients involved had difficulties taking initiative, for example to employ daily activities or to chat with care givers, as was expressed by a project leader who said: 'Clients are often not easily mobilized and cannot mobilize and motivate themselves either.' For these reasons, some team members argued that recovery was not a suitable concept for their client group.

Therefore, the fact that improvement teams were partly governed through autonomy sometimes made them change their proposed roles, thereby changing the predefined topic as presented by faculty. In general, such leeway was seen as important to having teams 'believe in' the changes, and in this sense teams were governed through their autonomy. But, once again, some teams did not use it 'appropriately' and waited for the faculty team to instruct them more directly.

The 'panoptic' function of the projects

At the same time that improvement teams were governed through autonomy, their actions were to some extent steered because faculty had ideas about improvements as well. The mere existence of the program already changed the behaviour of the teams and organizations. Having organizations observed – along with the organizations' awareness of being observed – is a 'panoptic' function of the projects, analogous to Foucault's analysis of the panopticon (Foucault, 1977; Simon, 2005). In the panopticon, subjects are both observed and aware of being observed, which makes them change their behaviour and internalize certain norms. Observation thus can have a disciplinary effect, especially when subjects know they *can* be observed at any time but do not know when (Foucault, 1977).

By exchanging information with faculty and with other organizations, information about the different organizations was made public in and by the CfB program. Some improvement team members remarked on that: 'Strangers are looking at our care', and they went on to argue that their management feared strangers' eyes. Another improvement team even used the panoptic function to change organizational processes that were not especially linked to their 'Social psychiatric care' project, because their manager was more willing to support the changes knowing they were being observed and judged for example by the measurement instruments. ‘Our managers are only sensitive to numbers’, as one team member said. The improvement team referred to this as ‘misusing the improvement project’.

Some managers used the panoptic function to build a good image of themselves and their organization. For example, the program leader of ‘Recovery-oriented care’ spoke about a ‘crisis team’ that aimed to improve the situation of 400 clients, which was, she said, ‘totally unrealizable’. She wondered whether the manager of the team had decided to participate because of the popularity of the recovery concept. ‘Now we can write down in our policy reports that we participated in ‘Recovery-oriented care’,’ was the rationale she ascribed to the (manager of the) crisis team, ‘while they [the improvement team] do not change their care practices accordingly’. Since the ‘crisis team’ set itself goals that were ‘totally unrealizable’, according to the program leader, it was – still according to her – also questionable whether they actually wanted to make improvements. Analysed from Foucault’s theory of power, the behaviour of the crisis team might be seen as a form of resistance, or, more specifically, a form of gaming, i.e., ‘cynical efforts to manipulate the rankings data without addressing the underlying condition that is the target of measurement’ (Sauder & Espeland, 2009 pp. 76). By participating in an improvement project and becoming known as a participant, an organization can thus influence its reputation without necessarily improving its care.

To summarize, although probably not a specific intention of the program, the projects functioned in a panoptic way: the organizations knew they could be observed, although they were not always certain when and what information was made visible.

Organizational measurement instruments

In contrast to the panopticon as analysed by Foucault (1977), the panoptic aspects of the CfB projects did not specify what counted as ‘good’ behaviour and what did not; teams and organizations might not have been sure of what was expected from them. An alternate way of steering teams was through measurement instruments, which led to forms of knowledge creation and certain ways of governing behaviour. In comparison with the panoptic aspects of the project the measurement instruments framed ‘good’ behaviour more specifically; so by using certain measurement instruments ‘good’ or ‘normal’ care was specified in more detail. The measurement instruments led to normalization for example in what was seen as good care or what were seen as normal clients, as we will now show.

The CfB QIC used two forms of measurement instruments, one directed at the institutional level and the other at the client level. Both tried to change certain assumptions within the organizations but did so in different ways. ‘Recovery-oriented care’ and

‘Recovery-oriented care and social participation’ employed a good example of institutional-level measuring. The faculty team used the ‘Recovery-Oriented Practices Index’ (ROPI) to assess the extent to which the participating departments delivered recovery-oriented care. Members spent usually a full day conversing with the various people – clients, manager, improvement team, project leader – who lived or worked at the site of the improvement project. They assessed issues like basic care, client self-management, and client participation in the neighbourhood. Based on the interviews and observations, each site was scored on the above items.

Although the faculty team did not frame the aims of the instrument in terms of Foucault’s theory of power, testing and changing the assumptions of the institutions were important aims of this instrument. According to the program manager, a shortage of personnel made it ‘absolutely impossible’ to stimulate clients’ recovery process. The instrument therefore, she said, ‘confronts institutions firmly with the extent to which they provide the preconditions for recovery-oriented care’. We observed such a confrontation during a ROPI assessment when team members were asked if they were proud of what they provided. After some moments of silence, one man said with tears in his eyes: ‘No. And I notice this makes me sad’. Whereas the care team officially was responsible for providing basic care (like providing food and shelter and making sure clients were clean), during the ROPI assessment this care team reported that they could not even provide basic care, resulting in clients being left unclean for weeks. By asking such ROPI questions, teams discussed their care and were made aware of its shortcomings, which might be seen as normalization. They saw that the care they delivered was not what was expected from a recovery perspective, and thus the instrument offered specifications on ‘normal’ vis-à-vis ‘deviant’ care. ‘Normal’ care is, among other things, care oriented towards recovery of clients, and the ROPI instrument specified the elements (enough personnel, client participation in the neighbourhood, etcetera) of such a recovery perspective.

Because some of the preconditions (like personnel capacity) were outside the purview of improvement teams, the faculty team gave the results to managers of the institutions, hoping that actions would be taken at that level. The program manager for example said: ‘I hope the ROPI will make managers aware of it: we have to perform better (...) if only to *begin* with providing recovery oriented care.’ So because the ROPI-results were given to managers, the instrument also governed entire departments of participating organizations. Because they received the results of the ROPI assessment, the actors in the organization knew they were being observed and judged by the faculty team and a variety of other parties. Thereby the instrument itself had a panoptic function.

As another consequence of the ROPI instrument, teams compared their clients to those of other teams. For example, at a project leaders' meeting of 'Recovery-oriented care and social participation' the teams' ROPI scores were presented graphically, offering the opportunity to compare results. The presenting faculty team member, however, warned teams that 'it is not a race against each other but with each other'. One project leader claimed her experience with doing this in the preceding 'Recovery-oriented care' project was that her team's low ROPI score evoked criticism from other teams. The project leader attributed the low score to a difficult client group.

This seems to be a paradoxical consequence of an instrument aimed to assess the extent to which professionals seek to go beyond the strict role of mental health care client and explore clients' potential. Hence, even when a measurement instrument is to assess only health care delivery, it may have consequences for how professionals perceive their clients (as abnormal, normal, difficult) compared to clients of other teams. In this way, the ROPI and the 'Recovery-oriented care' project in general introduced a 'normal' client and a normal way of delivering care to which all teams were encouraged to relate.

To summarize, as an illustration of institutional-level measurement, the ROPI produced different ways of directing behaviour: (1) it tested the organizational preconditions for delivering recovery-oriented care, thereby having a 'confrontational' function for both improvement teams and organizations' managers; and (2) by producing (knowledge on) a normal way of delivering care it made some teams define their care and client group (for example, a 'difficult' client group) in a way that could be different from the stated intentions of the instrument.

Measurement instruments at client level

In contrast to the projects 'Recovery-oriented care' and 'Recovery-oriented care and social participation', the other improvement projects mainly used client-level instruments. For instance, in the project 'Not (only) the mind but (also) the body' biometric measures like blood pressure or BMI were assessed. Such measures steered the behaviour of improvement teams by, for example, raising awareness of clients' physical health. The program leader of the project 'Not (only) the mind but (also) the body' said the awareness was the first result of the improvement project. In that sense, an improvement project first has to create a problem and has to make teams aware of it (cf. Callon, 1986; Hilgartner, 1992). By using specific measurement instruments, for example to measure certain physical measures such as blood pressure, actors can come to define certain situations as problematic; it provides them with a norm for how to judge clients' situation, for example whether or not clients were healthy.

Making actors define a certain situation as problematic can be seen as a normalizing effect of the measurement instrument that contributes to how 'normal' care is defined and thus to how improvement teams think about, judge, and go about providing care.

Furthermore, the instruments contribute to a particular conceptualization of the problem. In 'Social participation', a dominant conceptualization was individualization: individual clients and their networks were often the starting point for improvement actions. 'Everyone decides for him/herself what he/she wants with his/her social life,' as the program leader strikingly articulated this way of constructing social participation. By formulating the indicators and encouraging improvement teams to measure on an individual level, faculty members contributed to such a conceptualization. Improvement teams were thus framed in a certain way, conceptualizing sociability by locating it within the individual, where it was also possible for example to focus on group-level sociability (Broer *et al.* 2011). As such, the measurement instrument created a problem as well as a particular conceptualization of the problem, which had consequences for the improvement actions (i.e., whether they were directed at the individual client or a group of clients).

Measuring at client level was not only a way of governing improvement teams, but had direct consequences on clients' behaviour as well, which we refer to as a change in their technologies of the self. We address these in the next section, and also analyse how changes in clients' technologies of the self are accompanied by changes in professionals' technologies of the self.

Technologies of the self

Ultimately, CfB aimed to improve clients' lives. Following our framework based on Foucault's theory of power, we conceptualized the improvements as changes in clients' technologies of the self, i.e., techniques 'which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being' (Foucault, 1988c pp. 18). Hence technologies of the self refer to subjects who perform self-regulating or self-disciplining behaviour; it is about people governing themselves.

There were several ways of addressing clients' technologies of the self within CfB. One was by using client-level measurement instruments. For example, the network circle used in 'Social participation' had clients talk about their wishes, a technology of verbalization. As a technique of the self, verbalization provides a way of construing one's self. It is not just a process that reflects inner mechanisms, but changes the way the mechanisms are perceived and acted upon, and changes the inner mechanisms accordingly (cf. Foucault, 1988c). In the social participation project for example, the technique of verbalization changed how clients perceived and acted upon their social lives. They were, for instance, confronted with their ‘empty’ social lives, as one project leader described the lives of several of his clients. Clients became aware of their small social networks when they were participating in the network circle conversation or in client meetings organized in the context of this project. As a result, clients sometimes began to exhibit more ‘social’ behaviour even though no formal improvement actions had been taken. One client for example came across the death announcement of one of his old friends and decided to go to the funeral. There he met some other old school friends with whom he re-established contact. The project leader said this was a good example of ‘the effect of talking about’ social lives or social participation, as the client would never have gone to the funeral if he had not attended the meetings concerning social participation.

Also client autonomy was deemed an important technology of the self. Making people responsible for their own lives is also a way of governing them towards certain aims and therefore autonomy can also be seen as a technology of the self and simultaneously a technology of governing others. Using the word ‘autonomy’, as many improvement teams did, and encouraging clients to become more autonomous is therefore a governing technology in itself. In CfB, many improvement actions were either meant to improve client autonomy (for example, asking after clients’ preferences) or the improvement actions were developed in such a way that they would not decrease client autonomy.

Governing through autonomy had different consequences. For one thing, it made clients more self-managing, such as cooking for themselves. ‘People who used to be too lazy to lift their cups [of tea or coffee] are now peeling potatoes for twenty people,’ one team member said at the closing conference of ‘Recovery-oriented care’. This improvement team further reported that their organization’s management strengthened this goal of clients cooking themselves because it would lead to a reduction in costs. In such cases, the concept of client autonomy aligns with the wishes of professionals and managers. But by introducing the concepts, clients were made more responsible for their own lives and failures. The desirability of this effect was sometimes discussed because it could also lead to clients failing repeatedly. Furthermore, some clients did not adopt autonomous behaviours, like those who held on to being dependent or those who claimed to have no wishes at all (Broer *et al.* 2010a).

Changes in governing clients’ technologies of the self were frequently accompanied by changes in professionals’ technologies of the self. One improvement team, for example, had invented various interventions to ‘recover’ their clients, but then realized it would be a form of 'forced' recovery. They therefore changed course; they now planned to study the negative impact professionals could have on clients and investigate which ward rules were perceived as restraining by clients. In this example, professionals' technologies of the self changed in two ways: (1) they critically examined their own behaviour of imposing improvement plans upon clients and (2) the ensuing change in improvement plan was to alter the behaviour of professionals rather than clients. Their aim is to think about their attitudes towards clients and to change these (since they planned to study the negative impact they could have on clients) – and this aim itself is already a different way of thinking about their attitudes and behaviour. Thereby, concepts like client autonomy are also techniques that enable professionals to govern their own behaviour.

Discussion

In investigating the role of power in the CfB program, we used Foucault's power theory. We investigated how the different actors involved were governed and how they came to govern themselves differently. We analysed the CfB program as a policy instrument that was used as a strategy to eventually achieve more desirable states in mental health care clients. On the one hand, the different actors were responsible for their own quality of care; on the other, improvements had to be made visible for example by also conducting an evaluation study that we analysed as being a policy instrument in itself. On the institutional level, three dominant ways of governing teams were employed: autonomy, the panoptic function of the projects, and measurement. Finally, clients' technologies of the self were addressed, for example, in that they had to become autonomous subjects. Such changes were accompanied by changes in professionals' technologies of the self.

The consequences of the governing mechanisms could always turn out to be different than expected. First, actors had the freedom to resist. Second, actors could use the governing mechanisms for their own means, like using the visibility of the project to build a better image for themselves. Third, actors could change the roles proposed to them by, for example, modifying the project and thereby changing the collaborative's pre-defined topic. However, even though such techniques sometimes led to resistance or unexpected behaviour, measuring produced particular knowledge that the different actors had to relate to, thereby producing 'normalizing' effects (Sauder & Espeland, 2009; Triantafillou, 2007). Whether actors obeyed or not, they still had to relate their care and clients to the knowledge on normal care and normal clients introduced and produced by the different techniques in CfB. Thereby, such techniques sought to facilitate the self-regulating capacities of organizations and professionals (Triantafillou, 2007). Having particular knowledge of oneself or of one’s own organization enables persons or organizations to act upon themselves in relation to political rationalities.

We are aware that this analysis sketches a picture of clients and professionals in which they are mainly subjected to expert regimes. Because our starting point was how governance took place and was given shape *through* the QIC, we necessarily did not take into account self-governance practices that were unrelated to the QIC. Yet in his later work, Foucault went beyond his normalization arguments and searched for ways in which individuals could become subjects who care and think for themselves instead of being subjected to expert knowledge and normalization practices (Foucault, 1988a; Randall & Munro, 2010). An interesting question for future research would then be whether self-care practices are possible in mental health care institutions – where expert regimes prevail – and if so, how such practices might be stimulated.

From a public policy perspective, however, the governance mechanisms might be most interesting and should be explored in more comparative analyses. Especially the focus on the consequences of the governing techniques has been useful for our analysis. Although this idea is not new in governmentality studies and Miller and Rose (2008) for example argue that technologies may produce unintended effects, governmentality is more often investigated in terms of its rationality and theoretical consequences than in terms of its empirical consequences. Whereas the investigation of technologies’ consequences might be less relevant when the aim is to characterise governmentalities in terms of ‘family resemblances’ like whether technologies use elements of advanced liberalism (Rose *et al.* 2006; Miller and Rose 2008), the (ethnographical) focus on their consequences provides more insight into the ways in which governmentality actually is created. The consequences then are themselves constituent of governmentality (Higgins 2004; Cadman 2010). Therefore, a focus on consequences of technologies provides more insight into the construction of governmentality.

Moreover, such a focus on consequences leads to new questions in the context of public policy, as our analysis shows. For example, an interesting set of questions concerns measurement and knowledge practices aimed to investigate public services. As measurement instruments are increasingly used to benchmark a diverse range of organizations, our analysis suggests investigating the consequences of the instruments in terms of resistance, normalizing effects, and how professionals deliver care and think about their clients. Whereas these questions receive growing attention in public administration literature (cf. Noordegraaf & Abma, 2003), measurement is still often evaluated in terms of its negative and perverse effects rather than its enabling effects (Triantafillou, 2007). Our analysis shows that measuring enables improvement practices, and studies on measurement practices should therefore be more sensitive to these effects. The focus should then be more on the consequences of specific measurement arrangements in specific situations.

Our analysis furthermore shows that a rather specific conceptualization of quality of care was adopted in many of the projects. Quality of care was almost always perceived as an issue for and a responsibility of care professionals, whereas management was not often mentioned at the conferences and meetings. It was up to improvement teams to seek commitment from managers. The ROPI instrument formed an exception, as the faculty team gave the results to organizations' managers to try to ensure better pre-conditions for recovery-oriented care. Hence, how faculty frames quality of care may have consequences for the extent to and the ways in which management is involved (Strating et al., 2008). Exploring different ways of conceptualizing and performing quality of care and the consequences of such articulations for the different actors involved might be an interesting focus for future research (cf. Zuiderent-Jerak et al., 2009).

Using Foucault's conceptualization of power thus allows for a more substantive discussion on the consequences of power mechanisms and therefore proves to be valuable for studying public policy. Such a conceptualization and analysis of power raises questions as to how public policy transforms citizens, professionals, and organizations and how it changes their self-governing capacities. Furthermore, a detailed description and analysis of these consequences also provides more insight into how governmentality is exactly created.

References

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*, 11-23.

Bate, P., & Robert, G. (2002). Studying health care "quality" qualitatively: The dilemmas and tensions between different forms of evaluation research within the U.K. National health service. *Qualitative Health Research*, *12*(7), 966-981.

Broer, T., Nieboer, A.P., & Bal, R. (2010a). Quest for client autonomy in improving (long term) mental health care. *International Journal of Mental Health Nursing*, *19*(6), 385-393.

Broer, T., Nieboer, A.P., & Bal, R. (2010b). Opening the black box of quality improvement collaboratives: an Actor-Network Theory approach. *BMC Health Services Research*, 10, 265.

Broer, T., Nieboer, A.P., Strating, M.M.H., Michon, H.W.C., & Bal, R. (2011). Constructing the social: an evaluation study of the outcomes and processes of a 'social participation' improvement project. *Journal of Psychiatric and Mental Health Nursing*, *18*(4), 323-332.

Callon, M. (1986). Some elements of a sociology of translation: Domestication of the scallops and the fishermen of st brieuc bay. *Power, Action and Belief: A New Sociology of Knowledge*, *32*, 196–233.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*(4), 11-19.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*. London: Penguin Books.

Foucault, M. (1978). *An introduction, the history of sexuality 1*. New York: Vintage Books.

Foucault, M. (1985). *The use of pleasure, the history of sexuality 2*. New York: Vintage Books.

Foucault, M. (1986). *The care of the self, the history of sexuality 3*. New York: Vintage Books.

Foucault, M. (1988a). The ethic of care for the self as a practice of freedom. An interview with Michel Foucault on january 20, 1984. In J. Bernauer, & D. Rasmussen (Eds.), *The final foucault* (pp. 1-20). Cambridge, Massachusetts: The MIT Press.

Foucault, M. (1988b). The political technology of individuals. In L. H. Martin, H. Gutman & P. H. Hutton (Eds.), *Technologies of the self* (pp. 145-162). London: Tavistock.

Foucault, M. (1988c). Technologies of the self. In L. H. Martin, H. Gutman & P. H. Hutton (Eds.), *Technologies of the self* (pp. 16-49). London: Tavistock.

Foucault, M. (2006). *History of madness*. London and New York: Routledge.

Foucault, M. (2010). *The government of self and others. lectures at the college de france, 1982-1983.*

Gordon, C. (1991). Governmental rationality: An introduction. In G. Burchell, C. Gordon & P. Miller (Eds.), *The foucault effect: Studies in governmentality* (pp. 1-53). Chicago: Chicago University Press.

Hacking, I. (1986). Making up people. In T.C. Heller, M. Sosna and D.E. Wellbery (Ed.), *Reconstructing individualism: Autonomy, individuality, and the self in western thought.* (pp. 222-236) Stanford, Stanford University Press.

Hacking, I. (1999). *The social construction of what?*. Harvard: Harvard University Press.

Heyes, C. J. (2006). Foucault goes to weight watchers. *Hypatia*, *21*(2), 126-149.

Higgins, V. (2004). Government as a failing operation. *Sociology*, *38*(3), 457-476.

Hilgartner, S. (1992). The social construction of risk objects: Or, how to pry open networks of risk. In J. F. Short, & L. Clarke (Eds.), *Organizations, uncertainties, and risk* (pp. 39–53). Boulder: Westview Press.

Kilo, C. M. (1998). A framework for collaborative improvement: Lessons from the institute for healthcare improvement's breakthrough series. *Quality Management in Healthcare*, *6*(4), 1-13.

Lacombe, D. (1996). Reforming Foucault: A critique of the social control thesis. *British Journal of Sociology*, *47*(2), 332-352.

Lascoumes, P., & Le Gales, P. (2007). Introduction: Understanding public policy through its instruments—from the nature of instruments to the sociology of public policy instrumentation. *Governance, 20*(1), 1-21.

Lemke, T. (2001). 'The birth of bio-politics': Michel Foucault's lecture at the collège de france on neo-liberal governmentality. *Economy and Society*, *30*(2), 190-207.

Noordegraaf, M., & Abma, T. (2003). Management by measurement? Public management practices amidst ambiguity. *Public Administration*, *81*(4), 853-871.

Power, M. (2003). The audit society—Second thoughts. *International Journal of Auditing*, *4*(1), 111-119.

Randall, J., & Munro, I. (2010). Foucault's care of the self: A case from mental health work. *Organization Studies*, *31*, 1485-1504.

Rhodes, R. A. W. (2007). Understanding governance: Ten years on. *Organization Studies*, *28*(8), 1243-1264.

Rose, N. (1998). *Inventing our selves: Psychology, power, and personhood*. Cambridge: Cambridge University Press.

Sauder, M., & Espeland, W. N. (2009). The discipline of rankings: Tight coupling and organizational change. *American Sociological Review, 74*(1), 63-82.

Simon, B. (2005). The return of panopticism: Supervision, subjection and the new surveillance. *Surveillance & Society*, *3*(1), 1-20.

Strathern, M. (2000). The tyranny of transparency. *British Educational Research Journal*, *26*(3), 309-321.

Strating, M. M. H., Zuiderent-Jerak, T., Nieboer, A. P., & Bal, R. A. (2008). *Evaluating the care for better collaborative: Results of the first year of evaluation*. Rotterdam: Dept. of Health Policy and Management.

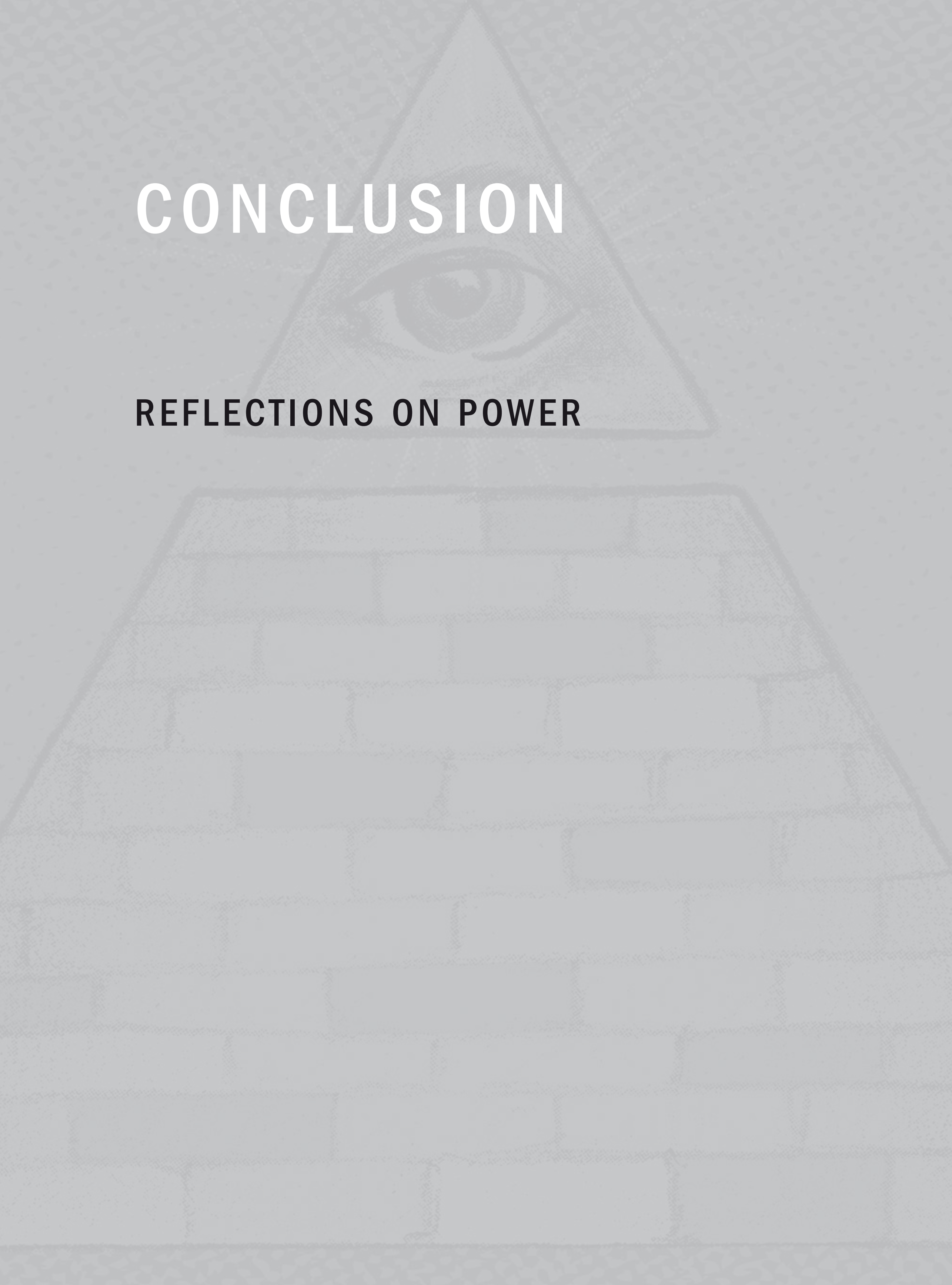
Triantafillou, P. (2007). Benchmarking in the public sector: A critical conceptual framework. *Public Administration*, *85*(3), 829-846.

Walt, G., Shiffman, J., Schneider, H., Murray, S. F., Brugha, R., & Gilson, L. (2008). 'Doing' health policy analysis: Methodological and conceptual reflections and challenges. *Health Policy and Planning*, *23*(5), 308-317.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine*, *69*(12), 1713-1721.

CONCLUSION

REFLECTIONS ON POWER



Good care

At the time of finishing my thesis, a fierce discussion was taking place in the Netherlands. Starting point was an intellectually disabled man named Brandon who inside his room in a care institution was tied to the wall for some eight hours a day for almost three years. The media and the public mainly reacted disapprovingly. There was even a call for a petition; the “Free Brandon” petition argues that Brandon’s situation is “scandalous, degrading, and barbarous” (Petities.nl, 2011). One of the managers of the care institution reacted and took a defensive stance: “It is a very tough job. We [the personnel of the care institution] are really dedicated. It’s shocking to see your work incriminated as “look how scandalously they go about” (De Volkskrant, 2011). His comment was supported by the Inspectorate and the Ministry of Health Care. These parties visited the care institution and came to the conclusion that no faults were made in Brandon’s case although the State Secretary said that she wanted to do her utmost to improve on this situation and similar ones. Currently, Brandon lives in another home with fewer clients and more care professionals per client.

This example is interesting for several reasons. First, it shows a distinction between two ways of judging whether a certain situation can be defined as ‘good care’. On the one hand, the general public outcry suggests that good care can be defined mainly from outside the care practices, as judged according to a general norm. Tying a patient to the wall from this perspective is bad care, regardless of the circumstances. On the other hand, the manager of the care institution and the ministry and inspectorate have taken the specific situation, the employees and the client and his family in consideration before pronouncing on a judgment. From this perspective, good care was provided in this case, although it was certainly not ideal. Second, the example shows that good care is (increasingly) governed by ‘outside’ parties.

The example thereby explicates the two questions that were central to this thesis:

- *How is good care enacted (performed, discussed, improved) in contemporary mental health care practices?*
- *How is (good) care governed on the different levels of the mental health care field?*

In this concluding chapter I describe the research methodology, address the above questions, the limitations of the study, and finally reflect upon the consequences of the findings in this thesis.

Theoretical inspirations

Theoretical inspirations for this thesis mainly came from Actor-Network Theory (ANT) and the work of Foucault. By drawing on ANT, I followed how good care was *enacted*. That means that I did not specify beforehand what good care should be or what would be considered the (moral) dilemmas within care situations. Rather, I followed how different – human and non-human – actors performed or enacted good care (Mol, 1998). Good care gets its meaning within the care practices rather than being defined from 'outside', from this perspective. Furthermore, from an ANT perspective one should investigate what issues the actors themselves struggle with.

Second, I drew on Foucault's theory of power. As introduced in chapter 5, one important term Foucault used is that of 'governmentality', which combines a certain political rationality with technologies of power. Drawing on this notion, I investigated the techniques used within CfB and the underlying rationalities, assuming that care is governed through these techniques. According to Foucault, power can be exerted through a heterogeneous range of techniques. In his analysis on the history of mental illness and psychiatry for example, he showed how the built environment of institutions, the distribution of patients over the institution, measurement instruments, questions and observations, and the like contributed to creating certain kinds of patients, for example the hysteric patient (Foucault, 2006; Foucault, 2008). These elements can, in Foucault's theory of power, all be referred to as techniques. Techniques then constitute people in certain ways, they lead to subjectification (Papadopoulos, 2008), or, in other words, to the creation of (certain) selves (Hacking, 1986). Measurement instruments are a good example of such a technique and of the consequences it may have. As measuring is a form of knowledge and creates further forms of knowledge, it is thus also a set of norms by which phenomena of deviance can be described and norms for behaviour constituted (Foucault, 2010; Sauder & Espeland, 2009). By having set, for example, a mean score as a standard, this value becomes a cut point that can transform people's (thinking about their) behaviour (Foucault, 1977; Triantafillou, 2007). Therefore, measuring has a normalizing effect.

Thus, in Foucault's theory of power, governance takes place through such techniques, which can be both techniques to govern other people or to govern oneself (Foucault, 1978). These techniques shape clients in certain ways but will also have consequences for identities of professionals, organizations, and the mental health care field in general. Therefore, Foucault's theory of power led to two questions for this thesis: how (by what techniques) is (good) care governed and what are the consequences of these governing techniques? A theoretical aim of this thesis was to combine Actor Network Theory with Foucault's theory of power; I will come back to this later.

Methodology

I studied good care and the governance of good care by following a large quality improvement collaborative (QIC) called Care for Better (CfB). Six projects were executed mainly in mental health care and were the setting of this thesis. In each project, 7 to 30 improvement teams – mainly consisting of mental health care professionals – participated to improve the care within their own organizations on a certain topic, for example the clients' physical health. I used two forms of data collection for this thesis: observations and interviews. During national conferences and other meetings organized in the context of these projects, the improvement teams and other stakeholders engaged in discussions on good care. Observing these discussions thus allowed me to address how good care was defined, discussed and improved within these projects and, to some extent, within mental health care in general. Furthermore, since the CfB program was set up to improve and therefore to govern mental health care, the conferences in general and the discussions also allowed me to address the question how governing was done. Thus, both for the question on good care and on governing care, ethnographic observations formed a large part of the methodology. Secondly, I relied upon interviews with different people to explore the rationality and ideals behind improvement actions and methods and to explore the consequences in more detail. Mainly I interviewed program leaders and different people from and associated with improvement teams.

Hence, rather than studying good care practices within care institutions, I studied improvement projects in which good care was made explicit. On the one hand, the improvement projects were meant to improve care and can thus be seen as forming part of the care practices. On the other hand, by making the care practices more explicit, the improvement projects can be seen as “magnifying glasses” (Todorov, 1997), ‘revealing’ idea(l)s and considerations also present in normal situations. During the discussions at the national conferences for example, specific care situations were considered from different perspectives, thereby ‘magnifying’ these situations.

‘Liberté, egalité, fraternité’

The first question explored in this thesis concerns the enactment of good care within the CfB program. While the adage ‘*rust, reinheid en regelmaat*’ (rest, pureness, and regularity) is sometimes used to typify the Dutch mental health care institutions of the beginning of the twentieth century (Sins, 2004), contemporary mental health care seems to be about different values. Important ideals now are client autonomy, freedom, self-fulfillment, equality and choice. Clients should be free to make their own decisions, should be and are equal to professionals and to others in general, and professionals should engage in 'professional friendships' with clients. Therefore, the new adage within mental health care could be described – slightly provokingly – as '*liberté, egalité, fraternité*'.

In the chapters in this thesis I explored these different ideals of good care. One important ideal, investigated in chapter 2, was that of sociality, which – in the 'social participation' project at least – could be enacted in two ways. First, sociality could be defined in an individualizing manner. For example, improvement teams asked after clients' wishes or after clients' (perceptions of) their own social networks. Thus, the starting point of improvement actions was an individual wish of a client and/or the perception of one's social network. Important 'techniques' for improving clients' social lives included having clients verbalize and act upon their wishes and their social lives. The second way of enacting sociality was in terms of normalization. Here, participating in activities in the neighborhood and meeting 'normal' people (i.e. not clients) were deemed most important.

Secondly, the ideal of autonomy received considerable attention within the CfB program, although only one of the improvement projects ('recovery oriented care') was specifically dedicated to client autonomy. In some cases client autonomy was the goal of improvement actions whereas in other cases the improvement actions ideally had to be developed in such a way so as not to decrease client autonomy, for example by ensuring that improvement actions were aligned with clients' preferences. I discerned four ways of approaching autonomy: removing restraints, putting clients' preferences centre stage, increasing independency of clients, and equalizing the relationship with clients. Each approach brought with it different moral dilemmas. For example, asking for clients' preferences and wishes sometimes presented the dilemma that clients said they had no wishes at all. So the specific approach to autonomy partly shapes what are seen as (moral) dilemmas (having no wishes is not a problem in the other three approaches to autonomy), and, the other way around, exploring what are seen as moral dilemmas also helps in deconstructing what is actually meant by the term 'autonomy' in a certain situation.

A final ideal that I explored within this thesis was that of client participation. Client participation could be achieved either by involving clients officially in the improvement team or by asking them to help develop and execute specific improvement actions. In either way many improvement teams were struggling to create a good structure of client participation without exerting power on them. Creating a structure for client participation was sometimes considered as exerting (negative) power in itself and therefore needed to be avoided. Furthermore, teams were struggling with whether or not to emphasize the (client) background of participating clients. On the one hand this background would set clients apart as a special (and unequal) group, on the other hand this background was often the reason and justification for their participation. In general, the concept of power had a profound influence on how the participation process was (not) performed, an issue to which I will come back below when discussing the governing of good care.

To summarize, there were different ideals on good care that often could have different meanings within different practices and for different actors. Even within one care situation, professionals often had to balance between different values, like improving care and maintaining client autonomy, or between different versions of autonomy. One interesting dilemma in this respect was whether or not clients should be allowed to categorize professionals as friends. On the one hand professionals sometimes argued for equality and asked themselves why clients should be approached differently than professionals. On the other hand, equal relationships were beyond reach given that professionals were paid to care for the clients. Furthermore, it was deemed good for clients to realize that professionals were professionals and could not become their friends, and that they should go looking for friends beyond the walls of the care institution. This example shows the existence of multiple values or value pluralism (Galston, 1999); in many situations there are multiple values at stake that cannot be addressed all.

Governing (good) care

The second question explored in this thesis concerns the governance of (good) care. The CfB program can be conceptualized as a policy instrument aimed to govern mental health care and the different actors involved. Therefore it is also a way of exerting power. It comprised several instruments or power techniques that all tried to constitute mental health care and mental health care actors in a certain way. Whereas power is sometimes seen as a predominantly negative concept, in this thesis I drew on Foucault's conceptualization of power, in which power can be both positive and negative, restrictive and enabling (Foucault, 1978; Triantafillou, 2007). Power, then, is produced in a relationship rather than being a characteristic or property of one person (Foucault, 1988). Furthermore, Foucault maintained that all relationships – even intimate ones – are also power relationships. There are no relationships without power; non-power is impossible (Foucault, 1988). Resistance for example, sometimes seen as antithetical to power, is the acknowledgement of the power relation; resistance is only needed and is only possible when one is already in a power relationship (Foucault, 1977; Sauder & Espeland, 2009).

Based on Foucault's theory of power I deduced two questions that became leading in my analysis of CfB as a policy instrument, as described above: how is power exerted (through what instruments) and what are the consequences. Within the CfB collaborative, several instruments were used to govern (and constitute) the different actors involved. One predominant way of steering improvement actions, professionals and clients was formed by the measurement instruments. Several of these instruments were described and analyzed in this thesis. For example, the ROPI instrument within the 'recovery oriented care' project was one way of introducing and strengthening a particular conceptualization of recovery and making actors uphold this conceptualization. Thus, it introduced a particular view on what constituted normal care and normal clients. Furthermore, the ROPI instrument was applied on ward level, rather than on professional or client level as were most of the other instruments. Therefore, the ROPI instrument and the way in which it was put to use also stimulated involvement of (middle) managers, as shown in chapter 5. Similarly, chapter 2 showed how the measurement instruments within the 'social participation' project strengthened an individual way of conceptualizing social networks, in which sociality was placed within individuals and in which clients did not automatically form each others networks. Such conceptualizations have consequences for how care is delivered, how clients are approached and thus for how clients are constituted or become (certain) subjects.

In a similar way, the evaluation study was a way of governing the different actors involved, as chapter 5 demonstrated. Evaluation is not only aimed to evaluate policies; it is a policy instrument in itself (N. S. Rose & Miller, 2008). Measuring whether improvements are attained and making actors knowledgeable of these measurement instruments lead to changes in behaviour. Moreover, evaluation is part of a specific form of governmentality. On the one hand the improvement teams participating in CfB were made themselves responsible for quality improvement, on the other hand improvements had to be demonstrated – for example by the activities of the evaluation study. In general, visibility of the improvement actions and of improvement actors functioned in the projects as a way of governing the actors, which I referred to as the panoptic function of the projects.

Finally, many of the values outlined in the above section as part of good care were also ways of governing the different actors. Autonomy, for example, was an ideal of good care and at the same time was a way of steering both professionals and clients. Professionals were encouraged to improve or at least maintain client autonomy or they themselves already considered client autonomy to be important. Furthermore, governance takes place by making clients responsible for their own lives or by making them verbalize their preferences. For example, asking after preferences first of all implies clients should have preferences and, secondly, outlines a specific domain on which they should have preferences (the question is always embedded in a situation). Also the way sociality is conceptualized is an ideal of good care and a way of steering mental health care organizations, professionals and clients. This conceptualization changes the way which organizations and professionals see and perform their tasks and it may change clients' perceptions of themselves. In chapter 5 I analyzed such ways of governing as 'technologies of the self'. Technologies of the self can be used by people themselves to govern their own behaviour but they can also be used to govern others. Either way, these technologies change not only people's behavior but also what subjects they are (for example autonomous subjects) (cf. Rose, 1998).

Power

Interestingly, it was not only I who questioned the issues of governing and power. Professionals themselves often reflected upon the power concept – either explicitly or implicitly – and scrutinized how they exerted power on clients. Mainly at the conferences, professionals discussed their improvement practices in terms of how these shaped identities of clients and also in terms of the acceptability of defining for clients what their identities should be. Even improving client autonomy was sometimes considered to be negative power, as chapter 3 showed. Many professionals said they had no right to determine for clients how they should live their lives, in other words to determine what subjects clients should be. Ideals such as autonomy, equality and empowerment were deemed paradoxical since these would always be defined (partly) by professionals – even merely ascribing significance to these ideals points, one could say, at inequality. Emphasizing equality is warranted only in situations where inequality is experienced.

Power was also a dominant theme in the analysis on and performance of client participation, as shown in chapter 4. Ironically, the reflection upon power (mechanisms) sometimes inhibited the practices that professionals wanted to create. On the one hand they wanted to enable clients to participate but on the other hand every action aimed to enable them was seen as (negative) power that should be avoided. These situations might be seen as a form of "paralysis by analysis". Because professionals analyzed the situation over and over again and framed every possible action as negative, the possible repertoire of behaviour became limited. This led to a situation that I referred to as 'mutual powerlessness': a situation in which none of the actors felt able to shape a practice of 'good' client participation, i.e. a situation that renders them *all* powerless in terms of client participation. Knowledge (for example on how power may work) may simultaneously generate power and powerlessness.

As the analysis on client participation in chapter 4 demonstrated, constantly criticizing mental health care and its 'practices of power' is analytically not interesting and furthermore does not help in improving care. Therefore, this thesis can be read as (a plea for) a reconceptualization of the power concept. By acknowledging that non-power is not possible, the discussion may shift from the question whether there *is* (professional) power – or not – to the consequences of applying specific power techniques. In chapter 5 for instance I argued that in the specific conceptualization of quality of care largely upheld within the CfB program, quality mainly was the professionals' responsibility. This conceptualization could have consequences for example for the involvement of managers. The 'recovery oriented care' project formed an exception to the general pattern; quality of care here was (also) a managerial issue and involvement of managers was considered necessary for improving basic conditions in the organizations. Hence defining quality of care in a certain way is a power mechanism with certain consequences for how improving is and can be done. Similarly, not analyzing and judging client participation in terms of whether there is power but in terms of how it can be performed in a more enabling way may open up possibilities for improvement practices. This also means that urging for client participation may not be the best way to actually establish a practice of client participation (cf. Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009). Thus, studying the consequences of certain actions rather than studying simply the presence of power mechanisms enriches discussions on and practices of client participation and discussions on power practices more generally.

Conclusion on governing good care

In general, the CfB program provided an interesting case for studying the governance of mental health care. It was a policy instrument in itself and comprised several techniques that governed the different actors involved, such as the measurement instruments including the evaluation study, the panoptic function of the projects, and the ideals of good care. One ideal seemed to be exerting no power at all, but this was also perceived as a rather paradoxical goal since professionals, too, often realized that non-power was not possible. By acknowledging this and by using Foucault's conceptualization of power, the specific power arrangements can be explored in terms of their consequences instead of being satisfied with the conclusion that there *is* power.

Limitations

In this thesis I chose to focus mainly on improvement practices rather than on 'normal' care practices in the care institutions. This might have led to a couple of limitations. First, following the care practices may well have provided more insight into clients' experiences, for example of the different ideals of good care, experiences I did not generally explore (except for asking professionals after clients' experiences, which is of course not the same as asking clients). I conducted some interviews with clients, which mostly made me feel uncomfortable and at times I even realized it might be unethical doing these interviews. One client was afraid that the interview would be reason for discharge out of the psychiatric institution and he sought reassurance over and over again. Another client after ten minutes became tired of telling his life story, and was happy when I suggested I'd better leave him alone. "Well, that is to say, when you have finished with the interview," he said politely. While clients who participated at the conferences or in improvement teams, had, to my mind, a 'public' function and thus could be interviewed about that public function, the interviews with others would construct them as clients receiving, instead of contributing to, care and as living their lives within care institutions, which might have the effect of contributing to their feelings of marginalization or powerlessness (cf. Moser, 2000). This is (partly) a consequence of my method. More frequent visits to the care institutions would have made it easier perhaps to talk with and especially to observe clients and thus to explore their experiences in a more informal way (cf. Pols, 2004).

A second limitation of my approach is that I mainly relied on the accounts of professionals, which are not merely reflections of the care practices. First, every way in which a situation is represented in words is a subjective account that might be totally different for another person (or even for the same person at another moment). Second, reflection itself is not innocent. It does not merely reflect ideals of good care that are already present in a given situation. Rather, it helps formulating these ideals and it may therefore also change the way the situation is thought about, judged, and acted upon. In the same way in which I in chapter 2 analyzed verbalization as a change (rather than a representation) of (inner) mechanisms, reflection can be seen as a change rather than as a representation of the care practices. What the focus on this reflection does show is what situations professionals think are important to reflect upon and how their perspectives on these situations are (constructed).

That does not mean that the findings described in this thesis are useless outside improvement settings. On the contrary, they do reveal some of the moral dilemmas that professionals have to engage with everyday. For example, the findings in this thesis show many similarities with the work of Jeannette Pols in terms of what values are considered to be important, how these values are defined, and what moral dilemmas are faced within long term mental health care. For instance, the analysis on autonomy in chapter 3 shows many similarities with the approaches to citizenship as analyzed by Pols (Pols, 2006). Studying washing practices therefore may lead to the same conclusions and approaches to autonomy as does studying improvement projects.

From a governmentality perspective the improvement projects furthermore offer relevant insights that are less visible when doing an ethnography in care institutions. The governing of and in mental health care is particularly brought out by the gathering of heterogeneous actors within improvement projects (government, ZonMw, researchers, program leaders, professionals, (some) clients, measurement instruments, etcetera).

Theoretical implications

To study the governance of good care, I combined Actor Network Theory with Foucault's theory of power. Together these theoretical frameworks enabled me to address several issues. First, following how governing is done by studying a policy instrument and its consequences gives the power concept more empirical specificity. It shows some of the power relations that come to be established as a result of the policy instrument. Foucault was said to be more concerned with analyzing 'large' discourses and their underlying rationalities (Law, 1994) and also so-called governmentality scholars like Rose mainly study power as a 'large' concept, for example in terms of neoliberalism (Rose & Miller, 2008). The ANT approach of following specific improvement practices gives more empirical specificity to the consequences of power mechanisms within a particular situation. For example, while autonomy can be seen as a governance mechanism and therefore can be analyzed from Foucault's theory of power, the analysis of chapter 3 shows that there are multiple ways in which autonomy can be maintained and improved – reflecting different rationalities. It also means that resistance and normalization, for example, get different meanings dependent on the approach to autonomy used. Thus, resistance could mean not wanting to live independently or not having any wishes at all. An ethnographic approach allows for a detailed exploration of these diverging reactions and consequences of power instruments (cf. Blommaert & Bulcaen, 2000; Mckee, 2009).

Also, the ethnographic (ANT) approach I adopted entailed studying the issues that actors themselves came up or struggled with. These issues are indicative of the power relations that become established. They for example hint at resistance or at normalization, or they show how actors perceive power mechanisms and why and when they struggle with exerting it. For example, the concept of autonomy was often used to problematize the notion of ‘improvement’, since what improvement would mean should not be determined (solely) by professionals. This then can be seen as a form of ‘resistance’ against improvement projects, or at least against the way they are often set up. Furthermore, different ideals of good care are aligned with different ways of thinking about and exerting power. For instance, the different enactments of sociality also implied different power rationalities and urged professionals, clients and organizations to take up diverging roles. Hence, following the actors and being sensitive to the ‘issues’ they come up with and to their idea(l)s of good care also provide an avenue for investigating the question concerning governing and its consequences. In that way, an approach based on ANT can be productively combined with one based on Foucault’s theory of power.

Finally, the combination of ANT and Foucault’s theory of power helps to understand some of the mechanisms underlying QICs. For example, the panoptical function of the improvement projects is a mechanism that becomes visible from an analysis based on Foucault’s theory of power. It thus shows how some organizations will use the project to improve their reputation or how improvement projects are used by improvement teams to convince their management of the necessity of certain changes not necessarily linked to the improvement project. Also, autonomy as a governance mechanism rather than the limit of power explains some of the workings of the collaborative and improvement actions. Therefore the combination of Foucault’s theory of power and the framework based on ANT is also useful for evaluation studies of QICs (and other policy instruments aimed to govern and improve health care). It provides insight into certain mechanisms and rationalities underlying the QIC and the consequences produced by the different techniques that make up the QIC.

Implications for evaluation studies of complex interventions

Notwithstanding the growing awareness that various methods are available to evaluate complex interventions in health care, one particular view still predominates. This view was sometimes put forward when doing the evaluation of CfB. To illustrate this, one of the program leaders reacted to my draft study written in Dutch. I quote from her email message: “On the one hand you want to evaluate the improvement project; on the other hand you try to engage in a content-based discussion on how (…) care is given shape (…). As to the latter, I think you should not do this; ZonMw has assigned iBMG [the institute where I work; TB] to evaluate the improvement projects and a discussion on the content of

(…) care does not fit that [evaluation] job, I believe.” In other words, evaluation should not be concerned with the content of the programs it is evaluating.

This idea sometimes also comes to the fore in evaluation literature of QICs. Researchers have been urged to “open the black box” of QICs, for example by determining how broad or small a topic is or whether there was a preparation period before the actual program started off (Wilson, Berwick, & Cleary, 2003). In this thesis however I approached and conducted evaluation in a different way. Rather than leaving the content aside and focusing on the (general) processes and outcomes, I argue that evaluation *should* also be about the issues that arise within the improvement and care practices (cf. Zuiderent-Jerak et al., 2009). From an ANT perspective but also from evaluation perspectives like fourth generation evaluation (Guba & Lincoln, 1989), evaluation is not possible without addressing the issues and the content of the care and improvement practices themselves.

Process and content cannot be (a priori) distinguished, as the different chapters of this thesis show. Ideals of good care shape the improvement processes at the same time as they are altered by them. The analyses on client participation in chapter 4 and on autonomy in chapter 3 are good examples. Since autonomy was deemed especially important, in good improvement processes (whatever their topics) client autonomy is recognized and respected. The ideals thus have consequences for how improvement is taken up. Opening the black box of QICs ideally provides more insight into the content of the care practices and helps being sensitive to the issues that the improvement actors themselves struggle with – and thus helps being sensitive to how these issues influence the improvement actions and, subsequently, the topic of the improvement project.

Yet given that the truth is multiple and given that effectiveness can be more than only the predefined outcomes and thus can mean different (possibly contradictory) things to different people, but also given that good care is multiple and concerns different (possibly contradictory) values, policy makers and other actors involved might have a hard job ‘using’ these findings for actual policy making or for their improvement or care practices in a straightforward way. Evaluating and describing QICs only in terms of (governing) good care would wrongly give the impression of a ‘soft’ notion of quality improvement, in which ‘anything goes’.

On the other hand, not immediately agreeing upon the goals of a program but following both how the program and its goals work out in practices (be it care or improvement practices) and what their underlying rationalities are may elicit a different kind of critique. For example, the analysis in chapter 2 shows that there were different ways of improving social networks of clients. These ways may all have led to a wider network and less loneliness.

But being more specific about the actual improvement processes opens the possibility of reflecting on constructing sociality in ways not limited to whether or not improvement actions lead to the expected or warranted results. This would make us more sensitive to underlying rationalities of improvement actions and consequences that perhaps could not have been predicted and would probably have gone unnoticed in other kinds of evaluation studies. Therefore, doing an evaluation in this way makes for a different kind of critique of QICs, complementing other evaluation methods.

This then may also be used in setting up improvement projects. Being aware of the performativity of instruments allows program managers to some extent to adjust the instrument to the practices they want to create. For example, when it is deemed important to involve managers in the improvement practices it makes sense to choose a measurement instrument on ward level rather than or next to instruments on client or professional level. When instruments do not only measure but do also influence the improvement practices, they should be selected in relation to the goals of improvement projects and to how improvement ideally is to be done.

Concluding remarks

Policy instruments such as quality improvement collaboratives provide insight both into the governance of care and into ideals of good care. These two issues are also interrelated, for one thing because professionals themselves often framed ideals in terms of (non-) power. While '*liberté, egalité, fraternité*' was the war cry of individuals who wanted to free themselves, in the CfB program it was mostly the professionals who used concepts such as freedom and autonomy in relation to their clients. This was a paradox highlighted over and over again. One way in which my thesis can be read is as a description and analysis of the different approaches used to overcome this paradox – a paradox that could never be (definitively) resolved, so it seemed. If I have learned one thing during my thesis research it is about the tragedy of many situations in long term mental health care, for clients as well as for professionals. The struggle to provide good care is not only about restraint practices or life-and-death situations but also about whether clients are allowed to categorize professionals as their friends and whether or not to emphasize clients' backgrounds. There are no easy solutions.

References

Blommaert, J., & Bulcaen, C. (2000). Critical discourse analysis. *Annual Review of Anthropology, 29*, 447-466.

De Volkskrant. (2011). *Er is niets fout gegaan met brandon in ‘s heeren-loo.* Retrieved 21-03, 2011, from http://www.volkskrant.nl/vk/nl/2672/wetenschap-amp-gezondheid/study/detail/1826920/2011/01/22/Er-is-niets-fout-gegaan-met-Brandon-in-s-Heeren-Loo.dhtml.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* London: Penguin Books.

Foucault, M. (1978). *An introduction, the history of sexuality 1*. New York: Vintage Books.

Foucault, M. (1988). The ethic of care for the self as a practice of freedom. an interview with michel foucault on january 20, 1984. In J. Bernauer, & D. Rasmussen (Eds.), *The final foucault* (pp. 1-20). Cambridge, Massachusetts: The MIT Press.

Foucault, M. (2006). *History of madness*. London and New York: Routledge.

Foucault, M. (2008). *Psychiatric power: Lectures at the college de france, 1973--1974* Picador USA.

Foucault, M. (2010). *The government of self and others. lectures at the college de france, 1982-1983.*

Galston, W. A. (1999). Value pluralism and liberal political theory. *The American Political Science Review, 93*(4), 769-778.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. California: Sage Publications.

Hacking, I. (1986). Making up people. In T.C. Heller, M. Sosna and D.E. Wellbery (Ed.), *Reconstructing individualism: Autonomy, individuality, and the self in western thought.* (pp. 222-236) Stanford, Stanford University Press.

Law, J. (1994). *Organizing modernity*. Oxford UK: Blackwell.

Mckee, K. (2009). Post-foucauldian governmentality: What does it offer critical social policy analysis? *Critical Social Policy*, *29*(3), 465-486.

Mol, A. (1998). Ontological politics. A word and some questions. *The Sociological Review, 46*(S), 74-89.

Moser, I. (2000). Against normalisation: Subverting norms of ability and disability. *Science as Culture*, *9*(2), 201-240.

Papadopoulos, D. (2008). In the ruins of representation: Identity, individuality, subjectification. *British Journal of Social Psychology*, *47*(1), 139-165.

Petities.nl. (2011). *Free brandon in ‘s heeren loo.* Retrieved 23-03, 2011, from http://petities.nl/petitie/free-brandon-in-s-heeren-loo

Pols, J. (2004). Good care: Enacting a complex ideal in long-term psychiatry. Trimbos Instituut.

Pols, J. (2006). Washing the citizen: Washing, cleanliness and citizenship in mental health care. *Culture, Medicine and Psychiatry*, *30*(1), 77-104.

Rose, N. (1998). *Inventing our selves: Psychology, power, and personhood*. Cambridge: Cambridge University Press.

Rose, N. S., & Miller, P. (2008). *Governing the present: Administering economic, social and personal life*. Cambridge: Polity Press.

Sauder, M., & Espeland, W. N. (2009). The discipline of rankings: Tight coupling and organizational change. *American Sociological Review, 74*(1), 63-82.

Sins, A. (2004). GGZ en filosofie van de levenskunst. *Deviant*, *41*, 34-35.

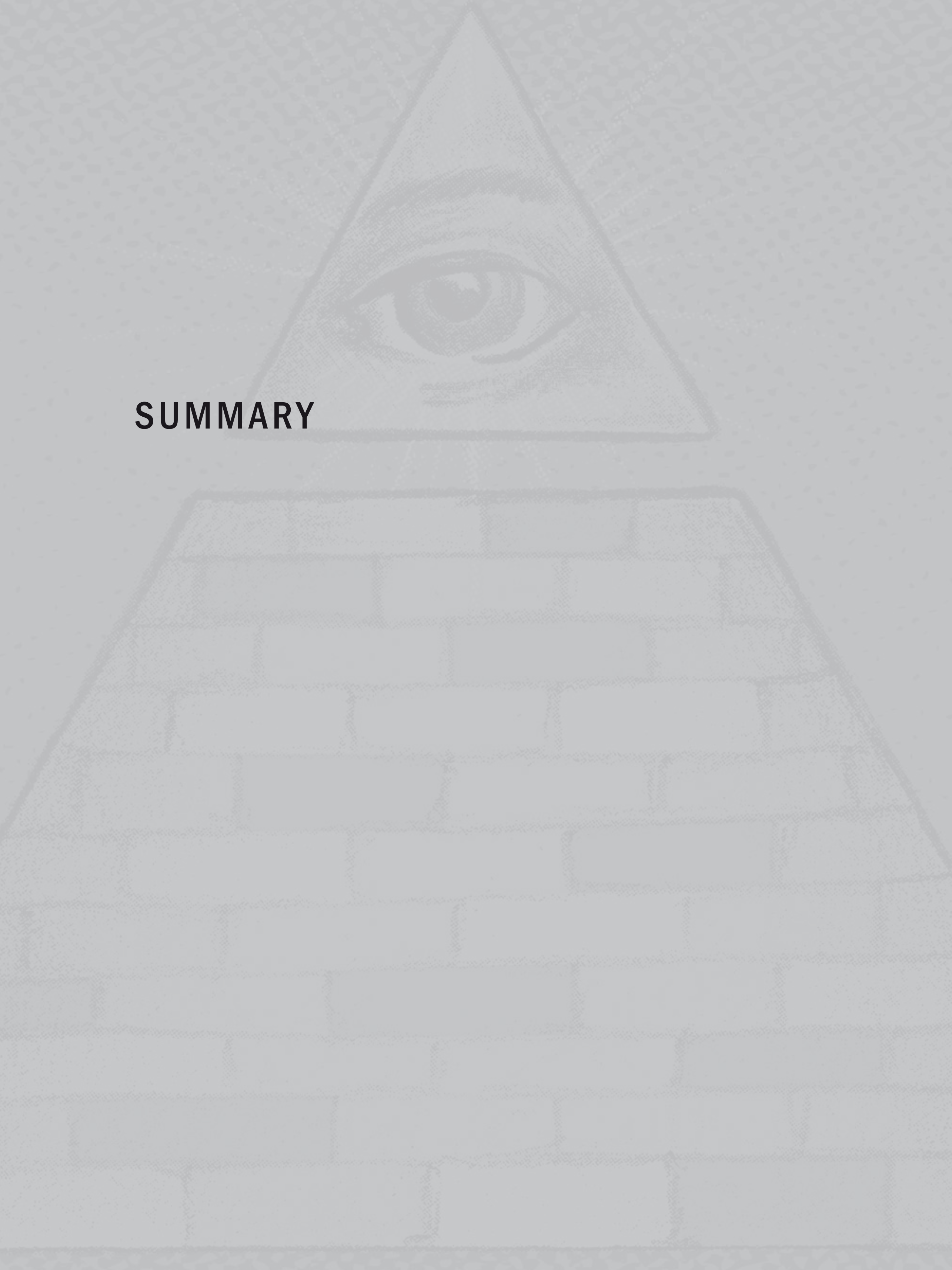
Todorov, T. (1997). *Facing the extreme: Moral life in the concentration camps.* Holt Paperbacks.

Triantafillou, P. (2007). Benchmarking in the public sector: A critical conceptual framework. *Public Administration*, *85*(3), 829-846.

Wilson, T., Berwick, D. M., & Cleary, M. P. P. P. D. (2003). What do collaborative improvement projects do? Experience from Seven Countries. *Joint Commission Journal on Quality and Patient Safety*, *29*, 85-93.

Zuiderent-Jerak, T., Strating, M., Nieboer, A., & Bal, R. (2009). Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine, 69*(12), 1713-1721.

SUMMARY



Summary

During the research for this thesis two interrelated questions emerged: what is good mental health care and how is it governed. I started out with the question what good care means in mental health care settings. Rather than defining good care and the values that should be incorporated in the notion of good care upfront, I followed – in line with Actor-Network Theory (ANT) – how different actors within the mental health care field defined and enacted good care. How do for example professionals go about providing good care? What values are deemed important? How are these values defined and performed? How do different actors decipher what is 'best' in a given situation? What do they see as (moral) problems in providing and improving care? From an ANT perspective it is thus assumed that good care can only be specified by following the actors within mental health care.

To explore these questions [on good care] I studied places where good care was explicitly reflected upon: improvement projects. These may provide an interesting avenue for studying (ideals on) good care. Such places may thus work as 'magnifying glasses' revealing ideals on good care that are also prevailing in the care practices themselves (within the institutions for example). My involvement in the evaluation study of a large quality improvement collaborative (QIC) gave me the opportunity to study such a place where different actors were discussing good care. This QIC, entitled Care for Better (CfB), was initiated by the ministry of Health. In this thesis, I followed six CfB projects. These projects were executed in a mental health care setting. Improvement teams participating in these projects often worked in psychiatric institutions or in a sheltered housing setting.

In order to study idea(l)s on good care, I mainly relied upon two research methods. First, I observed conferences and meetings organized in the context of the different improvement projects. By means of these ethnographic observations, I followed the discussions, the issues that the improvement actors struggled with, the way in which they set about improving care, the way in which improvement actions (were said to) work(ed) out, and improvement actors' ideas, ideals and motivations for providing and improving care in the way they did. Second, I conducted interviews with different actors involved, for one thing with the aim of making their ideas, ideals and motivations more explicit. Mainly I interviewed program leaders and different people from and associated with improvement teams.

Still in the process of data collection, I realized that the improvement projects were not just concerned with discussing care practices and discussing good care. As CfB was a policy instrument, it was (also) set up to govern good care and thus to make different actors perform care in a different way than before. In other words, CfB and the different

techniques used within CfB were also ways of exerting power. This is when the second research question emerged: how is good care governed? To answer this question I relied upon Foucault’s theory of power. According to Foucault, power can be exerted in various ways, also referred to as techniques. Foucault’s theory of power provoked several questions that were important in this thesis. What are the techniques used to govern? What techniques do different actors involved use to establish a certain performance of (good) care? And what consequences do these techniques have in terms of subjectification, i.e. identities of different actors involved, like clients, professionals, mental health care organizations? Importantly, in Foucault’s theory of power, governing takes place on all levels (and not just from government) and it can involve governing other people *and* governing oneself – governing takes place both within and between individuals. Thus, people play a profound role in governing themselves, something Foucault referred to as ‘technologies of the self’. The questions concerning governance of care and concerning good care are related. First, governance within a care setting always takes place with an orientation on a certain definition of good care. Second, ideals of good care always reflect an idea on how governance can and must take place, i.e. what is the best way to exert power (for example on clients or organizations).

In this thesis I thus explored how good care is defined, performed, problematized and governed in and by the CfB QIC and what the consequences are of these processes for the kinds of subjects being created on different levels of the mental health care field. Furthermore, although my thesis is not (a presentation of) an evaluation study, it does address some evaluation-type questions. Mainly, this thesis aims to describe the QIC and its processes and consequences, as a means to open the “black box” of QICs. How can we describe QICs? What are QICs? Here I used the ANT perspective as inspiration, by assuming that an improvement project is (re)constructed during implementation. Both humans and ‘things’ play a role in this construction process. In the improvement projects for example measurement instruments were used to monitor progress of improvement teams. These instruments have a profound influence on how the improvement projects are executed, as would be the assumption from an ANT perspective. To summarize, one of the aims of this thesis is to investigate how the construction process takes place.

Chapter 1 “opens the black box” of quality improvement collaboratives, by taking up a dynamic perspective based on Actor-Network Theory. Two research questions are central. First, I explore how the topic of the ‘recovery oriented care’ project came to be constructed, by the way in which the program management team presented the ‘quality problem’ and possible solutions and by the way in which improvement teams translated these to their own organization and in their own improvement actions. The analysis shows that the problematisation seemed to undergo a shift of focus away from the one suggested by the project leaders. The problematisation depended on both the expert knowledge and the local knowledge of improvement teams.

The second question of this chapter explores how one of the measurement instruments (the network circle) used in the 'social participation' improvement project influenced the improvement topic, i.e. the problematisation process. The network circle, selected by faculty, had several roles. It not only measured results, but also steered improvement actions in the desired direction. As this analysis illustrates, measurement practices in improvement projects not only endorse faculty's problematisation but also carry (subtle) assumptions about who should be able and who has the obligation to do something about the problem. Measurement practices may change the improvement practices – and consequently the improvement projects – in foreseen and unforeseen ways. Taken together this analysis shows that the improvement topic and thereby the ideals on good care can change in the course of a project, for instance due to diverging improvement actions and measurement instruments. Ideals on good care influence the choice of improvement actions to be executed but the ideals are in turn influenced by improvement projects, for example by the measurement instruments.

In *Chapter 2* I further explore the 'social participation' project. The mere existence of the project already indicates that 'social participation' is part of good care. It is thus assumed that (at least some) clients wish to become more social and that these clients want or need to do so with the help of professionals. Yet what is less clear from the outset is what is meant by 'social participation'. Therefore, the main question of this chapter is how social participation or, as I call it, 'sociality' is defined and performed in this project. Rather than determining beforehand what sociality should be and thus establishing a norm as to judge if the program has improved sociality, I investigated how sociality is defined within the project. I undertook a dual approach: investigating the predefined outcomes and analyzing the improvement processes in terms of how these processes construct sociality. As to the predefined outcomes, clients' social networks were not widened, but clients felt significantly less lonely at the end of the project. In a bottom-up analysis of data gathered on the improvement processes I articulated two ways of constructing sociality: individualization, in which clients had to verbalize their wishes (verbalization) and to act upon them more actively (enterprising); and normalization, in which a good social life was one embedded in ‘normal’ community. Since these ways of constructing sociality could not be totally deduced from the measurement instruments used and from the outcomes on the predefined indicators, the mixed methods design proved valuable in providing insight into the improvement project and its consequences. As one of the consequences for example, clients in the normalization approach ideally should participate in ‘normal’ society, by which their living place in fact is devalued and by which they may not be seen as full contacts of fellow clients. This may contribute to feelings of being excluded from normality. Exploring ideals of good care within improvement projects thus makes visible consequences that may go unnoticed when studying only whether a project led to the predefined goals, and is therefore of complementary value.

In *chapter 3* I explore the concept of ‘autonomy’. This concept proved to be central within almost all improvement projects of CfB. Improvement teams struggled with the question how to improve care while not decreasing client autonomy, or made increased client autonomy one of their improvement goals. Discussions at the national conferences were often devoted to this topic. Because it was such a relevant issue for improvement teams, I decided to investigate the autonomy concept in more detail as one of the contemporary ideals on good care. Therefore, I investigated what autonomy meant for the different actors and how they enacted autonomy. I distinguish four different approaches to improve or maintain client autonomy: (1) professionals removed constraints to autonomy and passed initiative to clients; (2) professionals made an active effort to learn and support client preferences; (3) clients were given opportunities towards independent lifestyles; (4) professionals tried to ‘normalize’ their relationships with clients to encourage roles other than those of client. By articulating the dilemmas professionals encountered within the different approaches, the limits of the different approaches to autonomy became more visible, at least within the mental health care setting. For whatever reason, clients had sometimes difficulty performing the behaviour that professionals deemed ‘autonomous’ in the various approaches. The chapter thereby contributes to a reflection on the desirability of the widespread use of autonomy, without aiming to disregard it altogether.

Next to and related to autonomy, client participation in the improvement processes was deemed important within CfB, as an ideal on good care and an ideal of a good improvement process. Therefore the aim of *chapter 4* is to explore how client participation proceeded within CfB. How were practices of ‘good’ client participation shaped? What were the consequences for professionals and clients? And how did that change – or not change

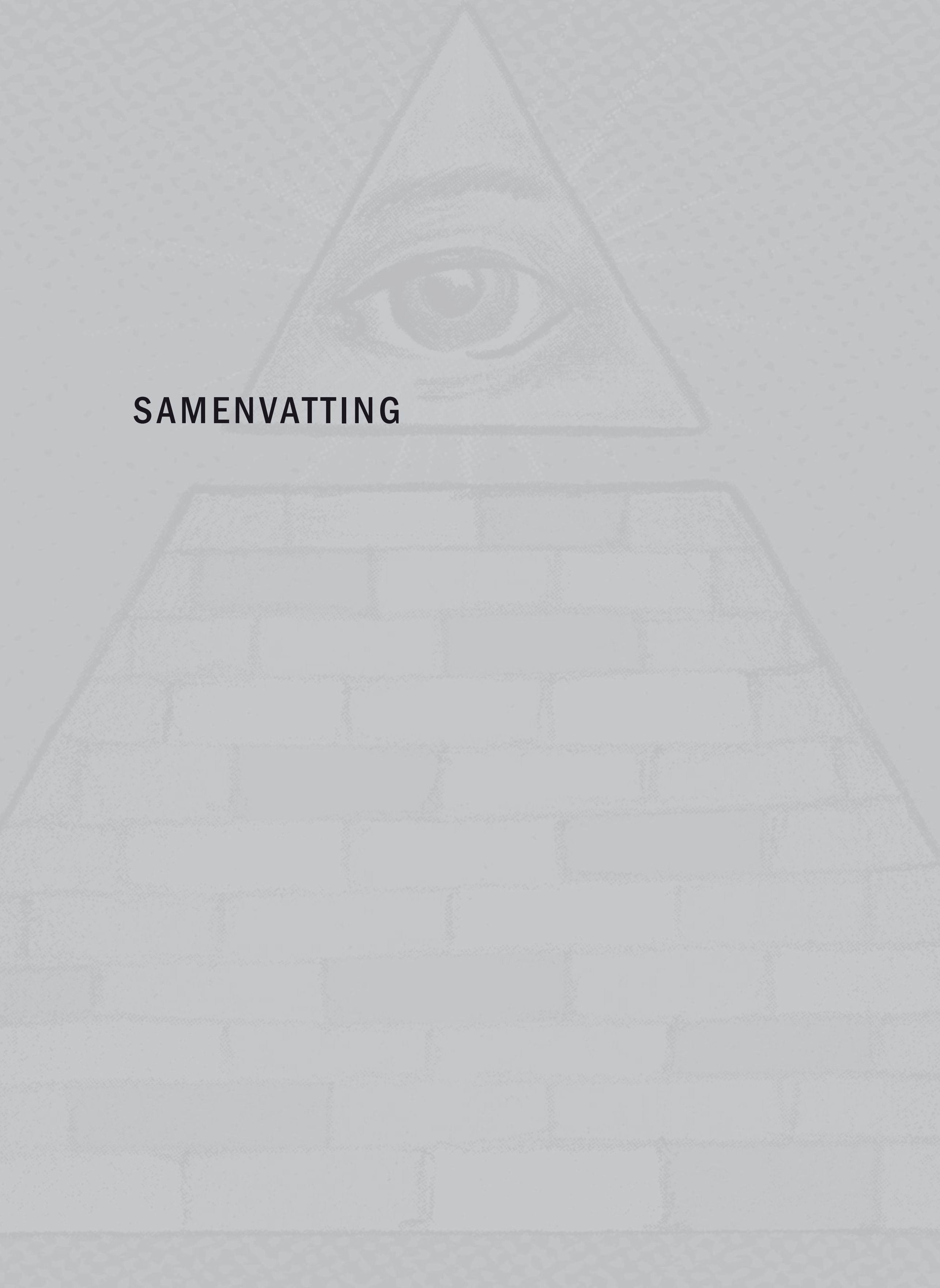
– relations between professionals and clients? The second aim of this chapter is to study the role of power in this process, for two reasons. First, in the literature client participation is often associated with and evaluated in terms of power, for example the notion that clients need to be em*power*ed. The question then is often how much power clients actually have. Second, within CfB the concept of power and the way in which power was conceptualized had a large influence on how participation was done. Contrary to many studies on client participation, I found that both clients *and* service providers frequently felt powerless in its practice, what I referred to as 'mutual powerlessness'. Professionals and clients alike struggled with the contributions clients could make to the improvement processes and what functions they should fulfill. Moreover, professionals did not want to exert power upon clients, but ironically just for that reason sometimes struggled with shaping practices of client participation. This mutual powerlessness (partly) disappeared when clients helped to determine and execute specific improvement actions instead of participating in improvement teams. One of the questions that this analysis brings forward is whether the usual conceptualization of power, in which power of professionals is seen as 'wrong' or at least as a restraint to the participation process of clients, is productive for discussions on and practices of client participation.

Chapter 5 brings together the different lines of the former chapters and is concerned more explicitly than the other chapters with governing good care, so with how power is exerted. Using a framework based on Foucault's theory of power, I give an overview of the different governance techniques used within CfB and their consequences, partly by conducting a meta-analysis of some of the former chapters of this thesis. I distinguish three empirical levels: (1) the CfB-program itself; (2) improvement teams and their organizations; and (3) professionals and clients. I described the CfB program itself as a strategy or a technique to govern care and the different actors involved and thus to constitute care and these actors, which I referred to earlier as subjectification. On the one hand, the different actors were responsible for their own quality of care; on the other, improvements had to be made visible for example by also conducting an evaluation study that functioned as a policy instrument in itself. On the institutional level, three dominant ways of governing teams were employed. First, it was deemed important that improvement teams were autonomous, i.e. that they had leeway to develop their own improvement actions. The idea was that this autonomy would heighten their motivation, and thereby autonomy was a power technique. At the same time, the improvement teams were not totally free to do as they liked. Other techniques were employed to steer improvement actions. Because improvement teams came together to exchange information with each other and with program management, their efforts were visible for other actors involved. Visibility thereby was a technique for making teams doing the ‘good’. In addition, the measurement instruments influenced what was seen as good care, and thereby were a steering technique as well. The measurement instruments furthermore influenced the way in which professionals thought about, judged and acted upon their work and the way in which clients thought about, judged and acted upon themselves. In other words, the measurement instruments addressed professionals’ and clients’ technologies of the self. Furthermore, the ideals on good care also changed both professionals’ and clients’ technologies of the self. The detailed description of the power techniques and analysis of these consequences in this chapter provide more insight into how governmentality and power are exactly created. Thereby, the analysis allows for a different kind of evaluation of QICs, in which the question is not only whether predefined goals are attained but also how power relations become established as a result of the policy instrument and stimulate reflection on these consequences, for example for the ideals on good care.

In the *conclusion* I reflect upon the added value of combining ANT with Foucault’s theory of power. I argue that following the actors and being sensitive to the ‘issues’ they come up with and to their idea(l)s on good care also form good entrance points for studying how governing is done and what its consequences are. Interestingly, power itself was often problematized within the different improvement projects, which sometimes led to a situation that I referred to as ‘mutual powerlessness’, mainly in the analysis on client participation. This thesis then can be read as (a plea for) a reconceptualization of power. By acknowledging that non-power is not possible, the discussion can transform from one concerned with whether or not there *is* (professional) power to one concerned with the consequences that specific power techniques produce. Power is not in itself positive of negative. Rather, the question is what consequences specific power arrangements produce.

An analysis of policy instruments such as a quality improvement collaborative may thus provide insight both into the governance of care and into ideals on good care. These two issues are also related to each other, for one thing because professionals themselves often framed ideals on good care in terms of (non-)power. Thereby, it became harder to shape improvement practices, client participation practices and sometimes the ideals on good care themselves. For example, even improving client autonomy was sometimes considered to be a (negative) power that had to be avoided. Thus, it was sometimes deemed undesirable for professionals to decide for clients that they should be autonomous. This was a paradox highlighted over and over again. Another, more empirical, way in which this thesis can be read is as a description and analysis of the different approaches used to overcome this paradox.

SAMENVATTING



Samenvatting

Gedurende mijn onderzoek voor dit proefschrift zijn twee vragen centraal komen te staan, namelijk: wat is goede geestelijke gezondheidszorg en hoe wordt deze (goede) zorg gestuurd. Het onderzoek startte dus met de vraag wat goede zorg betekent in de huidige Geestelijke Gezondheidszorg (GGz). Om die vraag te beantwoorden ben ik niet gestart met een bepaalde definitie van goede zorg en welke waarden in het begrip ‘goede zorg’ meegenomen zouden moeten worden. Integendeel. Geïnspireerd door Actor-Network Theory (ANT) heb ik gevolgd hoe de verschillende actoren in de GGz goede zorg definieerden en vooral hoe zij dit in praktijk brachten. Een aantal vragen speelde daarbij een rol. Hoe bepalen bijvoorbeeld hulpverleners wat goede zorg is? Welke waarden worden belangrijk gevonden? Hoe komen deze waarden in de praktijk tot uitdrukking? Hoe beslissen de verschillende actoren wat ‘het beste’ is in een bepaalde situatie? En wat zien zij als (morele) problemen in het leveren en verbeteren van zorg? ANT veronderstelt daarmee dus dat wat goede zorg is tot uitdrukking komt in het handelen van de actoren in de GGz in plaats van dat het van buitenaf gedefinieerd kan worden, zoals sommige ethici bijvoorbeeld beargumenteren.

Om deze vragen naar goede zorg te beantwoorden heb ik praktijken bestudeerd waar goede zorg expliciet ter discussie stond, namelijk verbeterprojecten. Omdat goede zorg er expliciet ter sprake komt bieden dergelijke praktijken een mogelijkheid om de vraag naar huidige idealen van goede zorg te onderzoeken. Ze kunnen daarmee werken als een soort ‘vergrootglas’ waarbij ze idealen van goede zorg zichtbaar maken die ook een grote rol spelen in de zorgpraktijken zelf (in de organisaties bijvoorbeeld). Mijn betrokkenheid in het evaluatieonderzoek naar een grootschalig verbeterprogramma bood me de gelegenheid een dergelijke plaats waar goede zorg expliciet ter discussie stond te onderzoeken. Het verbeterprogramma Zorg voor Beter (ZvB) is opgestart door het Ministerie van Volksgezondheid. Voor dit proefschrift heb ik zes verbeterprojecten gevolgd die onderdeel waren van ZvB. Deze projecten speelden zich voornamelijk af in de GGz. De verbeterteams die deelnamen aan de projecten waren grotendeels afkomstig van psychiatrische instellingen of instellingen voor begeleid of beschermd wonen.

Om de idealen van goede zorg te kunnen onderzoeken heb ik hoofdzakelijk twee onderzoeksmethoden gebruikt. Ten eerste heb ik gebruik gemaakt van etnografische observaties. Ik heb geobserveerd tijdens conferenties en andere bijeenkomsten die in het kader van de verbeterprojecten waren georganiseerd. Door middel van deze observaties heb ik verschillende zaken kunnen volgen tijdens deze bijeenkomsten: de discussies, de thema’s waar de actoren zelf mee worstelden, de manier waarop ze de zorg wilden verbeteren, de manier waarop verbeteracties uitwerkten (volgens hen), en achterliggende ideeën, idealen en motieven voor het uitvoeren van bepaalde verbeteracties. Ten tweede heb ik gebruik gemaakt van interviews met verschillende mensen betrokken bij het verbeterprogramma. Deze interviews waren onder andere bedoeld om de achterliggende ideeën, idealen en motieven meer expliciet te maken. Voornamelijk heb ik programmaleiders en mensen van en betrokken bij de verbeterteams geïnterviewd.

Tijdens het verzamelen van de data realiseerde ik me dat de verbeterprojecten niet alleen draaiden om het bediscussiëren van zorgpraktijken en van goede zorg. Omdat ZvB een beleidsinstrument is, is het (ook) ingezet om de zorg te sturen en dus om de verschillende actoren op een andere manier zorg te laten leveren. Met andere woorden: ZvB en de verschillende technieken die daarin werden gebruikt zijn ook manieren om macht uit te oefenen. Daarom ontstond een tweede vraag tijdens het doen van dit onderzoek: hoe wordt (goede) zorg gestuurd? Om deze vraag te beantwoorden heb ik grotendeels gebruik gemaakt van Foucault's machtstheorie. Volgens Foucault kan macht uitgeoefend worden op verschillende manieren, en die manieren worden ook wel aangeduid als technieken. Daarmee leidt deze theorie tot een aantal subvragen dat in deze these aan de orde is gekomen. Wat zijn de technieken waarmee gestuurd wordt? Wat zijn de consequenties van deze technieken in termen van subjectifering, dat wil zeggen voor de identiteiten van verschillende betrokken actoren zoals cliënten, hulpverleners en GGz instellingen? Bij het beantwoorden van die vragen heb ik gebruik gemaakt van het idee dat sturing en dus machtsuitoefening op alle niveaus plaatsvinden (en dus niet alleen vanuit de overheid of alleen topdown) en dat sturing zowel tussen als binnen individuen plaatsvindt. Mensen spelen een belangrijke rol in het sturen van zichzelf, wat Foucault definieerde als 'zelftechnieken'. De vraag naar sturing en die naar goede zorg hangen met elkaar samen. Allereerst vindt sturing altijd plaats in de richting van een bepaalde definitie van goede zorg. Ten tweede bevatten idealen van goede zorg ook altijd een achterliggende gedachte over hoe sturing plaats kan en mag vinden, dus wat de beste manier is om macht uit te oefenen (bijvoorbeeld over cliënten of over GGz-organisaties).

In dit proefschrift heb ik dus onderzocht hoe goede zorg wordt gedefinieerd, uitgevoerd, bediscussieerd en gestuurd in en door het verbeterprogramma Zorg voor Beter en wat de consequenties hiervan zijn in termen van subjectifering oftewel identiteiten op de verschillende niveaus in het GGz veld. Hoewel dit proefschrift niet (alleen) een evaluatieonderzoek poogt te zijn beantwoordt het wel een aantal evaluatievragen. Een belangrijk doel van het proefschrift is namelijk om het verbeterprogramma zelf en de verschillende projecten, processen en consequenties gedetailleerd te beschrijven, om zo de "black box" – zoals verbeterprogramma's in de literatuur vaak worden aangeduid – te openen. Vragen die dan centraal staan zijn: hoe kunnen we verbeterprogramma's beschrijven? Wat zijn verbeterprogramma's? Ook hier heb ik het ANT perspectief als inspiratiebron gebruikt, namelijk door te veronderstellen dat een verbeterprogramma wordt ge(re)construeerd tijdens de uitvoering. Zowel mensen als 'dingen' spelen een rol in dit constructieproces. Zo werden in de verbeterprojecten bijvoorbeeld meetinstrumenten gebruikt onder andere om de voortgang van verbeterteams te meten. Vanuit een ANT perspectief kunnen deze meetinstrumenten ook een grote invloed hebben op hoe de verbeterprojecten worden uitgevoerd. Samenvattend is een van de doelen van dit proefschrift dus om te onderzoeken hoe het constructieproces (van een verbeterproject) plaatsvindt, door dit constructieproces en de verschillende invloeden daarop te volgen.

Hoofdstuk 1 opent de "black box" van verbeterprogramma's door middel van een dynamisch perspectief gebaseerd op Actor-Network Theory. Twee onderzoeksvragen stonden centraal. Ten eerste heb ik onderzocht hoe het onderwerp van het project 'herstelgerichte zorg' tot stand kwam. Daarbij heb ik zowel gekeken naar de manier waarop het programmamanagement van dit project het 'kwaliteitsprobleem' presenteerde en wat zij zagen als mogelijke oplossingen, als naar de manier waarop de verbeterteams dit vertaalden naar hun eigen organisatie en in hun eigen verbeteracties. De analyse laat zien dat de 'problematisering' – de manier waarop het probleem gedefinieerd en dus uitgevoerd wordt – veranderde in de loop van het project en daarmee een andere vorm aannam dan de oorspronkelijke suggestie van het programmamanagement. De problematisering hing af van de 'expert' kennis van het programmamanagement en van de lokale kennis van verbeterteams.

De tweede analyse die centraal stond in dit hoofdstuk betrof een meetinstrument van het 'sociale participatie' verbeterproject. Ik heb onderzocht hoe het meetinstrument – de netwerkcirkel – het verbeteronderwerp (dus de problematisering) beïnvloedde. De netwerkcirkel vervulde verschillende rollen in dit verbeterproject. Het bracht niet alleen de resultaten in kaart maar stuurde verbeteracties ook in een bepaalde (gewenste) richting. Zoals deze analyse verder liet zien ondersteunen meetpraktijken niet alleen de problematisering van het programmamanagement maar bevatten ze ook (subtiele) assumpties over wie de mogelijkheden en de plicht heeft iets aan het betreffende probleem te doen. Meetpraktijken kunnen daarmee verbeterpraktijken en dus verbeterprojecten op voorziene en onvoorziene manieren beïnvloeden. Samengenomen laten de twee analyses in dit hoofdstuk zien dat het verbeteronderwerp en daarmee idealen van goede zorg kunnen veranderen in de loop van een project, onder andere door uiteenlopende verbeteracties en door de meetpraktijken.

Idealen van goede zorg beïnvloeden welke verbeteracties worden uitgevoerd maar worden op hun beurt weer beïnvloed in verbeterprojecten, bijvoorbeeld door meetinstrumenten.

In *hoofdstuk 2* heb ik de analyse van het ‘sociale participatie’ project voortgezet. Alleen al het bestaan van dit project laat zien dat ‘sociale participatie’ als onderdeel wordt gezien van goede zorg. Een (impliciete) veronderstelling is dus dat (sommige) cliënten socialer willen worden en dat deze cliënten dat willen of moeten bereiken met hulp van hulpverleners. Maar wat precies onder ‘sociale participatie’ wordt verstaan is niet direct duidelijk. Daarom is de hoofdvraag van dit hoofdstuk hoe sociale participatie of, zoals ik het heb genoemd, ‘socialiteit’ wordt gedefinieerd en uitgevoerd in dit project. De beantwoording van deze vraag bestond uit twee delen. Ten eerste heb ik gekeken of er in het project significante verbeteringen optraden wat betreft de van tevoren opgestelde doelen, gemeten met centrale en min of meer verplichte meetinstrumenten. Ten tweede heb ik de verbeterprocessen zelf geanalyseerd waarbij ik heb gelet op hoe deze processen precies ‘socialiteit’ construeerden. Wat betreft de kwantitatieve uitkomstmaten heeft het verbeterproject niet geleid tot grotere sociale netwerken maar gaven cliënten aan het eind van het project wel aan minder eenzaam te zijn. Een bottom-up analyse van de verbeteracties liet vervolgens twee manieren van het creëren van ‘socialiteit’ zien: een individualiserende benadering waarin cliënten werd gevraagd hun wensen te uiten (verbalisering) en er actief iets mee te doen, en een normaliserende benadering waarin een ‘goed’ sociaal leven ingebed is in de ‘normale’ gemeenschap. Omdat deze twee manieren van het construeren van socialiteit niet direct uit de meetinstrumenten of uit de uitkomsten van het project konden worden afgeleid, is een van de conclusies van dit hoofdstuk dat het specifieker kijken naar de (uiteenlopende) verbeterprocessen reflectie mogelijk maakt op deze processen, de manieren van het construeren van socialiteit en de consequenties ervan, consequenties die niet per definitie gebonden zijn aan de vooraf gedefinieerde doelen. Een van die consequenties bijvoorbeeld is dat cliënten in een normaliserende benadering idealiter contact zouden moeten hebben met mensen van buiten de instelling, zodat ze een gelijkwaardige en ‘normale’ positie kunnen innemen. Dat betekent dat het hebben van contact met medecliënten als minder ‘goed’ wordt beschouwd dan het hebben van contact met mensen van ‘buiten’, waarmee cliënten zelf niet altijd als volwaardige partners worden beschouwd van hun medecliënten. Door het zichtbaar maken van dit soort consequenties biedt het onderzoeken van verschillende idealen van goede zorg in verbeterprojecten een goede aanvulling op de vraag of de doelen van een project zijn behaald.

In *hoofdstuk 3* staat het thema ‘autonomie’ centraal. In bijna alle verbeterprojecten van ZvB bleek autonomie een belangrijk concept. Verbeterteams worstelden met de vraag hoe de zorg te verbeteren zonder de autonomie van cliënten aan te tasten, of ze stelden zelfs als voornaamste verbeterdoel het verhogen van de autonomie van cliënten. Discussies op de werkconferenties gingen geregeld over autonomie. Omdat dit zo belangrijk werd gevonden door veel van de verbeterteams en ook vaak door het programmamanagement, heb ik een analyse gemaakt van het autonomie concept binnen ZvB, als een van de idealen van goede zorg in de hedendaagse GGz. Ik heb daarbij onderzocht wat autonomie voor de verschillende actoren betekende en hoe zij autonomie concreet vormgaven. De analyse leidde tot vier verschillende manieren om autonomie van cliënten te behouden of te vergroten: 1) hulpverleners verwijderden zogenaamde belemmerende elementen en legden verder alle initiatief (bijvoorbeeld tot contact) in handen van cliënten; 2) hulpverleners vroegen naar wensen en voorkeuren van cliënten en namen deze als leidraad voor hun handelen; 3) hulpverleners bevorderden de zelfstandigheid van cliënten; 4) hulpverleners probeerden hun relatie met cliënten te ‘normaliseren’ om cliënten aan te moedigen ook andere rollen aan te nemen dan slechts die van GGz-cliënt. Door per benadering te kijken wat de morele dilemma’s waren waar hulpverleners mee worstelen werden ook de grenzen van de verschillende benaderingen van autonomie meer zichtbaar, althans in de GGz. Cliënten vertoonden soms niet het gedrag dat hulpverleners als ‘autonoom’ definieerden. Daarbij draagt dit hoofdstuk bij aan een reflectie op de wenselijkheid van de populariteit van autonomie, zonder het als geheel onbelangrijk of onwenselijk te willen afdoen.

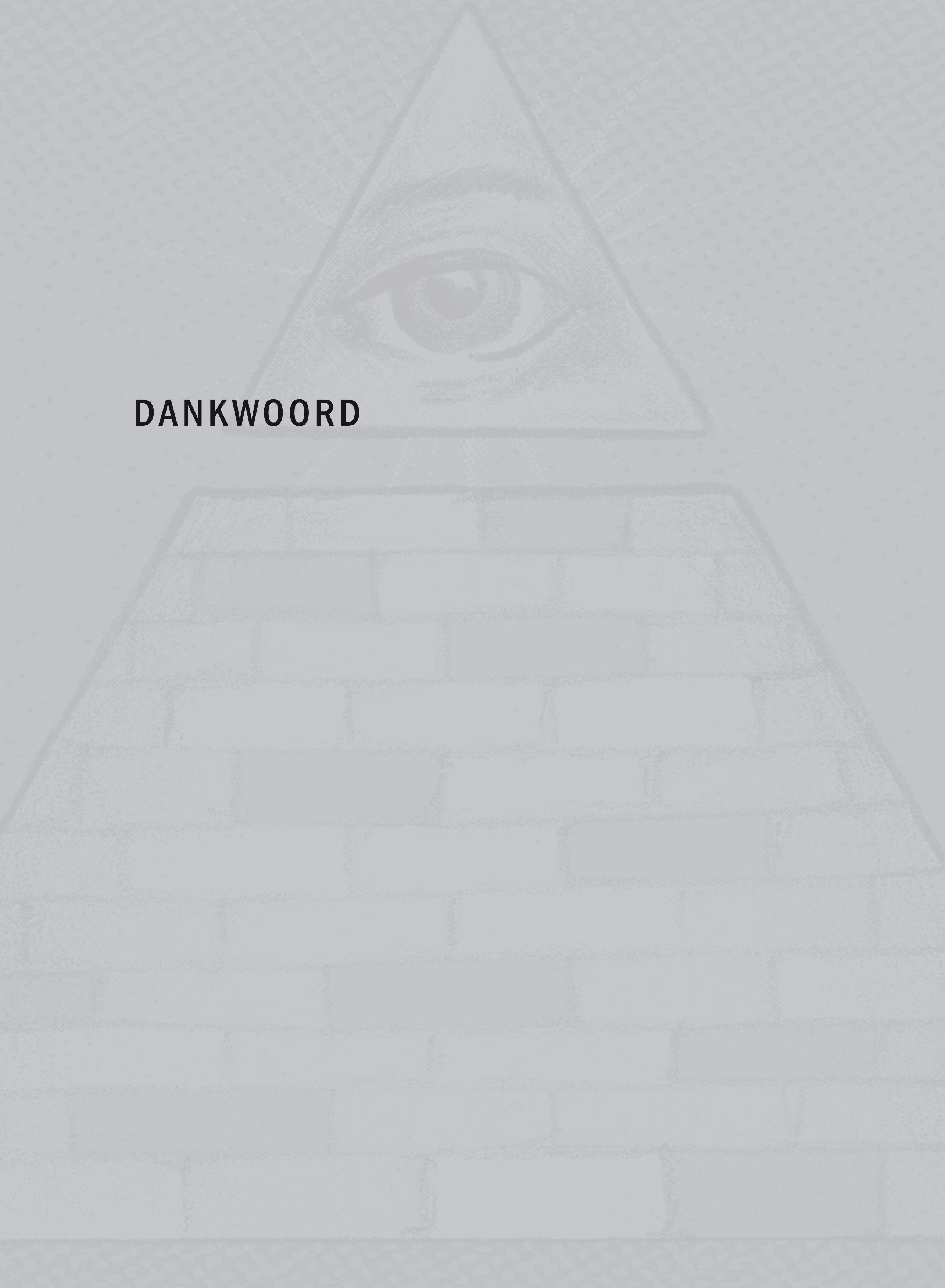
Naast en in relatie tot autonomie werd cliëntenparticipatie in het verbeterproces belangrijk gevonden binnen ZvB, als een ideaal van goede zorg en een ideaal van goed verbeteren. Het doel van *hoofdstuk 4* is daarom te onderzoeken hoe cliëntenparticipatie is vormgegeven binnen ZvB. Hoe worden praktijken van cliëntenparticipatie vormgegeven? Wat zijn de consequenties voor hulpverleners en cliënten? En hoe verandert dat (niet) de relatie tussen hulpverleners en cliënten? Het tweede doel van dit hoofdstuk is om de rol van macht in dit proces van cliëntenparticipatie te onderzoeken, om twee redenen. Ten eerste wordt cliëntenparticipatie in de literatuur vaak geassocieerd met en geëvalueerd in termen van macht. Bijvoorbeeld, cliënten moeten em*power*ed worden. De vraag die dan vaak wordt gesteld is hoeveel macht cliënten daadwerkelijk hebben in het participatieproces. De tweede reden waarom de rol van macht in dit hoofdstuk is onderzocht is omdat macht en de manier waarop macht in ZvB werd geconceptualiseerd een grote invloed hadden op hoe participatie werd vormgegeven. In tegenstelling tot veel studies naar cliëntenparticipatie bleek uit mijn analyse dat zowel cliënten *als* hulpverleners en managers zich vaak machteloos voelden in het participatieproces, wat ik ‘wederzijdse machteloosheid’ heb genoemd. Hulpverleners en cliënten vonden het vaak lastig te bepalen welke bijdrage cliënten zouden moeten en kunnen leveren aan het verbeterproces en welke functies cliënten zouden moeten vervullen in dit proces. Bovendien wilden hulpverleners vaak in het geheel geen macht uitoefenen over cliënten, maar ironisch genoeg was dat soms juist de reden waarom de vormgeving van cliëntenparticipatie leek te stranden. Deze wederzijdse machteloosheid verdween gedeeltelijk op het moment dat cliënten niet formeel lid waren van een verbeterteam maar werden gevraagd alleen bij specifieke verbeteracties mee te denken en te helpen. Een van de vragen die deze analyse oproept is of de gebruikelijke conceptualisering van macht, waarbij alle macht van hulpverleners eigenlijk als ‘verkeerd’ wordt gezien of in elk geval als belemmerend voor het participatieproces van cliënten, productief is voor discussies over en praktijken van cliëntenparticipatie.

Hoofdstuk 5 brengt de verschillende lijnen van de vorige hoofdstukken gedeeltelijk samen en is meer expliciet dan de andere hoofdstukken gericht op de vraag naar hoe zorg gestuurd wordt, dus op hoe macht wordt uitgeoefend. Gebruikmakend van Foucault’s machtstheorie heb ik een overzicht gegeven van de verschillende sturingstechnieken in ZvB en de consequenties daarvan, deels door een meta-analyse van sommige eerdere hoofdstukken uit te voeren. Ik onderscheid daarbij drie empirische niveaus: 1) het programma zelf; 2) de verbeterteams en verbeterorganisaties; 3) en hulpverleners en cliënten. Het programma ZvB zelf heb ik in de analyse beschreven als een techniek om de zorg en de cliënten gebruikmakend van die zorg te sturen en daarmee om zowel de zorg als actoren in die zorg vorm te geven, wat ik eerder al aanduidde als subjectifering. Aan de ene kant waren de verschillende betrokken actoren zelf verantwoordelijk voor het verbeteren van zorg maar aan de andere kant moesten verbeteringen wel concreet aangetoond kunnen worden, bijvoorbeeld door het evaluatieonderzoek dat zelf als beleidsinstrument fungeerde (in plaats van alleen een instrument om een beleid te evalueren). Op organisatie- of verbeterteamniveau waren drie sturingstechnieken het meest opvallend. In de eerste plaats werd het belangrijk gevonden dat verbeterteams zelf autonomie hadden, dat wil zeggen de vrijheid om hun eigen verbeteracties te bedenken. Het idee was dat juist deze autonomie in het bedenken van verbeteracties hen zou motiveren, en daarom werkte autonomie als een sturingstechniek. Toch stonden de verbeteracties niet geheel vrij en werden er ook technieken toegepast om de verbeteracties wel te sturen. Doordat verbeterteams bij elkaar kwamen en informatie uitwisselden met elkaar en met programmamanagement, waren hun werkzaamheden erg zichtbaar voor andere betrokkenen. Zichtbaarheid was daarmee een manier om de verbeterteams aan het 'goede' te laten werken. Daarnaast beïnvloedden de meetinstrumenten wat als goede zorg werd gezien, en waren deze dus een manier om verbeterteams en betrokken organisaties te sturen. De meetinstrumenten beïnvloedden bovendien de manier waarop hulpverleners dachten over hun werk en hoe ze hun werk uitvoerden, en de manier waarop cliënten dachten over zichzelf en hoe zij zichzelf stuurden. Met andere woorden: de meetinstrumenten beïnvloedden de zelftechnieken van hulpverleners en cliënten. Daarnaast waren ook de idealen van goede zorg manieren om deze zelftechnieken te beïnvloeden. De gedetailleerde beschrijving van de machtstechnieken en de analyse van de consequenties leidden tot meer inzicht in hoe stuurbaarheid en macht precies worden gecreëerd. Daarmee maakt de analyse in dit hoofdstuk een ander soort evaluatie van verbeterprogramma's mogelijk, waarbij de vraag niet alleen is of vooraf bepaalde doelen behaald zijn maar ook en vooral hoe machtsrelaties tot stand komen als gevolg van het beleidsinstrument en wat de consequenties daarvan zijn, bijvoorbeeld voor idealen van goede zorg.

In de *conclusie* reflecteer ik op de toegevoegde waarde van het combineren van ANT met Foucault's machtstheorie. Ik betoog daar dat het volgen van de actoren en het ingaan op de kwesties waar zij zelf mee worstelen of die zij zelf belangrijk achten ook een goede ingang vormt voor een onderzoek naar hoe sturing plaatsvindt en wat de consequenties ervan zijn. Opmerkelijk was dat macht zelf vaak ter discussie werd gesteld in de verschillende verbeterprojecten, wat soms leidde tot een situatie die ik aanduidde als 'wederzijdse machteloosheid', met name in de analyse van cliëntenparticipatie. Daarmee kan dit proefschrift worden gelezen als een (pleidooi voor een) herconceptualisering van macht. Door te onderkennen dat er altijd macht is wordt de vraag niet (meer) of er (hulpverleners-) macht *is* maar wat de *consequenties* van specifieke machtstechnieken zijn. Macht is niet in zichzelf positief of negatief. Waar het om gaat is welke consequenties specifieke (constellaties van) machtstechnieken hebben.

Analyse van beleidsinstrumenten zoals verbeterprogramma's kan veel inzicht verschaffen in de sturing van zorg en in de idealen van goede zorg. Die sturing en de idealen zijn aan elkaar gerelateerd, alleen al omdat hulpverleners de idealen van goede zorg vaak in termen van (niet-) macht definieerden. Daarmee werd het vaak lastiger om verbeterpraktijken, cliëntenparticipatie en soms ook de idealen van goede zorg zelf vorm te geven. Het verhogen van autonomie van cliënten bijvoorbeeld werd soms als (negatieve) macht gezien en daarmee als onwenselijk. Het werd dan als onwenselijk geacht dat hulpverleners voor cliënten 'bepaalden' dat deze autonoom zouden moeten zijn. Dat leidde tot een paradox die vaak werd benadrukt in ZvB. Een andere manier waarop dit proefschrift daarom kan worden gelezen is als een beschrijving en analyse van de verschillende benaderingen om deze paradox teniet te doen.

DANKWOORD



Dankwoord

Misschien is het dankwoord nog wel het moeilijkste onderdeel van het schrijven van een proefschrift. Wie noem je wel en wie noem je niet? Waar leg je de grens van het dankwoord? En hoe doe je ooit recht aan iedereen die op een of andere manier een bijdrage heeft geleverd aan de totstandkoming van het proefschrift? Maar zoals Alberto Manguel met instemming Stevenson citeert: “Ons doel in het leven is niet om te slagen maar om zo opgewekt mogelijk door te gaan met mislukken.”[1] Laat dat ook het motto zijn van mijn dankwoord.

Om te beginnen heb ik een oude schuld in te lossen uit de periode waarin mijn afkeer van dankwoorden zo groot was dat ik weigerde er een te schrijven. Trudy Dehue, als bachelor- en masterthesebegeleider heb je een grote rol gehad in de ontwikkeling van zowel mijn interesses als mijn denken. Alsnog hartelijk dank daarvoor!

Via Trudy ben ik in Rotterdam bij het iBMG terechtgekomen waar ik met veel plezier aan mijn proefschrift heb gewerkt onder begeleiding van Roland Bal en Anna Nieboer. Roland, ik ben nog steeds onder de indruk van jouw vermogen *alles* te weten, of het nu gaat over Foucault, over verschillende methodologische stromingen of zelfs over *The Fountainhead*. Bovendien ben jij in staat die kennis onmiddellijk toe te passen, en daarmee om mee te denken in een analyse over willekeurig welk onderwerp en om die analyse goed te kunnen plaatsen in een lopend debat. Anna, dankzij jouw kennis en ideeën en nuttig commentaar zorgde je er bij ieder artikel weer voor dat ik verder keek dan mijn eigen analyse van de empirie, dat ik deze plaatste in bredere discussies en concepten. Bovendien wist jij een bijna paradoxale combinatie van geduld en ‘aansporen’ uit te stralen, waardoor ik voldoende tijd en ruimte had om aan mijn proefschrift te werken en het toch op tijd af kon krijgen. En ondertussen waren jullie allebei altijd tolerant ten opzichte van mijn onwetendheid en straalden jullie vertrouwen uit dat een nog mager uitgewerkt idee uiteindelijk wel een artikel zou worden. Dank daarvoor!

Daarnaast heb ik veel gehad aan het bredere Zorg voor Beter team. Mathilde, bij jou kon ik altijd langskomen, welke vraag ik ook had. Uren achtereen heb je geduldig met mij achter SPSS gezeten en op iedere vraag had je een antwoord (en niet alleen over statistiek). Esther, Teun en Annemiek, dank voor de feedback op mijn artikelen in wording en voor de gesprekken over methodologie, theorie en etnografie. Peter en Sarah, eigenlijk had ik sinds de verhuizing naar het J-gebouw een soort van ‘tweede’ kamer waar ik altijd binnen kon komen en me bijna net zo thuis voelde als op mijn eigen kamer. Dank voor alle goede gesprekken, borrels, steun, advies en betrokkenheid!

Veel dank ben ik verschuldigd aan alle mensen van het Trimbos Instituut die hebben meegewerkt aan mijn proefschrift, onder wie Sonja van Rooijen, Harry Michon, Anneke van Wamel, Simone van de Lindt, Annemieke Hendriksen-Favier, Caroline Place en Laura Neijmeijer. Ook de mensen werkzaam in of betrokken bij de deelnemende zorginstellingen wil ik van harte bedanken voor hun medewerking aan het proefschrift. Ik ben blij met de gastvrijheid die ik kreeg tijdens werkconferenties en tijdens werkbezoeken in instellingen. Bovendien heb ik in interviews en observaties veel gehoord over en gezien van de verbeterpraktijken en van het dagelijks werk en leven van veel mensen betrokken bij de GGz. Zonder dat had ik mijn proefschrift niet kunnen schrijven.

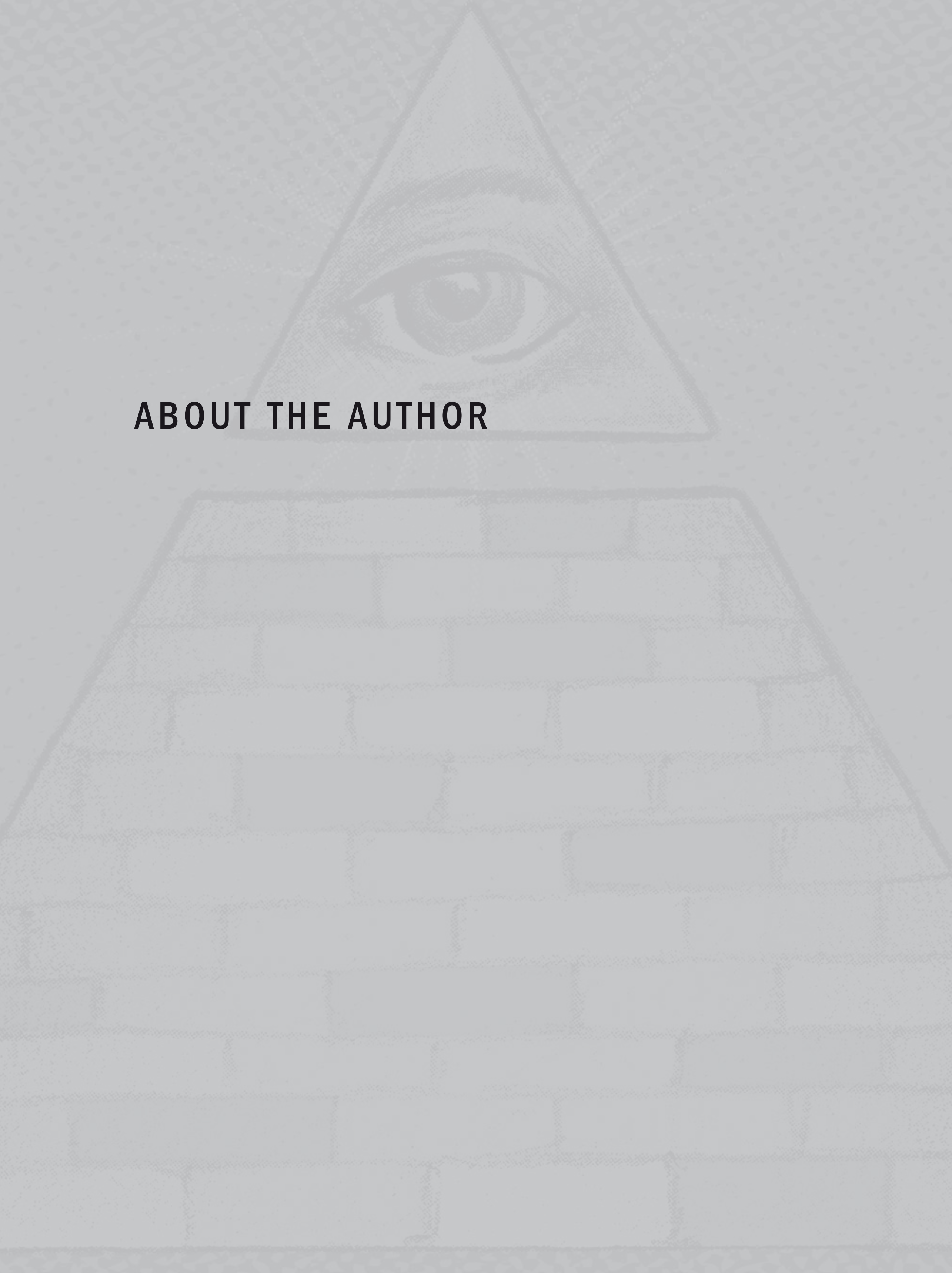
Minstens zo belangrijk als inhoudelijke gesprekken zijn de gesprekken tussen de bedrijven door. Ik heb geluk gehad met drie leuke en goede kamergenoten in de afgelopen vier jaar: Birgitha, Liesbet en Henk. Gesprekken over het schrijven van artikelen, over de wetenschap, over zelfreflectie, over tennis en over Federer maakten het altijd weer leuk om naar iBMG te komen.

Ook bij de sectie HSMO heb ik me thuis gevoeld; het was een fijne en goede omgeving om mijn proefschrift in te kunnen schrijven, met Joris als betrokken sectieleider en Marie Louise, Jacqueline en alle anderen om mee te praten, te lunchen en sectie-uitjes te organiseren en te doen. Lex, ik mag dan wel in een andere sectie (gaan) werken maar ik blijf gewoon om acht uur ’s morgens en op alle andere tijdstippen aan je bureau verschijnen voor een kletspraatje, de nieuwste roddels en advies op allerlei gebieden. Dank voor je betrokkenheid en je fijne aanwezigheid tijdens mijn proefschriftperiode!

Endnotes

1 Alberto Manguel (2004). Dagboek van een lezer. Amsterdam: Ambo.

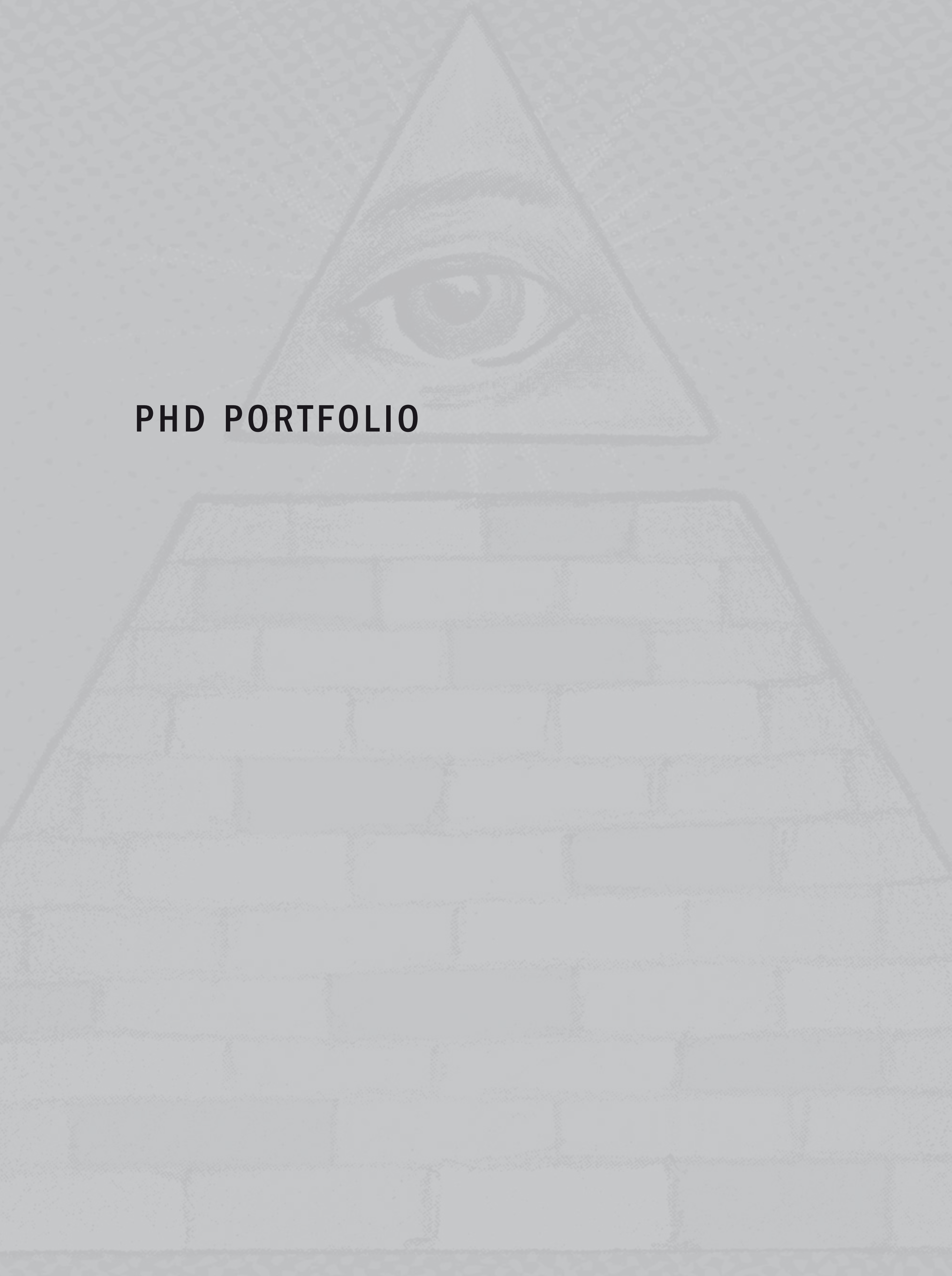
ABOUT THE AUTHOR



About the author

Tineke Broer was born on September 9th 1984 in Steenwijk in The Netherlands. She studied psychology at the University of Groningen between 2003 and 2007. Her master thesis focused on the Diagnostic and Statistical Manual of mental disorders, which she analyzed from an Actor Network Theory perspective. In 2007, she started a Phd project at the Institute of Health Policy and Management. This project was concerned with improvement projects in mental health care. The main question in following these improvement projects was: how is mental health care delivered, improved, and governed? The Phd project led to several publications in international peer reviewed journals. In addition she has taught several courses at the Institute of Health Policy and Management, such as philosophy of science, qualitative health research and organization sciences. Currently she is involved in the evaluation of patient participation projects in long term care and in a project on the evaluation of quality programs and complex interventions.

PHD PORTFOLIO



PhD Portfolio

PhD student:	Tineke Broer
Department:	Institute of Health Policy and Management
PhD period:	2007-2011
Promotor:	Prof. Dr. Roland Bal
Supervisor:	Dr. Anna Nieboer

PhD training

Courses

Course on qualitative research (6 days)	2011
WTMC workshop “STS goes mental”	2011
WTMC workshop on Knowledge transfer	2010
Academic writing for PhD students	2010
Workshop Comparative relativism, Kopenhagen	2009
Hospital ethnography workshop, Sussex	2009
Atlas.ti	2008

Presentations

Quality Improvement Research Network, Barcelona	2010
EASST – international conference	2010

Teaching qualifications and experience

Courses followed

Theatre techniques for teaching	2011
Training on problem-directed education (PGO)	2008
Basis course didactic skills	2008

Teaching experience

Philosophy of science	2010-now
Supervision of bachelor theses	2010-now
Qualitative research methods	2010-now
Change management in health care	2010-now

Organization sciences	2007-2009
Introduction in health care	2008-2009