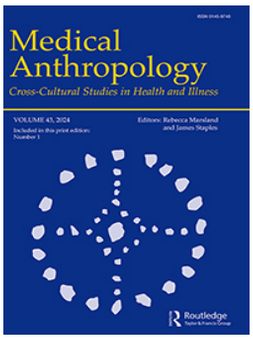

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Uncertainty Work: Dealing with a Psychiatric Crisis in Two European Community Mental Health Teams

Christina Gerdien Roelofke Muusse[a,b], Cornelis L. Mulder[c,d], Hans Kroon[a,e], and Jeannette Pols[b,f]

[a]Zorg & Participatie, Trimbos-Institute, Utrecht, Netherlands; [b]Ethics, Law & Humanities, Amsterdam UMC Locatie AMC, Amsterdam, Netherlands; [c]Department of Psychiatry, Erasmus Medical Center, Rotterdam, Netherlands; [d]Antes, Parnassia Psych-Medical Centre, The Hague, Netherlands; [e]Tranzo Scientific Center for Care and Welfare, Tilburg University Tilburg School of Social and Behavioral Sciences, Tilburg, Netherlands; [f]Department of Anthropology, University of Amsterdam, Amsterdam, Netherlands

ABSTRACT

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

KEYWORDS

Community mental health care; deinstitutionalization; Italy; Netherlands; temporality structures; uncertainty work

In this article, we describe how the workers in two community mental health care teams (CMHTs) in two different cities in Europe dealt with the uncertainty they encountered when anticipating the possibility of a client[1] experiencing a psychiatric crisis while working in a community setting. We argue that contrasting the ways of dealing with this uncertainty in everyday care in an Italian (Trieste) and a Dutch (Utrecht) CMHT can teach us more about how a crisis can be dealt with outside the walls of a psychiatric hospital and the pros and cons of the different ways of working.

We choose to contrast a CMHT in Trieste, Italy, and one in Utrecht, the Netherlands because they differ in some important aspects (Muusse and Van Rooijen 2015). One of the most salient differences between Trieste and Utrecht is the low number of psychiatric hospital beds available in the former's mental health system. While Trieste has 15 beds per 100,000 inhabitants, in the region of Utrecht, there are 89 per 100,000.[2] There are some other differences in the organization of care influence the way a crisis is dealt with: in Utrecht's mental health system, CMHTs provide ambulatory care, but during a crisis, most people are admitted to a (closed) clinical ward, either voluntarily, or with a juridical measure.[3], In Trieste, Community Mental Health Centers (CMHCs) are central to the mental health system, from which the outreach services are provided. Each center has a small number of beds (6–8) and people can walk in without referral or appointment. Next to these centers, there are also small psychiatric wards of six beds and, in contrast to Utrecht, all facilities in Trieste conduct an open-door policy, which means that there are neither seclusion facilities nor closed clinical wards. The way of working in Trieste often raises the question of how they manage psychiatric crisis situations in

CONTACT Christina Gerdien Roelofke Muusse cmuusse@trimbos.nl Zorg & Participatie, Trimbos-Institute, Da Costakade 45, Utrecht 3500AS, The Netherlands.

Media teaser: How is a psychiatric crisis dealt with in two European community mental health teams that differ in the number of beds and use of coercion?

the community with such a low number of clinical beds, no closed doors, and a relatively low amount of forced care (Barbui and Tansella 2008; Portacolone et al. 2015).To answer the question of how to shape community care outside the walls of a psychiatric hospital, we contrast the practices of the CMHTs in Trieste and Utrecht to learn about practical differences in dealing with a crisis in the community and the notions of good care that are at stake. To do this, we analyze the daily care practices of the two CMHTs as forms of "uncertainty work" (Hautamäki 2018; Moreira et al. 2009; Pickersgill 2011). We use the concept of uncertainty work concept as a tool to articulate the importance of everyday caring activities and routines in understanding how a possible crisis can be prevented or dealt with in the community, even with a low number of beds and forced care, as in Trieste. Our focus, then, is not so much on specific crisis interventions but rather encompasses a shift toward a broader time frame by articulating ways of intervening in the community setting to prevent escalations as forms of uncertainty work.

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

Methodological considerations

Conceptualizing uncertainty

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

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

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

In this article, we take a different approach; we conceptualize uncertainty as a practice. While classical sociological work around uncertainty deals with overarching concepts such as late modernity and the new risks that emerge with the decline of institutions (Beck 1992; Giddens 1999), the critique of these theories is that they do not attend to the daily practice in which uncertainty and risks are dealt with. Others, therefore, introduced the terms "risk work" (Brown and Calnan 2016; Stanley 2018; Warner and Gabe 2004; Zinn 2016) and "uncertainty work" (Hautamäki 2018; Moreira et al. 2009; Pickersgill 2011) to redirect the focus to the practicalities of dealing with uncertainty.

We use this concept of uncertainty work as an analytic tool to describe how a possible crisis is dealt with in the two teams and how this can help us to articulate ways of intervening to prevent or deal with a possible crisis in a community setting. We describe how uncertainty work in the two CMHTs gets shaped in practice and how this goes together with different qualifications about what is seen as a good way to perform uncertainty work while also uncovering what negatives there are to be avoided.

In focusing on daily care practices, we do not conceptualize beforehand what uncertainty work might entail. Neither do we approach a "crisis" as an isolated event in time. Instead, by using uncertainty work as an analytic tool, we make a shift toward a broader time frame in which we describe different ways of caring, relating, and intervening that contribute to preventing escalations and crises in a community setting.

Conducting the research

To answer the questions raised above, the first author observed the daily practices of care in both teams.[4] She joined caregivers[5] in Trieste[6] and Utrecht for several weeks,[7] observing their daily routines, such as home visits, clinical encounters, and team meetings. Alongside the fieldwork, she interviewed stakeholders and service users in both cities. A selection of important team partners was made, and these were approached for an interview. Interviews were also conducted with some team members to further reflect on their work. Service users were approached by their case manager for an interview about their experiences with care and support from the CMHT. At the end of the fieldwork, a group discussion with the team was organized at both field sites. During the fieldwork, there was also an exchange between the two teams: the team in Trieste visited the Dutch CMHT, and they mutually took part in an international meeting on crisis prevention.[8] The researcher was always open about her role during site visits and meetings. In the waiting area of the CMHTs, information about the research was provided, including a picture of the researcher and her contact details. All material was anonymized, and no names or other personal details were collected. Pseudonyms are used in this text.[9] The first author has been involved in studies on community mental health care in the Netherlands and Trieste for several years. Familiarity with both research sites over an extended period enabled easy and quick access to the field and aided the researcher in understanding what was going on.

Two modes of ordering care: Building relationships or connecting expertise

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

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

"la liberta e terapeutica!" – this slogan, going back to the 1970s, can still be found on one of the walls of the former hospital grounds in Trieste, Italy. It was during the 1970s that a "revolution" took place. The psychiatrist Franco Basaglia advocated a radical change. In his analysis of psychiatry as a total institution, he stated that to understand a person, a diagnosis should be placed in "parentheses" (Basaglia 1967, in Burns and Foot 2020). To be able to make this shift from "patient to citizen" an essential step was to close the psychiatric hospital and organize mental health care in the community instead (see also Foot 2014; Portacolone et al. 2015). This movement in Trieste led to a specific practice of mental health care characterized by a low number of beds, a minimum of restraint, and an open-door policy. This means not only that there are no seclusion facilities, but also that because of the idea that seclusion hampers recovery, all doors are open, also in the clinical facilities.

Central to the mental health system in Trieste are the Community Mental Health Centers (CMHCs). There is no need for a referral to get into the care of a center, and each center has a small number of beds (6–8). With the center as a base, the CMHT provides outreach services for the area they have responsibility for. The center is also the place where treatment and care are provided and where people can have lunch. The centers have the responsibility to be accessible and accountable for the neighborhood and to respond quickly to a crisis when necessary (Mezzina 2016). This is why the center is also open to neighbors, family, and others. Nurses take a turn in the reception to respond quickly to demands for care. As described elsewhere (Muusse et al. 2020), the care provided by the

CMHT in Trieste is characterized as "radical relational:" care is not only aimed at the individual and his or her (psychiatric) problems but also toward building and maintaining a social network around service users. We therefore describe mental health care in Trieste as a relational mode of ordering care. In Trieste, a crisis is seen as a crisis of the context and is part of the cyclical approach to care conducted. Preventing a crisis and building and maintaining networks by working on relationships are thus intertwined and seen as core tasks of mental health care.

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

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

Utrecht's mode of ordering care: Connecting expertise

In the Netherlands, the deinstitutionalization process was more gradual; community care was built up while hospital care was reformed but without totally dismantling the mental hospital. In Utrecht, care is more specialized, with different teams organized around different specializations. The CMHT in Utrecht is office-based and provides care during office hours. If more care is needed, people are referred to other mental health services, such as clinical facilities. Outside the realm of psychiatry, the CMHT can refer to social welfare, GPs, and other care providers that support people with psychiatric vulnerabilities. It is seen as essential to connect these different areas of expertise to create continuity of care.

In Utrecht, due to a reorganization aimed at providing more community-based care, the CMHT consists of workers from mental health treatment and mental health-supported living organizations that work together to provide specialized mental health care in the community for people with complex mental health problems. This team was formed as a result of a reorganization of care aimed at closing the gap between mental health *support* (e.g., assistance with daily activities, the household, and administration) and mental health *treatment* (evidenced-based interventions, medication, and hospitalization), and making care more easily accessible by decentralizing mental health care to local communities.

In Utrecht's CMHT, the focus is on the individual autonomy of clients. In this mode, specialized care should address the individual client's specific needs in the least intrusive and inexpensive way. Supporting people in self-management and regaining agency are formulated as important goals. In Utrecht, crises are primarily defined as a crisis of the individual, whether due to medical or social reasons.

To get into the care of the CMHT, people need a referral that states that they are in need of specialized mental health treatment. As described elsewhere (Muusse et al. 2021), treatment for people with a Severe Mental Illness (SMI) at Utrecht's CMHT ideally is temporary; if a situation improves or stabilizes, then specialized treatment is no longer seen as a necessity, and people are referred to other partners in the network for treatment and support (for instance, the GP and social welfare teams). The care of the CMHT is thus seen ideally as a temporary intervention aimed at treatment for those needing specialized mental health care.

People may also be referred to more specialized treatment for a specific diagnosis if necessary. It is important to connect these different areas of expertise and forms of treatment and support to provide integrated care. We therefore refer to this mode of ordering care as connecting expertise. Although the

focus is on specialized medical treatment, a relational way of working is an important part of the daily care practice (see Muusse et al. 2021).

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

Uncertainty work in practice

Uncertainty work as attempts to categorize: Who qualifies as a patient?

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

> The worker from the municipality explains that the municipality and psychiatric care work together on specific projects. Often it concerns people with social problems and a lack of social network.

Interviewer: How does this work exactly? In the Netherlands, the cooperation between the two domains is sometimes difficult . . .

Respondent: [laughs] Here also, especially when there is no psychiatric diagnosis but social services have the idea that there are problems indeed. (Interview, municipality, Trieste)

In both cities, in dealing with the uncertainty of whether one qualifies as a patient, defining a psychiatric problem is important. One way of doing this is by setting a diagnosis. Setting a diagnosis is a way to categorize problems into the domain of mental health care instead of defining them as social problems (Mackintosh and Armstrong 2020, Pickersgill 2011). In Trieste, going back to Basaglia, the idea of a diagnosis to define a person's problem is highly contested. Still, a diagnostic orientation is needed, next to other factors related to the social implications of a crisis, the impact on the social context, and the network (Mezzina and Vidoni 1995). In Utrecht, the importance of setting a diagnosis is more pronounced since the task of the CMHT is more specialized than in Trieste: they only have to provide care for those with complex problems in need of specialized mental health care, while the CMHT in Trieste needs to care for all people in their district with problems categorized as psychiatric.

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

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

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

Setting a diagnosis is an important element in both CMHTs, but it is operated differently in the two modes of ordering care. In Trieste's relational approach, once a problem is categorized as psychiatric,

the CMHT has to keep providing care for that person since they are responsible for all mental health care in their district, and referrals are avoided as much as possible, because transitions in care could cause ruptures, thus enlarging the risk of a crisis.

In Utrecht, the CMHT is part of a more differentiated care landscape with several teams providing different diagnosis- and problem-related types of specialized care. This differentiation increases uncertainty about what exactly is specialized psychiatric care and what kind of problems this might address: are the problems indeed psychiatric problems in need of specialized care, and are they complex enough? The differentiated care landscape provides more possibilities for referral but also more uncertainty around whether a person is in the right place. The idea that specialized care is scarce and waiting lists should be avoided puts extra pressure on the care workers to make a proper "categorization" (Lane 2019; Mackintosh and Armstrong 2020; Pickersgill 2011). The question about who qualifies as a patient in Utrecht is thus more complex: it is not only about whether one is in need of psychiatric care but also about who should provide this care and for how long.

Uncertainty work as a relational endeavor

Once someone is in the care of a CMHT, another source of uncertainty can arise when professionals do not know how service users are doing; for instance, when contact is problematic. In the practice of Trieste, it is stressed that having a relationship with both the service user and their network is an important instrument to know what is going on and to prevent a crisis:

Interviewer: Does it happen you do not see the crisis coming?

Nurse: Yes, it happens if somebody stays home without frequent contact.

Interviewer: What do you do to prevent this?

Nurse: Some people are more often discussed and validated because there is a necessity. For instance, when someone is living alone, we will pay home visits more frequently. Another reason to pay more attention is the intensity of the disease or if there is a risk of a severe crisis. We also pay extra attention if people refuse contact and do not want to visit the center.

Interviewer: How do you decide that someone needs more frequent visits?

Nurse: It can be a personal evaluation because you know the person. Then it is easier to notice little signals. (Group interview, Trieste)

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

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

In this example, based on past experiences, there is the fear that the situation will worsen. The uncertainty work performed consists of conducting house visits during and outside office hours and continuing to offer the client medication. The woman accepts the contact, although she first refuses the medication. But the intervention seems successful: the next day, another nurse takes her to the GP for her somatic symptoms, and she is pleased with the nose spray she has been given. She then comes to the center again for medication and dinner.

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

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

> The team discusses a man on the FACT board: they discuss that the team has to visit him more frequently, just to ring the bell to see how he is doing.

Psychologist: We have him in sight. If he becomes more paranoid, we have to watch him more carefully. There is the risk that if he breaks down, it will be a severe case.

Nurse: We hope that in this way, he "will ring on our bell" when he does become psychotic instead of ending up in a police cell. (Field notes, Utrecht)

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

In both teams, relational approaches, such as staying close and knowing what is going on, offer insight into how one is doing, avoiding further uncertainty and reducing the risk of a possible crisis. One difference between Trieste and Utrecht is how the organization of care facilitates this. In Trieste, there is always one nurse available to act quickly in emergencies, and the team can offer a bed in the center or persuade people to have lunch or dinner at the center to see how they are doing. More importantly, ideally there is contact between the CMHT and the broader network to keep an eye on the situation and to involve people in care. In Utrecht, this is different: the CMHT takes a relational approach to prevent further deterioration as well, and uses the instrument of the FACT board to structure this. However, in terms of how care is organized, Utrecht's CMHT's options to stay in contact are more limited. They do not have their own center to facilitate low-threshold contact with clients and do not provide treatment outside of office hours. Utrecht's CMHT thus depends on other teams to provide these forms of care, including hospitalization. Uncertainty work, then, means connecting the expertise of different services, with the risk of relational discontinuity. Another difference is to whom this relational approach is directed. In contrast to Utrecht, in Trieste, it is not only about the individual patient and his or her family. Service users are seen as part of a broader social network with which relations need to be strengthened. Lastly, ordering care from a relational approach in Utrecht is in need of a more strongly articulated legitimation. As we described elsewhere, in Utrecht, there is a stronger focus on medical specialization, which is supported by the idea of evidenced-based working and the bureaucratic way of ordering care, while ordering care from a relational perspective has no such strongly articulated legitimation and a lack of professional specialization (Muusse et al. 2021:12).

Managing prognostic uncertainty: Creating continuity of care

Observing how the CMHTs conduct uncertainty work highlighted its temporal, prognostic aspect. Uncertainty work is not only about what is going on at this moment, but it is also an anticipatory project directed at what might happen in the future. In the teams, we observed that one way of

reducing this prognostic uncertainty was promoting relational continuity of care. How this is done differs between the modes of ordering care in Trieste and Utrecht.

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

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

In the relational mode of ordering care in Trieste, creating personal continuity by crafting long-lasting relationships between the team and the service users as part of a network is seen as a way to "buffer" for the uncertainty of a crisis that might occur (Muusse et al. 2020).

In Utrecht, the CMHT has a different position in the care landscape. Without the function of a center that operates 24/7, the team needs other service providers to create continuity of care. Continuity is thus not always based on a personal relationship but by working together with other service providers:

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

Another difference with Trieste's CMHT is in what is seen as good mental health care. As we described above, in Utrecht, the CMHT offers specialized mental health care, ideally seen as a temporary and linear intervention. Treatment in Utrecht ideally starts when someone is categorized as needing specialized mental health treatment and ends when this treatment is either successful or has reached a point where no further progress is expected. At this point, people are referred to other service providers such as diagnosis-specific teams, social support, or the GP. The importance of making progress is underlined by the negative way of labeling a situation without it, stating that care had the risk of turning into "*pappen en nathouden*" – a Dutch expression close to the English "plastering over the cracks,"[10] which has a negative connotation and refers to a way of maintaining stability without specific clinical interventions and without any progress being made:

Psychiatrist: We have to avoid a contact of "pappen en nathouden." Preferably we have her in care for a marked period in which we do a good hetero anamnesis. Then a discussion starts on who should provide support when the temporary intervention of the team has ended. Social welfare is suggested but is questioned as well.

Mental health nurse: You know how that goes, they will ask if she has a support request and since she does not utter her needs, they will probably step out too soon. (Field notes, Utrecht)

In this example, care is first linked to the idea of making progress and treatment as a temporary intervention. This resonates with a view on care that places treatment in a clinical, linear time frame (see also Hautamäki 2018).[11] But this linear time frame is questioned as well. We observed that although treatment from Utrecht's CMHT ideally is time-limited, in practice, many patients are in the team's care for more extended periods, often for years. In these cases, the team perceives a patient as too vulnerable to be referred elsewhere. The decision regarding who only needs the care of the team as a temporary intervention and who needs more long-term support is often not easy to answer, and in Utrecht, it becomes another source of uncertainty. The question of who qualifies as a patient in

Utrecht is not only at stake at the beginning of a care trajectory but becomes a recurrent discussion (see Muusse et al. 2021). A case manager explains the dilemma in a group interview:

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

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

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

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

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

Taking positive risks

Both in Trieste and Utrecht, uncertainty work to prevent a crisis consists of activities that reduce risks and which are aimed at stabilizing a situation or restoring an equilibrium. Attempts to create continuity in care and a relational approach are important strategies to achieve this, although how this is done differs. But risks are not always seen as something to be avoided. Taking "positive risks" can be a part of the uncertainty work conducted if this helps in maintaining relationships and thus having sight on a situation. An example from Trieste:

> In a group interview, the team members discuss the situation of a young man living with his father. He states that he has the devil in his head but refuses anti-psychotic medication. So far, "the devil" is telling him good things, but years ago, he attempted suicide in a very violent way. The psychiatrist states that they have decided not to force him to take medication. A nurse asks, "You do not prescribe medication because?" The psychiatrist responds, "He does not want it, but also . . . . , we are afraid that he will then refuse all contact. He states that something good will happen on his birthday. I have a bad feeling about it, but I want to give him a chance." In the meantime, they visit the man at home a few times a day and take him out for coffee. When the birthday arrives, nothing happens, and the man is willing to accept medication. (Field notes, Trieste)

In this case, different risks are balanced. There is a risk of suicide if they do not force him to take medication. But this way of solving the uncertainty could mean losing contact with the man, thereby increasing the uncertainty about how he is doing. Also, the alternative for enduring uncertainty in this case would involve forms of forced care. Although forced care is seen as inevitable in some cases, it is one of the bads to be avoided if possible. In Utrecht as well, positive risk-taking is part of the uncertainty work conducted:

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

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

When uncertainty work fails: Different ways of intervening

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

> The team discusses a man who refuses all contact. He doesn't show up at appointments, and when the case manager drops by his house, he either refuses to open the door or is not there. The man is placed on the FACT board and frequently discussed in the following days. Different team members drop by his house to see if he is there, but they cannot establish contact. They contemplate whether they should put adhesive tape on his door to check if he still goes out or put a letter under the doorpost with a contact request. But these interventions are also questioned: A nurse asks out loud, "How far can we go? Does someone not have the right to refuse contact?" (Field notes, Utrecht)

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

What is seen as "good care" while facing the uncertainty of a possible crisis differs in Trieste and Utrecht's two modes of care. From the radical relational way of ordering care in Trieste, intervening from within the relationship is seen as good care, while coercive measures such as forced hospitalization or treatment are rather avoided and, in any case, difficult to conduct with the low number of beds

available. In Utrecht, a more individual view on autonomy brings to the fore questions like "Does someone have the right to refuse care?" This more juridical way of ordering care limits the options of persuading people to care and conducting relational ways to reduce the uncertainty of a crisis that might occur (Muusse et al. 2022)

Discussion

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

In the relational mode of ordering care in Trieste, uncertainty is mainly dealt with by building up relations with both service users and their network. These long-lasting relationships function as a "buffer" for a crisis and give carers insight into how service users are doing, thus reducing the uncertainty of not knowing what is going on. Building on relations and being able to interfere quickly can also avoid escalations or prevent situations from deteriorating further. This also means that the risk of having to use coercion is reduced. The organization of care in the CMHC in Trieste facilitates this mode of ordering care; care is organized so that a quick response is actioned if something seems off, there are no waiting lists, and both outreach and care in the center are provided by the same team, thus strengthening the relationships between the CMHC's team and the service users. In this mode of ordering care, hospitalization in case of a crisis is not seen as an option to deal with uncertainty about what to do in case of a crisis. Having only a minimum number of beds to use as a "last resort" asks for other ways of dealing with a possible crisis or escalation, such as a low threshold to care, a relational approach, building a network, and flexibility in scaling up care in and outside office hours, to be able to intervene as much as possible before a situation escalates. Moreover, a comprehensive and multi-disciplinary team approach – based on the person and his/her social context – is adopted rather than specialized care provided by diverse professionals.

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

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

2021) to describe situations that were not so much goal-oriented but about staying close and building relationships that buffered in a crisis. The quest then becomes how more or less intense forms of "watchful waiting" can be facilitated, especially in systems where the idea of treatment as a goal-oriented and temporary intervention is dominant.

In the literature around uncertainty as an analytical concept in health care the importance of categorization strategies and the use of protocols to reduce risk are often described (see f.i. Lane 2019; Mackintosh and Armstrong 2020; Pickersgill 2011). By using uncertainty work as an analytic tool, we demonstrated that reducing the risk of a possible crisis is also a relational endeavor. With the concept of watchful waiting, we described how this relational continuity is important in both practices. However, it is more difficult to perform in a system with a more linear time frame in which care is ideally seen as a temporary intervention. Although a lot of uncertainty work is related to avoiding disruptions, it is important to point out that in this relational endeavor, it is not always about reducing risk. Taking positive risks can be a way to maintain and strengthen relationships and avoid forced care.

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

Notes

1. In mental health care, there is an ongoing debate about the terms client/patient or service user. We choose to align with the language used at the field sites in the choice of use of terms service users (Trieste) and clients/patients that are used interchangeably in Utrecht. If we address both sides, we use the term clients.
2. Number of beds in 2018. Personal e-mail conversation. asugi.sanita Trieste. Number of beds, Utrecht region, 2017: 89 per 100,000 (Vektis).
3. If we compare the region Utrecht (bigger than Utrecht city alone) and Trieste, then involuntary measures (forced hospitalization and/or treatment) are about 10 times lower. Utrecht (2019) had 217 involuntary measures per 100.000 inhabitants (number of involuntary measures retrieved by de rechtspraak). In Trieste (2019), there were 21.8 involuntary measures per 100,000 inhabitants (number of involuntary measures retrieved by asugi. Sanita Trieste). Numbers are indications. There are, for instance, differences in the juridical system.
4. In Trieste the CMHT is based in a Community Mental Health Center (CMHC), which includes beds, a dining hall, etc. In Utrecht the CMHT is based in a polyclinical setting without further care facilities. If we address the teams we use the acronym CMHT for both sites, if we specifically address the center as a physical place in Trieste we use CMHC.
5. In this article, we use the broad term 'caregiver 'for different professionals working in the teams. Both in Trieste and Utrecht these were mainly psychiatrists, psychologists and mental health nurses. In Utrecht, an expert by experience was also part of the team.
6. Although the first author has a basic understanding of Italian, this was done together with an interpreter who was familiar with mental health care, so as to get a detailed understanding of the daily practice.
7. In the Netherlands the first author was present in the CMHT of Utrecht across two periods of first three and then two months. In Trieste, the fieldwork was divided into three more intense periods of five weeks in total. In addition to this fieldwork, the first author has been involved in studies concerning community mental health care in the Netherlands since 2006 and in Trieste since 2014. The first research in Trieste is reported on in "Freedom First" (Muusse and Van Rooijen 2015).
8. The Dutch organization of which the CMHT is a part has a longer tradition of conducting visits to Trieste. Some of the workers, including the team leader, visited Trieste on at least one occasion. Both teams, together with the first author, provided a workshop on the CCITP around crisis care (October 2018, Rotterdam).

9. The METC from VU University (FWA00017598) has declared that the Medical Research Involving Human Subjects Act (WMO) does not apply to the study. Ethical permission was provided by the ethical commission of the Trimbos-institute (TET).
10. This expression was used more often to refer to cases where there was long lasting support without a defined start or end point.
11. A linear way of ordering time also resonated with what is labeled as a "managed care model," in which care is aimed at acute symptoms and time limited. See for instance Lester (2009, 2019).

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Notes on contributors

Christina Gerdien Roelofke Muusse, studied Cultural Anthropology at the University of Amsterdam and is a researcher at the Trimbos- Institute, Netherlands institute of mental health and addiction. She is part of a team aimed at improving care, support, and participation for people with severe mental illness. She obtained her PhD at the Amsterdam UMC, Department Ethics, Law & Humanities, Amsterdam UMC, Amsterdam, The Netherlands.

Cornelis L. Mulder is a psychiatrist and professor of public mental health. He is program leader of the Epidemiological and Social Research institute at Erasmus University Medical Centre, department of psychiatry, and psychiatrist at Parnassia Psychiatric Institute. He is involved in research projects concerning help seeking behavior, motivation and compliance, emergency psychiatry, victimization,

Hans Kroon is professor of Community Mental Health Care and Recovery at Tilburg University and head of the department Mental Health Care and Participation at the Trimbos-institute. His research is primarily focused on (organization of) care, quality of life and perspectives of persons with severe mental illnesses, using mixed methods.

Jeannette Pols is professor Anthropology of Everyday Ethics in Healthcare. She works with the Department of Anthropology, University of Amsterdam, and with the department of Ethics, Law & Humanities of the Academic Medical Centre in Amsterdam of the same university. Her research analyses the everyday negotiations of values in clinical practice, for patients at home, and within the sciences that study care practices. This work pertains specifically to the ethnographic study of the practical and desirable ways in which technologies shape care and societies with the aim to improve situations, and evaluates to what types of effects this leads.

ORCID

Christina Gerdien Roelofke Muusse http://orcid.org/0000-0003-1746-1236
Hans Kroon http://orcid.org/0000-0002-2259-1628
Jeannette Pols http://orcid.org/0000-0003-0157-2388

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