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Tinkering as Collective Practice: A Qualitative Study on Handling Ethical Tensions in Supporting People with Intellectual or Psychiatric Disabilities

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ABSTRACT

The values of patient autonomy and community participation have become central in health care. However, care practices involve a plurality of possibly conflicting values. These values often transgress the borders of the individual professional–client relationship as they involve family members, other professionals and community organisations. Good care should acknowledge this relational complexity, which requires a collective handling of the tensions between values. To better understand this process, we draw on [Mol, A. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. Routledge; Mol, A., I. Moser, and J. Pols. 2010a. *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Transcript Verlag.) by developing the notion of collective tinkering. An ethnographic study was conducted in two teams in community housing services for people with Intellectual Disabilities and Severe Mental Illness. Collective tinkering is analysed (1) within teams; (2) between professionals, family members and professionals from different organisations providing care for the same client; and (3) in organising practices for a collective of clients. Collective tinkering involves assembling goods into a care practice, attentively experimenting with these care practices, and adjusting care accordingly within a collective of those involved in care for a particular client (group). When collective tinkering does not occur, the stakeholders excluded (e.g. clients or family members) may experience poor quality of care.

Introduction

The care relationship is an important part of the quality of social work (Lindvig et al. 2019; Topor and Ljungberg 2016; O'Leary and Tsui 2019). While the determinants of the quality of the care relationship in long-term care have been described, the ethical dimension of what constitutes a good care relationship is often overlooked (Scheffelaar et al. 2018). It is

important to study this dimension as different values play a role in the care relationship and need to be combined in care practices.

Addressing the ethical dimension is currently specifically prudent in relation to tensions with the values of autonomy and community participation. These values have gained prominence and are promoted in care models such as recovery-oriented care, rehabilitation or person-centered care (Farkas and Anthony 2010; Claes et al. 2010; Rapp and Sullivan 2014; Farone 2006). Highlighted in these care models is the involvement of clients in care planning (Claes et al. 2010; Anthony et al. 2014), the support of clients in managing activities of daily living and participating in the community (Farkas and Anthony 2010; Dean et al. 2016; Salzmann-Erikson 2013) and the move from institutional settings to supported independent living (de Heer-Wunderink et al. 2012; McPherson, Krotofil, and Killaspy 2018; Bredewold, Hermus, and Trappenburg 2020). This focus on autonomy and community participation has increased the complexity of the care relationship, as is pointed out by care ethicists and shown in ethnographic research (Pols, Althoff, and Bransen 2017; Ferrier 2018).

How individual professionals provide good care while handling this complexity has been conceptualised as tinkering, which is often described in the analysis of the relation between an individual client and a care professional (Mol 2008; Mol, Moser, and Pols 2010a). However, care is often a collective practice, where teams, family members and professionals from different organisations collaborate (Ursin and Lotherington 2018; Gherardi and Rodeschini 2016). Insight into how professionals handle complexity within these collectives is currently lacking. Our study develops a notion of tinkering as a collective practice through ethnographic fieldwork in community housing services for people with serious mental illness (SMI) or intellectual disability (ID). This way, we contribute to theories on the ethics of care that do justice to the complexity of care practice and provide directions for improving the quality of care (Mol, Moser, and Pols 2010a). We do so by answering the following research question: *how do social care professionals tinker collectively to provide good care?*

The complexities of collective care

When complexity is discussed in social work, it is often with reference to clients' multi-problems and the number of care-relationships clients are in (Almqvist and Lassinantti 2018; Gridley, Brooks, and Glendinning 2014). However, in this paper, we direct our gaze to another type of complexity; complexity in terms of how the care relationship is practiced. We do so by drawing on a specific strain of ethics of care which connects with Science & Technology Studies (STS) (Mol, Moser, and Pols 2010a; Gray 2009). STS is a scientific field that studies science and technology as cultural artefacts that are constructed and become embedded in our social reality through networks of both humans and non-human actors. Adding to ethics of care, this view highlights materiality as relationships stretch beyond humans to objects. Moreover, an STS approach highlights how bodies, objects and subjects come into being through practices (e.g. de La Bellacasa 2011).

To talk about care as a practice gives a specific focus on how we address the care relationship and its ethical dimensions. It means we do not talk about abstract values on how social care professionals ought to behave or about what clients prefer professionals to do. Instead, we talk about what professionals and clients do together

when care is practiced. Moreover, the care relationship is not about social care professionals and clients alone. It is also about family members or other important persons in clients' lives and various professionals from different organisations, like therapists providing treatment or policemen providing safety in the neighbourhood where clients live (Landeweer 2018). Adding an STS approach points us moreover to the impact of materialities on the care relationship. For example, housing, electronic questionnaires and smartphones can impact this relationship (Laholt et al. 2019; Gibson et al. 2020; Piat et al. 2017). So, when we talk about the care relationship in this paper, we talk about it as a practice between clients and professionals amid a collective of people and things.

When we say this care relationship is complex, we refer to two related complexities. First, how there are different ways of doing 'good' care, which may be in tension with each other. What is 'good' practice in a care relationship can vary and conflict. From the perspective of ethics of care, this is not about deliberating abstract principles, it is about considering good care in a specific situation, finding local solutions to specific problems (Mol, Moser, and Pols 2010a). What is 'good', and should be considered when evaluating or crafting a care practice, is plural as it may include many different things beyond values (Willems and Pols 2010; Mol, Moser, and Pols 2010b). Mol, Moser, and Pols (2010b) give the example of eating in a nursing home. Here self-determination matters as people are offered choices in what to eat, as does taste and coziness of eating a meal together (Matscheck, Ljungberg, and Topor 2020). These may be in conflict as coziness may entail sitting together in a small group, while choice entails having many different foods available. This plurality of 'goods' at stake in practice makes the care relationship complex. Moreover, values can take on many different meanings and be put into practice in many ways. For example, autonomy as a core value of social work is defined by some as fostering service user choice and minimising dependence (Furlong 2003; Munson 2020), while others see it as a relational concept and emphasise interdependence (Heidenreich et al. 2018; Juhila et al. 2021). These different conceptions of autonomy give rise to various, sometimes conflicting, practices (Heerings et al. 2020). Moreover, organisational procedures also embed conceptions of autonomy which can conflict with professionals' perceptions of good care (Matscheck, Ljungberg, and Topor 2020; Davies and Gray 2015).

A second related complexity in the care relationship distinguished by Mol, Moser, and Pols (2010a) is about orderings of reality or multiple ontologies (Mol 2002). These ontologies are important to consider as these also determine what is considered 'good'. In this paper, we focus on the ontology of clients: on ideas about 'who clients are' and how these ideas shape and are shaped by care practices. We consider the ontology of clients as the dynamic interplay of clients' and professionals' understandings of clients' identity, shaping what people can make themselves up to be (Bröer and Heerings 2013). Ontology is not merely discursive but is enacted in material practices (Mol 2002). These different ontologies shape the notion of good care can be illustrated by an example from the work of Pols (2006). She shows how different washing styles enact clients as different citizen types, for instance focusing more on client's choice-making, on learning to be independent or on relating to others. This example shows the 'same' client can be enacted differently through different practices. These multiple enactments may be in tension with each other which adds to the complexity of the care relationship.

Tensions aggravate when professionals, clients and family members have different views on what is good care or hold different ontologies of clients (Heerings et al. 2020; Jingree and Finlay 2012). Moreover, clients often receive care from a multitude of health and social services including supported living, sheltered work and leisure activities. As providing integrated care is increasingly emphasised to be important, different conceptions of good care between professionals of these different organisations or different ontologies of clients may increasingly surface as well. It is therefore important to gain insight into how these differences are dealt with.

How to provide good care within the complex care relationship: collective tinkering

In light of the above, Mol, Moser, and Pols (2010a) conceptualised good care as: 'Persistent tinkering in a world full of complex ambivalence and shifting tension' (14). Tinkering in this definition is about finding local practical solutions through attentive experimentation; a reflective and experimental process of all involved, through which care practices are invented that bring together different goods and ontologies. The effects of these care practices need to be attentively followed as what is 'good' can only be established in practice. As clients and contexts are ever-changing, different goods, ontologies and tensions are brought to the fore. Tinkering therefore is an ongoing process. As care practice is a collective of people and things, tinkering also relates to the material objects that are part of care practices. These need to be adapted to the situation and vice versa to create good care in a persistent process of tinkering (Willems and Pols 2010). Compared to person-centered theories and models, the tinkering approach emphasises experimenting with practices over shared decision-making. Moreover, the tinkering approach is relationship-centered rather than person-centered as it focusses on how goods put forward by both clients and professionals are assembled in a practice (Mol 2008; Mol, Moser, and Pols 2010a). The advantage of this 'tinkering approach' to good care is that it aligns with how social care professionals already 'do' good care amidst the complexities that they face, as this concept was developed through ethnographic studies on care practices. The added value lies in making visible and strengthening these practices (Mol 2008; Weinberg and Banks 2019).

While tinkering is posed as a relational concept that can be used to understand complex care practices, including all relations important to providing care, it is mostly used to analyse the micro-relationships between professional and client. Despite some exceptions (Pols, Althoff, and Bransen 2017; Ursin and Lotherington 2018; Gherardi and Rodeschini 2016; Moreira 2010), there is little focus on the wider network of care relations, including teams of professionals, informal caregivers and other health/social care providers (Uhrenfeldt and Høybye 2015). As argued in the previous section, complexities and dynamics in such settings abound, as well as the need to handle tensions between different goods and ontologies. As care is increasingly a collective effort, handling tensions between goods and ontologies have become a collective process. Who is part of this collectivity is defined in practice as those involved in the care of a particular client. This may include family members and professionals from other organisations but also managers at the organisational level as their policies co-constitute care. This raises the question how tensions between different goods and ontologies are tinkered with

within such collectives. Our study takes up the challenge of conceptualising collective tinkering through conducting ethnographic fieldwork in community housing services for people with SMI or ID.

Materials and methods

Study design and setting

This ethnographic study took place in a Dutch community service organisation that cares for people with SMI or ID. Autonomy-related values such as self-determination and community participation are inscribed in the organisations' mission statement, policies and practices.

Two care teams in a community housing service participated, one providing support to people with SMI (care team 1) and one providing support to people with ID (care team 2). The teams of social care professionals and a peer support worker (expert-by-experience) provide support in three types of housing arrangements: a supervised group home with shared facilities and an office for professionals; single apartments in a building with only service users, with each their own facilities and the professionals' office nearby; and houses where service users live independently. Housing is organised as a stepped process where service users are moved from one setting into more independent settings. Each service user has a personal care plan, including goals for care that are negotiated between clients and professionals, evaluated each year. Goals include being able to keep up personal hygiene and a household, develop a vocation, organise finances, etc. Professionals support service users in these goals through supportive conversations, teaching skills, giving practical assistance and connecting service users to other services.

Participant observation

Participant observation was conducted by the first author and enabled observing care practices as they unfolded. The fieldwork took place over 6 months, 3 months in each team, 12 visits totaling 19 h for the first team and 12 visits, 65 h, for the second, in the period from autumn 2017 to spring 2018. The first author observed shift handover meetings when all clients were briefly discussed (team 2); bi-weekly team meetings (both teams); coffee moments for clients (both teams); meals (team 2); care moments (both teams); informal discussions between professionals in the office (both teams); and activities in the dayroom of the communal house (team 2). Extensive field notes were made shortly after each observation. Experts-by-experience who provide support to clients were interviewed. As they worked in different teams, they could elaborate on complex situations they had witnessed, serving as co-ethnographers in situations that did not cater for the researcher's presence.

Interviews

In depth- interviews were conducted by the first author to gain insight into the complexities of fostering autonomy and community participation. Table 1 presents an overview of participants.

Table 1. Interviews.

		Care team 1 SMI N	Care team 2 ID N
Interviews	Service users	8	12
	Peer support workers	8*	
	Family members	3	4
	Family support workers	3**	
	Professionals	8	10
	Team coaches	2**	
	Team managers	1	1
	Managers on the organisational level	3**	

Note: * In multiple teams; ** not in a team.

Professionals either were trained as social workers at a University of Applied Sciences, or as support workers through post-secondary vocation education or training on the job. The topic list was similar for all respondents and opened with 'What do you find important in the care relationships you are involved in?'. Each 'good' was prompted for narrative exploration of situations in which the value was easily practiced or proved complex when different goods were in tension. When values such as self-determination and (community) participation were not named spontaneously, these were prompted by the researcher referring to the mission statement of the organisation, after spending elaborate time exploring the situations brought up by the interviewees. Interviews were audio-recorded and transcribed verbatim. Five clients and one professional refused recording of their interview; here extensive notes were taken and elaborated shortly after.

Data analysis

The various complexities described by respondents and observed during the fieldwork were analysed thematically by the first author and refined in deliberative sessions with the three other authors. The first round of inductive coding was guided by three questions: (1) which goods do different stakeholders find important for good care?; (2) when goods are put into practice, which situations are complicated by tensions between different goods and ontologies?; and (3) how do stakeholders tinker with these tensions?

After the first round, it struck the researchers that tinkering not only involved service users and professionals but was a collective process. This became the focus of the second round of coding, guided by three questions: (1) how do collectives tinker; (2) who is involved or excluded in tinkering; and (3) how is collective tinkering shaped by the organisational context of the care team? Open coding guided by these questions was followed by a round of axial coding and selective coding. For this process of coding, we used the constant comparative method as described by Boeije (2002). Coding was done in Atlas-ti.

Table 2. Data validation sessions.

	Care team 1 participants SMI	Care team 2 participants ID
Service users	5	5
Professionals	8	9
Family peer support	6 (both SMI and ID, not in a team)	

Data validation sessions

For the purpose of member check and data enrichment, five data validation sessions with service users, professionals and family peer support workers (see Table 2) were held.

For these data validation sessions, vignettes about complex situations (5–8 vignettes per group) were developed through thematic analysis of the data (see the first round of coding) (Wilks 2004). The participants were prompted to reflect on the recognisability of the vignettes, and if important complex situations were missed. For service users and professionals, all participants of the interviews were invited. As most interviewed family members had expressed their reluctance in joining a group discussion due to time restrains, this data validation session was organised with family peer support workers only. This session took place during one of their monthly peer-to-peer coaching meetings.

Ethical issues

The ethical board of Erasmus Medical Centre judged the study as not in need of ethical approval under Dutch law (MEC-2017-122).

Results

In this section, we analyse tinkering as a collective practice, focusing on three types of collectives: (1) care team including clients; (2) a care team including clients, family members and professionals of other care/community organisations; and (3) a collective of clients for whom care arrangements are created. The cases of three clients – Max, Jesse and John (pseudonyms) – are highlighted as the data collected on these cases most clearly show the differences in the way the two teams included in the study managed or did not manage to tinker collectively.

Tinkering in teams

Tinkering in a team happens in some cases but not all, impacting the quality of care. In this section, the case of Jesse (team 1) and Max (team 2) are contrasted to show the added value of collective tinkering.

Jesse receives support with independent living. He lives in a studio apartment with kitchen and bathroom in a building he shares with four other service users. Jesse used to study art and live in a student home but became homeless during the first episode of psychosis. His symptoms have diminished with the use of medication, and he is in the process of finding a vocation. Jesse likes to spend evenings reading and drawing, while having a drink. His room is covered with paintbrushes, dirty laundry, dishes and cigarette butts. The problems for Max are much the same as Jesse's. He lives in a small room in the communal house, bordering the living room. His room is crowded as he moved in from a big apartment and brought along all his precious possessions. The only free walking space in the room, surrounding his bed, is full of dirty dishes and laundry, trash and cigarette ash.

In both cases, team members differ on how they work up the reality of who the client is and which goods should be prioritised. In Max's case, some team members see his unhygienic living conditions as due to personal incompetence. Others see Max as

someone able but not willing. These different ontologies evoke different values in caring for Max. If Max is incompetent, good care involves helping him clean. If Max is competent but unwilling, helping him would hinder his goals to live independently. The team agrees that living in neglect will pose harm to Max. Something has to change. The team organises his care collectively. Daily tasks, such as reminding Max to clean his room, are put on an agenda that the professionals who happen to work that shift execute. The team discusses Max's case at the twice daily handover meeting between shifts or at their bi-weekly meetings.

This is different for Jesse as team 1 has limited structures in place to discuss clients. Clients are cared for individually, with one or two caretakers making appointments with the client. This team has no meetings between shifts where they discuss all clients, only monthly meetings where they discuss only those clients who the professionals have put on the agenda. In Jesse's case, some professionals in the team stress the value of self-determination, pointing out that Jesse might not share the norms of having a tidy house that other team members might have and that the entire team should abide by how Jesse wants to live. Other team members emphasise the value of preventing harm from living in unhygienic conditions. Although the team discusses Jesse's case, they do not negotiate on the different values. The professionals favouring the value of self-determination simply convince the others that good care for Jesse means following his wishes.

> So, I have this client who everyone finds really smelly and difficult. And they have a point, he is a bit stinky. When it comes to cleaning, he just lets things go. So, I try to tell the team that we're not talking about 'Mr. Stinky', we're talking about Jesse, who's just like … like … anyone else and a very smart guy. But Jesse says: 'I don't like things clean and tidy.' We have to know that, we have to understand how it works for him, and we shouldn't go there every Friday and make him feel uncomfortable by cleaning up his place.

Instead of helping him clean his room, Jesse's care professionals do sometimes nudge him. For instance, by reminding him his laundry is starting to smell bad. This, however, seems to have limited effect in terms of the state of Jesse's house and only partly attends to the tension between the value of self-determination and other values such as preventing harm from living in neglect. Not attending to this ongoing value tension stops the team from inventing experiments that would assemble the different goods and create 'better' care. Moreover, the team excludes the views of Jesse's mother from the conversation. She contacts the professionals several times, expressing concern about the possible harms, feeling that the approach chosen does not foster an independent lifestyle. While the professional holds an ontology of Jesse as someone capable of deciding for himself in his household, mother's ontology is different. She does not see him as fully capable. Instead, she pictures him as being too hindered by his symptoms to accept help in cleaning.

> At one point I thought, this room is filthy. The professionals kept pointing to his autonomy. I said, 'The situation is out of control and he was offered help, so will someone from [care organization] please help Jesse clean his room.' Well, Jesse didn't want that. Because you're touching his stuff, I get it. But they could have taken a structured approach. It would've benefited him, being able to do his own cleaning in due course. […] Of course, he'd say no. That's part of his schizophrenia, to say no to that sort of thing. It fits the diagnosis. […]. But you start thinking, it must go wrong sometime, he'll either get food poisoning or some other nasty disease.

The team did not take the mother's view into account in their decision on how to care for Jesse. This not only limits their creativity in crafting care practices that arrange the differing goods, it leaves the mother feeling that Jesse is not receiving good care.

In contrast, professionals of care team 2 realised that for Max, emphasising the value of self-determination and leaving him in neglect simply does not work as it evokes ongoing tension with the value of preventing harm. This tension fosters a creative experimentation process to find ways to not interfere with Max's autonomy yet improve his hygiene. They follow these experiments closely and invent new ones when they do not work. Failed experiments include reminding Max to clean his room, telling him the consequences of not cleaning, and to thoroughly clean his room themselves when he is on holiday. Some interventions disturbed Max, and none led to cleaner conditions in the long run. The team then decided to arrange for a professional to come to help him every other week. This seemed to have a better effect and even Max was content. As he explained to me when we were eating a jelly pie he had made, he now feels he has more 'living space'.

Even though in Max's case it looks like collaborative tinkering created 'better care', this is not the end of the story. While team members agreed on the assemblage of goods in the experiment, they still held different ontologies on who Max is. Some felt that Max should get ongoing help as clearly, he could not keep his room tidy on his own. Others felt that helping him clean risked keeping him lazy and would stop him from being able to do his own housekeeping in due course. For these team members, the tension between the values of preventing harm and developing independence persists. This ongoing tension might motivate the team collectively to invent new experiments negotiating these values in the future.

In both cases, Jesse and Max were left out of the team's collective tinkering process. Professionals often tried to engage clients in their own care, for instance, through developing a personalised care plan. However, many decisions on client's care were taken in meetings between professionals. Here clients' needs were advocated by team members. While some ontologies and values put forward in team meetings likely have been influenced by conversations they had with clients, team members often did not engage in-depth with clients to understand clients' needs fully on their own terms. Instead, team members decided on what represents value for clients and who they make themselves up to be, in ways that sometimes did not altogether align with clients' own views. Moreover, the teams barely considered material arrangements that co-constitute the tensions between values and ontologies.

Both these points are especially clear in Max's case. He points to the importance of material arrangements in constituting his situation. Interviewed, Max felt that his 'neglect' was caused by not having enough space to keep all his valuables because he had moved in from a larger apartment. As far as he was concerned, he is not lazy, because he does valuable work as a DJ on his own online radio station. He prefers the privacy of his room above sitting in the communal areas, but due to the limited space, he cannot work anywhere else than in bed. If the team had considered Max's goods, his definition of himself and the material arrangement, it might have fostered the development of care practices that better fit his needs. In other cases, professionals seemed to represent clients stated needs more adequately. For instance, in Jesse's case, where care is crafted on the single value of self-determination, his view on housekeeping seems

dominant. In terms of collective tinkering, however, this is not 'good care' as Jesse was left out of the decision to exclude the goods of developing an independent lifestyle and preventing harm from his care practice.

Tinkering in teams including family members and other care/community organisations

The second type of collective tinkering we analysed takes place between team members, family members and other care and community organisations. A complex situation both teams encounter is clients making friends with people who manipulate them into criminal activities. This requires collective tinkering with a wide range of organisations, including other care organisations, local police and the municipality. In care team 2, this situation involved John, who wanted friends and let a few 'cool men' befriend him. They often spent time in his home and one of the men even slept on his couch. John's sister found out about this and suspected possible harm. She questioned the good intentions of the men and wondered if John really desired this situation or if he was simply not capable of refusing the men. She contacted the care professional who took her concern seriously.

The professional found out that John had given the men access to his bank account and they were depositing criminally obtained money and withdrawing it in cash on John's bankcard. John collaborated in this as the men offered him a few Euros in return, making John feel he was one of the 'big men'. Different goods were in tension here. John's bank account facilitated self-determination on spending some of his money and fostered an independent lifestyle because he could do some of his own shopping. After some deliberation, the care team and John's sister decided that the situation posed too great a risk for John and they crafted a care arrangement for his money to be kept under curation.

Later on, John wanted to fix up his house, but not having a lot of money he posted an advert on Facebook asking who might want to help him. A few men replied. So far John's situation follows the autonomy-related value of community participation. One of the men did not have anywhere to live and proposed living with John while he worked on his house. One of the team members learned of this and suspected potential harm. A professional with a good relationship with John tried to find out more about the situation and learned the names and home village of the men. He contacted a care professional he knew in that village who suspected they wanted to use John's house to grow marijuana. This unfolding tension then required assembling the goods at stake: John's self-determination versus preventing John from the harm of complicity in criminal activity. John's ontology of himself also needed to be part of the negotiation, or at least the professionals' representation of it. As John was perceived to see himself as 'a big man' he would not easily accept that these men were not his friends but were using him, and convincing him of this would harm his self-esteem. Thus, they crafted a care practice assembling the goods and ontologies. The care professional who knew the men would inform them that John's care organisation had eyes on them, and the police would be called if they pursued criminal activities. The experiment worked: the men stopped seeing John.

This incident made another tension clear. As John lived a few blocks away from the care unit and rented his own house from the social housing company, his care workers

had little oversight. This material arrangement contributed to the professionals being quite late in picking up the potential harmful situation and was limited in their interventions as they were not allowed to enter the house, change the lock or set rules about who could come in. These values were assembled in a new material arrangement by moving John closer to the care office into a unit owned by the care organisation. This also required the involvement of a wider collective of stakeholders, such as the manager agreeing to the move and the care organisation providing one of their houses. For John, having friends and being one of the 'big boys' was also an important value at stake; however, the new care arrangement did not address this so much.

Tinkering for a collective of clients

Collective tinkering not only happens in relation to individual clients. When creating care practices for a collective of clients, goods and ontologies also require negotiation.

A complex situation mentioned by both teams centres on clients' loneliness. One care practice addressing loneliness for a collective of clients involves organising 'coffee moments'. Here again, different goods and ontologies need to be negotiated. On the one hand, coffee moments potentially limit community participation, as clients are then less inclined to seek social contact in the community. On the other hand, coffee moments provide a safe space for peer support. Besides these different values, multiple ontologies of clients are evoked: as clients capable of engaging in social relations in the community and as vulnerable clients needing a safe space to foster social contact. One professional in the first team voices these tensions:

> Group sessions are nice, having coffee once in a while […] and catching up with others. But don't have coffee moments for the sake of having them, every day a cup of coffee. They should go to an activity center, or a cafe. Then they'll meet new people and join the community. When they ended up in the healthcare system, they were cut off by society. And now they are allowed back in again. So, let them try, for God's sake.

The two teams assembled these tensions differently, resulting in different arrangements for the coffee moments. Care team 1 organises coffee moments on Sundays only, as this is when most community options for socialising are closed. This is reflected in the material aspects of this arrangement. The space where the coffee moments take place is not inviting. It looks like a conference room and is in fact the same space were team meetings take place. In care team 2, the value of offering peer support in a stigma-free environment resonates more with the team members, as is expressed by the following quote.

> It is important to facilitate […] those coffee moments. You could call that inward-looking. But Ryan, with snot in his hair and Emma, who stinks, they're not going to be invited into people's homes. But they do come to these coffee moments. And so, you bring them together. Nobody here ever says, 'Did you notice how badly Emma smelled? Or how filthy Ryan is?

Care team 2 arranges coffee moments twice a day in the communal living space of one of the houses where residents live together. This material arrangement adds to the homely atmosphere. Clients who receive care from this team but live independently are welcome too. This way of organising coffee moments was under threat as managers on the organisational level introduced a policy to arrange housing in such a way that every client has 'their own front door'. This policy was introduced to materialise the value of living an

independent lifestyle. Due to this policy, care team 2 was in the middle of re-organising the housing situation. Service users were moved one-by-one to their own apartment, each with their own kitchen and living space. This rearrangement led to the demise of the coffee moments as this new set-up offered limited space for organising communal moments. Social contact for service users was also reduced as clients could now more easily decide for themselves to stop socialising with their neighbouring service users, as they no longer shared a house and occasional coffee moments were no longer in their own home. This example makes clear not only that professionals need to adapt care practice for a collective of clients but also that collective-client practices are enabled or limited by other layers in the care organisation, such as managers.

The new context required inventing new experiments in assembling the values of promoting well-being through social contact, self-determination and independent living. The value of preventing harm was also part of this assemblage as professionals feared lonely clients would be more prone to engage with people who could take advantage of them (see the example of John). The team experimented with connecting service users to community organisations that arrange 'buddy contact'. Although the team felt this was not the best way to facilitate social contact, the corporate 'own-front-door' policy for service users limited their ability to provide the social contact they wanted, through regular, easily accessible coffee moments. Here, the team and organisation managers undertook no collective tinkering, no experimenting with other material arrangements to assemble the values of providing social contact and fostering an independent lifestyle.

Discussion

Community housing services are increasingly organised through individualistic practices such as the move from group homes to independent living arrangements. However, social care professionals often collaborate with others to provide good care, such as team members, informal carers and professionals from other organisations. Practicing care in such collectives is complex as different goods and different ontologies of clients are in tension, especially as autonomy and community participation have gained prominence. Good care amidst these complexities is enacted through persistent collective tinkering: attentively experimenting with care practices in which different goods and ontologies are assembled in collectives of people and things.

The complexity of providing care collectively in light of ethical tensions is still barely studied in social work literature (Hannah and Jindal-Snape 2014). Some studies do describe ethical tensions related to teamwork and collaboration with service users and family members (Wilkins 2012; Saario et al. 2018), inter-professional and multi-organisational collaboration (McDermott 2011; Brewster and Strachan 2014) and between professional and organisational values (McAuliffe 2005). We align with these studies by taking an empirical and situated approach to ethics (Banks and Williams 2005) and promoting ethical pluralism (McDermott 2011). However, our notion of collective tinkering (Mol, Moser, and Pols 2010a), expands these discussions of ethics in social work in several ways.

First, by expanding ethical pluralism beyond values to a plurality of 'goods' including different orderings of reality (ontologies), we were able to conceptualise how tensions are negotiated in situated practices (e.g. clients either as unwilling or unable). Second, by

including materiality in ethical negotiations (e.g. the communal rooms for coffee moments, or the small room of Max) we were able to show how material arrangements and settings provide specific opportunities as to how 'good' care can be negotiated. Third, by focusing on how collectives bring together different goods within care *practices*, we were able to shift attention to the 'doings' of good care. This focus on ontological politics, materiality and practice puts this approach apart from dialogue-based hermeneutic approaches to negotiating ethical tensions, as these accounts highlight merely the discursive practice of dialogue (Clark 2012).

Other ethical concepts such as 'ethics work' do put practice central stage (Saario et al. 2018; Banks 2016); however, the work of collective tinkering is not encompassed in current conceptualizations of ethics work. Collective tinkering adds a type of ethics work focusing on how professionals provide *good care* while assembling different goods in practice in collectives with clients and others that care. Here ontologies and materiality come to matter too. Through developing the notion of collective tinkering, we not only enrich the understanding of ethics work, moreover – in line with the ethics of care agenda – we strengthen *care practices* in social work (Banks 2016; Meagher and Parton 2004). Here lies the added value of our approach to professionals, the notion of collective tinkering enables them to articulate their work in bringing about good care. At the same time, the notion of collective tinkering sensitises them to engage with other (human and non-human) actors and assemble different 'goods' together in practice.

Our notion of collective tinkering differs from 'individual' tinkering between professionals and clients in several ways. First, by including stakeholders involved with the client, collective tinkering adds goods and ontologies important in dealing with the situation which aids the creative process of inventing and experimenting with the care practices that assemble these goods. Different views on ontologies or values within a collective may continue even when a care practice is assembled. This creates tensions that might drive a collective to keep experimenting with other ways of caring, possibly inventing even 'better' care. When tinkering is not a collective process, for instance, when family members are not involved, as is shown in the case of Jesse, these stakeholders might feel that the quality of the provided care is poor, given that their goods are not assembled in the care practice.

Second, collective tinkering needs organisational structures beyond direct professional–client contacts. Structures that provide the time and space for the wider collective involved in care to come together, reflect and shape care practices. Policy contexts, both on the national or organisational level partly bring such structures into being. In the UK context, for instance, safeguarding policies would have provided a structure for interdisciplinary discussion of cases of abuse both by criminals such as in the example of John or from self-neglect in the case of Jesse (McDermott 2011; Stevens et al. 2017). In our Dutch case, however, such structures were lacking. Also, on the organisational level, there are differences between teams that have structures for discussing cases together, such as regular team meetings. However, having structures in place for discussing cases does not suffice, as tinkering requires professionals to feel safe enough to express doubts and dilemmas, actively deliberate on different goods and ontologies, assemble these in care practices and keep on evaluating and changing care practices to come to a better assemblage of values or to tune in to changing clients or contexts.

Thus, even if there are spaces where professionals meet to discuss complex cases, collective tinkering need not occur. Moreover, in many contexts, existing structures for discussing cases are insufficient for collaborative tinkering as stakeholders such as family members, other layers of the care organisation or professionals working in other community organisations are not included. This makes this kind of collective tinkering dependent on the efforts and networks of individual professionals. As Rutz and de Bont (2019) show in the case of youth inspectors, structures that permit collective deliberation to handle complexities improve the quality of compromises. It would thus seem that including the wider collective in tinkering would add to finding more robust goods.

This also includes the position of clients, which we found had no (or a marginal) role in collective tinkering, resulting in care that does not include their ontologies of themselves or the goods they prioritise. While clients and professionals may tinker in their personal care moments, clients are hardly present when teams of professionals, family members or other organisations assemble different goods and ontologies into care practices. This reflection of asymmetric power relationships demands critical examination (Martin, Myers, and Viseu 2015). Partly, the lack of client involvement in collective tinkering might be understandable in the context of community housing services. When situations become especially complex, clients often seem hindered by their competence or symptoms, at least in the eyes of family or professionals, and are thus deemed unable to maintain a coherent view of the potentially harmful consequences of their actions (e.g. John befriending criminally-minded men) (Mol, Moser, and Pols 2010b; Pols, Althoff, and Bransen 2017). Even in cases where clients have been assessed as lacking capacity in decision-making, involving clients with disabilities in tinkering is certainly not impossible, although it requires professionals to emphasise clients' experience-based expertise over their perceived incompetence (Cardol, Rijken, and van Schrojenstein Lantman-de Valk 2012). Moreover, for clients to voice an opinion of 'good care' in a group of professionals and be an equal partner in deliberating the different values might be quite demanding for clients with ID or SMI – and for professionals too (Saario et al. 2018). The challenge is to create space and means for negotiating different goods where such epistemic injustice is alleviated (Tronto 2010; Abma et al. 2020). There have been calls to create deliberative spaces in which all involved in care, including professionals, clients, family members and managers negotiate complexities related to values together (Visse, Abma, and Widdershoven 2015; Janssens et al. 2015). However, for collective tinkering, deliberation is not enough. In order to enable collective tinkering, reflective spaces also need to engage collectives in designing care practices that assemble different goods together (Heerings et al., forthcoming).

Disclosure statement

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Data availability statement

The data that support the findings of this study are available on reasonable request from the corresponding author. The data are not publicly available due to them containing information that could compromise research participant privacy and consent.

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References

Abma, T. A., M. Visse, A. Hanberger, H. Simons, and J. C. Greene. 2020. "Enriching Evaluation Practice Through Care Ethics." *Evaluation* 26 (2): 131–146.

Almqvist, A.-L., and K. Lassinantti. 2018. "Social Work Practices for Young People with Complex Needs: An Integrative Review." *Child and Adolescent Social Work Journal* 35 (3): 207–219.

Anthony, W. A., M. L. Ellison, E. S. Rogers, L. Mizock, and A. Lyass. 2014. "Implementing and Evaluating Goal Setting in a Statewide Psychiatric Rehabilitation Program." *Rehabilitation Counseling Bulletin* 57 (4): 228–237.

Banks, S. 2016. "Everyday Ethics in Professional Life: Social Work as Ethics Work." *Ethics and Social Welfare* 10 (1): 35–52.

Banks, S., and R. Williams. 2005. "Accounting for Ethical Difficulties in Social Welfare Work: Issues, Problems and Dilemmas." *British Journal of Social Work* 35 (7): 1005–1022.

Boeije, H. 2002. "A Purposeful Approach to the Constant Comparative Method in the Analysis of Qualitative Interviews." *Quality and Quantity* 36 (4): 391–409.

Bredewold, F., M. Hermus, and M. Trappenburg. 2020. "'Living in the Community' the Pros and Cons: A Systematic Literature Review of the Impact of Deinstitutionalisation on People with Intellectual and Psychiatric Disabilities." *Journal of Social Work* 20 (1): 83–116.

Brewster, E., and L. Strachan. 2014. "Professional and Interprofessional Ethics: an Intellectual Disabilities Perspective in an Interprofessional health context." In *Exploring the Dynamics of Personal, Professional and Interprofessional Ethics*, edited by Divya Jindal-Snape, and Elizabeth S. F. Hannah. Bristol: Policy Press.

Bröer, C., and M. Heerings. 2013. "Neurobiology in Public and Private Discourse: the Case of Adults with ADHD." *Sociology of Health & Illness* 35 (1): 49–65.

Cardol, M., M. Rijken, and H. van Schrojenstein Lantman-de Valk. 2012. "Attitudes and Dilemmas of Caregivers Supporting People with Intellectual Disabilities who Have Diabetes." *Patient Education and Counseling* 87 (3): 383–388.

Claes, C., G. Van Hove, S. Vandevelde, J. van Loon, and R. L. Schalock. 2010. "Person-Centered Planning: Analysis of Research and Effectiveness." *Intellectual and Developmental Disabilities* 48 (6): 432–453.

Clark, C. 2012. "From Rules to Encounters: Ethical Decision-Making as a Hermeneutic Process." *Journal of Social Work* 12 (2): 115–135.

Davies, K., and M. Gray. 2015. "Mental Health Service Users' Aspirations for Recovery: Examining the Gaps Between What Policy Promises and Practice Delivers." *British Journal of Social Work* 45 (suppl_1): i45–i61.

de Heer-Wunderink, C., E. Visser, A. Caro-Nienhuis, S. Sytema, and D. Wiersma. 2012. "Supported Housing and Supported Independent Living in the Netherlands, with a Comparison with England." *Community Mental Health Journal* 48 (3): 321–327.

de La Bellacasa, M. P. 2011. "Matters of Care in Technoscience: Assembling Neglected Things." *Social Studies of Science* 41 (1): 85–106.

Dean, E. E., K. W. Fisher, K. A. Shogren, and M. L. Wehmeyer. 2016. "Participation and Intellectual Disability: A Review of the Literature." *Intellectual and Developmental Disabilities* 54 (6): 427–439.

Farkas, M., and W. A. Anthony. 2010. "Psychiatric Rehabilitation Interventions: A Review." *International Review of Psychiatry* 22 (2): 114–129.

Farone, D. W. 2006. "Schizophrenia, Community Integration, and Recovery: Implications for Social Work Practice." *Social Work in Mental Health* 4 (4): 21–36.

Ferrier, C. 2018. "Risking Subjectivity in Everyday Social Work Practice." *Ethics and Social Welfare* 12 (2): 181–187.

Furlong, M. A. 2003. "Self-determination and a Critical Perspective in Casework: Promoting a Balance Between Interdependence and Autonomy." *Qualitative Social Work* 2 (2): 177–196.

Gherardi, S., and G. Rodeschini. 2016. "Caring as a Collective Knowledgeable Doing: About Concern and Being Concerned." *Management Learning* 47 (3): 266–284.

Gibson, B. E., G. Terry, J. Setchell, F. A. S. Bright, C. Cummins, and N. M. Kayes. 2020. "The Micro-Politics of Caring: Tinkering with Person-Centered Rehabilitation." *Disability and Rehabilitation* 42 (11): 1529–1538.

Gray, M. 2009. "Moral Sources and Emergent Ethical Theories in Social Work." *The British Journal of Social Work* 40 (6): 1794–1811.

Gridley, K., J. Brooks, and C. Glendinning. 2014. "Good Practice in Social Care for Disabled Adults and Older People with Severe and Complex Needs: Evidence from a Scoping Review." *Health and Social Care in the Community* 22 (3): 234–248.

Hannah, E. F., and D. Jindal-Snape. 2014. "Setting the Scene: Personal, Professional and Interprofessional Ethics." *Exploring the Dynamics of Personal, Professional and Interprofessional Ethics*: 3–18.

Heerings, M., H. van de Bovenkamp, M. Cardol, and R. Bal. 2020. "Ethical Dilemmas of Participation of Service Users with Serious Mental Illness: A Thematic Synthesis." *Issues in Mental Health Nursing* 41 (4): 283–295.

Heerings, M., H. Van de Bovenkamp, M. Cardol, and R. Bal. Forthcoming. Ask Us! A Method for Critical Reflective Co-Design of the Care Relationship in Long Term Care.

Heidenreich, K., A. Bremer, L. J. Materstvedt, U. Tidefelt, and M. Svantesson. 2018. "Relational Autonomy in the Care of the Vulnerable: Health Care Professionals' Reasoning in Moral Case Deliberation (MCD)." *Medicine, Health Care and Philosophy* 21 (4): 467–477.

Janssens, R. M., E. Van Zadelhoff, G. Van Loo, G. A. Widdershoven, and B. A. Molewijk. 2015. "Evaluation and Perceived Results of Moral Case Deliberation: A Mixed Methods Study." *Nursing Ethics* 22 (8): 870–880.

Jingree, T., and W. Finlay. 2012. "'It's got so Politically Correct Now': Parents' Talk About Empowering Individuals with Learning Disabilities." *Sociology of Health & Illness* 34 (3): 412–428.

Juhila, K., J. Ranta, S. Raitakari, and S. Banks. 2021. "Relational Autonomy and Service Choices in Social Worker–Client Conversations in an Outpatient Clinic for People Using Drugs." *The British Journal of Social Work* 51 (1): 170–186. https://doi.org/10.1093/bjsw/bcaa011

Laholt, H., K. McLeod, M. Guillemin, E. Beddari, and G. Lorem. 2019. "Ethical Challenges Experienced by Public Health Nurses Related to Adolescents' use of Visual Technologies." *Nursing Ethics* 26 (6): 1822–1833.

Landeweer, E. 2018. "Sharing Care Responsibilities Between Professionals and Personal Networks in Mental Healthcare: A Plea for Inclusion." *Ethics and Social Welfare* 12 (2): 147–159.

Lindvig, G. R., I. B. Larsen, A. Topor, and T. D. Bøe. 2019. "'It's not Just a lot of Words'. A Qualitative Exploration of Residents' Descriptions of Helpful Relationships in Supportive Housing." *European Journal of Social Work*, 1–13. https://www.tandfonline.com/doi/full/10.1080/13691457.2019.1682523

Martin, A., N. Myers, and A. Viseu. 2015. "The Politics of Care in Technoscience." *Social Studies of Science* 45 (5): 625–641.

Matscheck, D., A. Ljungberg, and A. Topor. 2020. "Beyond Formalized Plans: User Involvement in Support in Daily Living–Users' and Support Workers' Experiences." *International Journal of Social Psychiatry* 66 (2): 156–162.

McAuliffe, D. 2005. "I'm Still Standing: Impacts and Consequences of Ethical Dilemmas for Social Workers in Direct Practice." *Journal of Social Work Values and Ethics* 2 (1): 1–10.

McDermott, S. 2011. "Ethical Decision Making in Situations of Self-Neglect and Squalor among Older People." *Ethics and Social Welfare* 5 (1): 52–71.

McPherson, P., J. Krotofil, and H. Killaspy. 2018. "Mental Health Supported Accommodation Services: A Systematic Review of Mental Health and Psychosocial Outcomes." *BMC Psychiatry* 18 (1): 128.

Meagher, G., and N. Parton. 2004. "Modernising Social Work and the Ethics of Care." *Social Work and Society [Internet]* 2: 1.

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

Mol, A. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. Oxfordshire: Routledge.

Mol, A., I. Moser, and J. Pols. 2010a. *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Bielefeld: Transcript Verlag.

Mol, A., 2010b. "Care and its Values: Good Food in the Nursing Home." In *Care in Practice*. Bielefeld: Transcript Verlag 2010.

Moreira, T. 2010. "Now or Later? Individual Disease and Care Collectives in the Memory Clinic." In *Care in Practice*. Bielefeld: Transcript Verlag 2010.

Munson, A. B. 2020. "Framing Life as Work: Navigating Dependence and Autonomy in Independent Living." *Qualitative Sociology* 43: 89–102.

O'Leary, P., and M-s. Tsui. 2019. "Editorial." *International Social Work* 62 (4): 1181–1182.

Piat, M., K. Seida, J. Sabetti, and D. Padgett. 2017. "(Em)Placing Recovery: Sites of Health and Wellness for Individuals with Serious Mental Illness in Supported Housing." *Health & Place* 47: 71–79.

Pols, J. 2006. "Washing the Citizen: Washing, Cleanliness and Citizenship in Mental Health Care." *Culture, Medicine and Psychiatry* 30 (1): 77–104.

Pols, J., B. Althoff, and E. Bransen. 2017. "The Limits of Autonomy: Ideals in Care for People with Learning Disabilities." *Medical Anthropology* 36 (8): 772–785.

Rapp, C. A., and W. P. Sullivan. 2014. "The Strengths Model: Birth to Toddlerhood." *Advances in Social Work* 15 (1): 129–142.

Rutz, S., and A. de Bont. 2019. *Collective Discretionary Room: How Inspectors Decide with Providers and Citizens. Inspectors and Enforcement at the Front Line of Government*. Cham: Springer International Publishing: Palgrave Macmillan. 187–204.

Saario, S., J.-M. Räsänen, S. Raitakari, S. Banks, and K. Juhila. 2018. "Doing 'Ethics Work' Together: Negotiating Service Users' Independence in Community Mental Health Meetings." *Ethics and Social Welfare* 12 (4): 370–386.

Salzmann-Erikson, M. 2013. "An Integrative Review of What Contributes to Personal Recovery in Psychiatric Disabilities." *Issues in Mental Health Nursing* 34 (3): 185–191.

Scheffelaar, A., N. Bos, M. Hendriks, S. van Dulmen, and K. Luijkx. 2018. "Determinants of the Quality of Care Relationships in Long-Term Care - a Systematic Review." *BMC Health Services Research* 18 (1): 903.

Stevens, M., C. Norrie, J. Manthorpe, S. Hussein, J. Moriarty, and K. Graham. 2017. "Models of Adult Safeguarding in England: Findings from a Study of Costs and Referral Outcomes." *The British Journal of Social Work* 47 (4): 1224–1244.

Topor, A., and A. Ljungberg. 2016. ""Everything is so Relaxed and Personal" – The Construction of Helpful Relationships in Individual Placement and Support." *American Journal of Psychiatric Rehabilitation* 19 (4): 275–293.

Tronto, J. C. 2010. "Creating Caring Institutions: Politics, Plurality, and Purpose." *Ethics and Social Welfare* 4 (2): 158–171.

Uhrenfeldt, L., and M. T. Høybye. 2015. "Care Interaction Adding Challenges to old Patients' Well-Being During Surgical Hospital Treatment." *International Journal of Qualitative Studies on Health and Well-Being* 10 (1): 28830.

Ursin, G., and A. T. Lotherington. 2018. "Citizenship as Distributed Achievements: Shaping New Conditions for an Everyday Life with Dementia." *Scandinavian Journal of Disability Research* 20 (1). https://www.sjdr.se/articles/10.16993/sjdr.35/

Visse, M., T. Abma, and G. Widdershoven. 2015. "Practising Political Care Ethics: Can Responsive Evaluation Foster Democratic Care?" *Ethics and Social Welfare* 9 (2): 164–182.

Weinberg, M., and S. Banks. 2019. "Practising Ethically in Unethical Times: Everyday Resistance in Social Work." *Ethics and Social Welfare* 13 (4): 361–376.

Wilkins, D. 2012. "Ethical Dilemmas in Social Work Practice with Disabled People: Young Adults with Autism." *Ethics and Social Welfare* 6 (1): 97–105.

Wilks, T. 2004. "The Use of Vignettes in Qualitative Research Into Social Work Values." *Qualitative Social Work* 3 (1): 78–87.

Willems, D. and J. Pols. 2010. "Goodness! The Empirical Turn in Health Care Ethics." Medische Antropologie 22 (1):161-170.