

Mutual powerlessness in client participation practices in mental health care

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Abstract

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

Objective The objective of this study is to gain insight into (i) the practice of client participation within a quality improvement collaborative in mental health care and (ii) the consequences of a Foucauldian conceptualization of power in analysing practices of client participation.

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

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

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

Introduction

Client participation has become a dominant policy goal in many countries including the Netherlands¹ and is a topic much discussed in the literature.^{2–10} The success of client participation is often measured in terms of the extent to which clients actually have a say in the participation process. Arnstein's¹¹ participation ladder, for example, describes a continuum of participation ranging from being informed to complete control. Also, discourse analyses often focus on the extent of power clients have within the participation process. A common finding is that service providers still control how client participation is performed and what topics clients can articulate, which limits the extent of client participation.^{4,12–18} As a consequence, clients are still often excluded from the participation process and their voices marginalized.^{12,19}

Although studies that point to the limited extent of client participation are valuable in creating some healthy scepticism towards those who claim to have achieved it, there are at least two sets of critiques concerning these studies. The first is about conceptualizing participation as a continuum. One of the critiques is that participation can take many different forms that can and should not be compared to each other solely in terms of clients' influence.^{9,20,21} Therefore, it would seem crucial to investigate the participation process itself. What does it mean in what setting?

The second set of criticisms involves the concept of power. In many studies on client participation, power is thought of as negative and repressive, at least when exerted by professionals. Such a conceptualization is debatable. Foucault in particular argued that power is produced in a relationship in which people always have the freedom to behave differently.^{22,23} From a Foucauldian point of view, power is not a characteristic or a resource of a person but is produced in a relationship to which the material, social and normative elements of the situation contribute. Furthermore, from this point of view, power can be positive and negative; it restrains certain repertoires of behaviour while enabling others.^{24–26}

Moreover, researchers focusing on power in client participation often seem to start from the assumption that clients do not have any, thus focusing on discourses that impede the client's voice. By doing so, situations in which clients' voices are marginalized can become exaggerated, whereas examples of their inclusion are dismissed. Such studies run the risk of overvaluing other actors' power discourses as opposed to those of the clients and therefore tend to assume (and conclude) that clients are excluded because of one coherent discourse.²⁷

In the light of these two sets of criticisms, this article addresses two interrelated questions. First, how is client participation performed? To do so, we will be (a priori) neutral to (i) the desirability of client participation and (ii) any assumption on how it should be performed.²⁸ Rather, we will follow the actors²⁹ to investigate how they perform participation. Second, we focus on what role(s) power plays within the participation process. We do so by conceptualizing power in a Foucauldian way, by treating it as a repressive and productive mechanism. Furthermore, we do not start from the assumption that clients have no power and that they are rendered disabled because of a coherent discourse.^{27,30} Rather, we focus on both exclusion and inclusion mechanisms.

We study the practice of client participation within a quality improvement collaborative (QIC) carried out in mental health care. Originally coming from industrial settings, the QIC method is increasingly adopted within health care settings mainly in Western countries.^{31,32} In United Kingdom, United States, Australia and also in the Netherlands, many QICs have now been carried out.^{31,33,34,36} Within QICs improvement, teams from different health care organizations aim to improve care on a certain topic. Next to the improvement goals themselves, an objective of many QICs is that clients should be involved in the improvement process.^{9,35,36} Therefore, QICs are relevant to the study on client participation.

The aim of this article is twofold. First, we study the consequences of a Foucauldian conceptualization of power in analysing practices of

client participation. Second, we assign the concept empirical specificity by studying how power is *produced*. Focusing on client participation – a setting in which researchers often explicitly refer to power mechanisms – makes the study on power production especially interesting.

Methods

Care for better

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

The first four, which ran for two rounds each, started in 2007. ‘Not (only) the mind but (also) the body’ aimed at improving the physical health of clients living in mental health care institutions. In this project for example blood pressure and weight were monitored and healthy diets encouraged. ‘Social participation’ aimed at making clients feel less lonely by enlarging and enriching their social networks. ‘Recovery-oriented care’ was devised to give clients more control over their lives. The project relied to a large extent upon the principles of the recovery movement, which was initially a user-led movement but is now also increasingly adopted by mental health-care professionals. The movement strives towards empowerment and participation of clients in the community.^{37,38} Finally, ‘Social psychiatric care’ was to improve outreach care. Outreach care teams aim to establish contact with those who avoid care but are thought to need it (by the professionals).

The next three projects were executed in 2008 and 2009. In a 2008 project called ‘Medication safety’, half the participating teams were from mental health care. Two additional projects set-

up in 2009 were a combination of subjects of the improvement projects mentioned above: ‘Recovery-oriented care and social participation’ and ‘Health and medication safety’.

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

All projects were similarly structured and relied to a large extent on the Breakthrough method.³⁹ The Breakthrough method, developed by the IHI in the USA, is one of the most popular QIC methods, spread mainly to Western Europe and Australia.^{31,32} It prescribes a structured, collaborative improvement method, including Plan-Do-Study-Act cycles and measuring the extent to which the goals are attained. The method’s collaboration of different improvement teams from different organizations is aimed at facilitating better quality improvement (processes) by sharing experiences.

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

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

Data collection

Our study was part of a larger evaluation study on CfB; in that context, we had access to conferences and other activities.³⁶ We relied upon two forms of data collection: observations and interviews (Table 1).

First, we conducted participant observations at 26 of the 44 conferences. We also observed five project leader meetings. The aim of these observations was to investigate how the programme management team instructed teams to shape client participation and to observe discussions surrounding the topic. We did not intend to give programme management or improvement teams suggestions on how they were doing, although they sometimes asked for our opinion. We also observed team discussions (sometimes with client participants) during the conferences and conducted many 'mini' interviews concerning client participation with team members (be they clients or not) at these conferences and meetings. These 'mini' interviews were non-planned and more or less informal conversations with team members, for example during breaks. Notes of these conversations have been made, either during the conversation or right after.

Second, we visited 13 improvement teams in their organizations to explore their improvement practices in depth. In 12 of those instances, we interviewed the project leader. Sometimes, additional interviews with team members were

Table 1 Types of data collection and research questions

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

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

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

Data analysis

Most of the interviews were recorded and transcribed verbatim. For some, it was not possible as they took place informally (for example, interviews conducted during walks through the health care organizations or the 'mini-interviews' at the national conferences). In such cases, we took detailed notes. We also took detailed notes during the observations of conferences and meetings, which were transcribed as soon as possible. We used Atlas.ti for the data analysis, which consisted of two parts. The first concerned a bottom-up analysis to explore how client participation was discussed and performed. During this analysis, we identified two forms of client participation: within the improvement teams and within specific improvement actions. Furthermore, many of the 'codes' identified could be analysed as either a specific power conceptualization or as an effect of power mechanisms, for example 'using words that clients were unfamiliar with' – pointing at the exclusion of clients through language use. So, it became clear that the concept of power and how it was conceptualized by different actors involved greatly influenced the procedure of client participation. The second

part therefore involved a theoretically driven analysis of power, in which we used a Foucauldian conceptualization of power. We conducted a discourse analysis, believed to be a valuable approach for studying the concept of power in client participation.¹² There are several ways in which discourse analyses can be conducted. The close examination of language patterns is one way adopted by some scholars studying client participation. As a consequence, the language patterns are sometimes put to the foreground and other elements that also play a role in client participation practices are then pushed back into the background.¹² Another way is studying how certain practices, made up by discursive, material and social elements, constitute client participation and thus how client participants are constructed.^{40,41} The latter approach, for example as outlined in critical discourse analysis, is what we apply in this article. We analyse how power relations are (re)produced within client participation practices and the consequences it has for the type (rather than extent) of participation.

Terminology

We are aware that any term used to refer to 'clients' has a performative effect: it may reproduce differences or express a certain view of what characteristics clients should have.^{42,43} The term 'service user' is, for example, a reflection of a consumerist tradition and therefore carries a positive view on client participation.⁴² We use the term 'client' because it was the one most used by the people involved (clients, professionals, programme managers). When appropriate, we use the terminology itself for the analysis of client participation practices.

Results

Client participation in improvement teams

Client participation at the conferences

The extent to which client participation was highlighted by the programme management team varied by project. The programme leader

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

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

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

Yet, at the conferences, team members were continually asking each other whether clients actually approved the improvement actions. For example, one team wanted clients to manage their own money, and another immediately

asked: 'Is that a wish of clients themselves?' This was one of the main comments from other improvement teams when a team presented its project and it shows how client involvement – or at least client approval – in developing improvement actions was set as the ideal. It sometimes also seemed to illustrate a fear of exerting power. Although professionals did not often use the term 'power', some of them seemed to be fully aware of professional power because of its presence in professional language, standards and attitude and therefore tried to *avoid* all ways of exerting power.

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

The fear of exerting power was also present in some of the improvement teams, mostly in 'Recovery-oriented care'. At almost every meeting of this project, professionals were cautious not to do anything that might be perceived as 'coercive' or 'imposing'. They even accused each other of exerting power on clients. For example, in a project leaders' meeting, a leader said that in her organization an 'expert and knowledge group' was established to ensure recovery-oriented care throughout the organization and 'define the boundaries of this process for all

departments of the organization'. Other project leaders immediately reacted, because recovery does not fit with words like 'boundaries', as such words seem to start from a professional or organizational perspective and thereby imply that recovery is not owned by clients themselves. Almost scrupulously, professionals investigated their own and other's words and behaviour to reveal possible power exertion. Power then was seen as being negative, restrictive and something that should be avoided in all cases.

The examples also show that, on the one hand, professionals struggle with 'new' concepts like recovery and client participation and therefore engage in 'self-disciplining' behaviour and, on the other hand, work in a professional and organizational context that also brings with it a particular normative framework and professional values – for example, recovery vs. the need to establish a uniform organizational policy. The examples thus show the existence of powerful and sometimes competing normative frameworks of professional work. Furthermore, because client participation has become a dominant policy goal, professionals reflect upon their behaviour in a different manner, showing the 'panoptic' function of stressing these concepts. In the panopticon, subjects are both observed and aware of being observed, which makes them change their behaviour and internalize certain norms^{44,45}, like the norm of client participation.

Inclusion and exclusion

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

This team participated in 'Recovery-oriented care and social participation'. It consisted of a quality employee, two managers, two care professionals and one client. During the meeting of the team, there were some moments indicating

the exclusion of the client. For example, the client raised the issue of whether the team would continue after the official project ended: 'This will stop, won't it, or have you no ideas about that?' The use of the 'you' indicated that she did not perceive herself to be in the position of having the right or the role to contribute to discussions concerning the future of the team.

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

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

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

Furthermore, the decision eventually made was the one that professionals planned to make before they solicited the client's opinion.

In another moment of the meeting, the question of who was to attend an upcoming national meeting of the project was raised. The client was not asked whether she would like to attend (although one of the care professionals was not asked either). Later in the meeting, however, the client spoke about the delicious lunches served at the meetings, after which she was asked to join the improvement team in attending. Either deliberately or unconsciously, the client was thus exerting power to join the conference. 'Yes, I'd like you to join us', the quality employee said to the client, 'also for reasons of equality'. Yet, this equality was not about the client-professional balance but, as it became clear, the balance of gender. The client's attendance made the composition of the group two women and two men rather than one woman and two men. The gender equality sought by the quality employee had the effect of undoing the inequality that is usually implied in the client-professional relationship. By explicitly referring to the client in terms of her gender, other differences are temporarily undone.³⁰ Moreover, it emphasizes the similarities between them.

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

Mutual powerlessness

Although there seemed to be not one coherent power discourse at work in the team meeting and the client claimed to feel equal to other members, the entire improvement team struggled with the specific role of the client. The client said that the idea was for her to think along with the improvement team and listen critically to the discussions. Furthermore, the idea was for the client to benefit from having a position in the team. And indeed it did her a tremendous service. She was asked to tell her story at one of the conferences, which, along with the positive

reactions from the audience (often from professionals), increased her self-confidence. She became more convinced that at some point she would be able to write a book, fulfilling a long-term wish.

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

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

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

What speaks out of these fragments therefore is not (only) professional and managerial power and client powerlessness or exclusion. Rather, various people seemed to be engaged in a situation that renders them *all* powerless in terms of client contribution. The client was unfamiliar

with the terms used in the meetings and furthermore struggled to find a way to add value, all the while trying to represent other clients. The manager, caregiver and quality employee admitted that the role of the client was not at all clear and that they were unsure how to make it clear without, as the manager added, emphasizing her background.

The function of clients was a struggle in other teams, too; there were many expressions of this mutual powerlessness. While some teams remarked that they began to 'look with different eyes' because of the clients, these teams were the exception to the rule. A former client in the expert team of 'Recovery-oriented care' organized a meeting for all client team members in the project, and the main complaint concerned role ambiguity. In reaction, a project leader expressed her powerlessness by saying that she, too, felt 'thrown to the lions'. In different teams from different projects, clients questioned the value of their role and were often quiet during discussions, perhaps because these were often framed in medical and professional terms and hard to follow for 'outsiders'. As these examples illustrate, encouraging the practice of client participation without devising a good structure for their involvement can lead to 'mismatch' practices that are not deliberately created, but that lead to costs on both client and professional sides.^{2,9}

Client participation in the improvement actions

All the above is not to say that clients were not involved in developing and executing improvement actions. Their opinions and perspectives were often collected in ways other than participating in improvement teams. For example, in 'Social participation', almost all improvement teams first asked about clients' social needs before starting to think of improvement strategies. Most of the teams did so using the network circle, a specific measurement instrument suggested by the programme management team that allowed improvement teams to have a conversation with clients concerning their social networks.⁴⁷

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

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

Members of the 'Recovery-oriented care' project explicitly said that the strategy of clients approaching other clients was chosen partly to escape exerting power. Professionals wanted their clients to recover but did not want to take the lead.⁴⁶ As the recovery movement itself is initiated by (former) clients, the role of professionals in such a recovery framework is often unclear and debatable. 'It isn't legitimate for professionals to tell clients the story of recovery', one team member said. A project leader said, 'In principle, recovery is owned by patients, we have to keep our hands off it'. If professionals tell the

story, clients often think it is a new kind of therapy and again something they *have* to do, as was expressed. In many teams, (former) clients indeed told fellow clients and professionals about their recovery process and about their ideas on how to stimulate clients' recovery processes. Thereby, it was also a way to avoid exercising power: Professionals did not have to lecture on recovery and on how clients might 'recover'.

Discussion

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

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

up to teams themselves to design the practice of client participation.

Despite these limitations, we believe that our study may form an alternative approach to studying client participation. Some studies on client participation reflect an attitude that is cynical at the same time as it is idealistic. On the one hand, they reveal all powers at work and point to a lack of 'genuine forms of user involvement'¹⁷ and of 'genuinely open dialogue[s]'¹²; on the other hand, the researchers thus believe that communication without (negative) power can or should be possible.²⁸ Yet, like the fact that non-behaviour does not exist, non-power is also impossible. Every action can be perceived in terms of power. Even the escape from exercising power that improvement teams sought in the solution of clients approaching other clients can be framed in terms of power because the professionals then determined that they should not be the ones guiding the conversation.

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

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Conflict of interest

The authors declare that they have no conflict of interests.

References

- 1 Van de Bovenkamp H. *The Limits of Patient Power: Examining Active Citizenship in Dutch Health Care*. Rotterdam: Erasmus University Rotterdam, 2010.
- 2 Anthony P, Crawford P. Service user involvement in care planning: the mental health nurse's perspective. *Journal of Psychiatric and Mental Health Nursing*, 2001; **7**: 425–434.
- 3 Pilgrim D, Waldron L. User involvement in mental health service development: how far can it go? *Journal of Mental Health*, 1998; **7**: 95–104.
- 4 Rutter D, Manley C, Weaver T, Crawford MJ, Fulop N. Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London. *Social Science & Medicine*, 2004; **58**: 1973–1984.
- 5 Stickley T. Should service user involvement be consigned to history? A critical realist perspective. *Journal of Psychiatric and Mental Health Nursing*, 2006; **13**: 570–577.
- 6 Rush B. Mental health service user involvement in England: lessons from history. *Journal of Psychiatric and Mental Health Nursing*, 2004; **11**: 313–318.
- 7 Crawford MJ, Rutter D, Manley C *et al.* Systematic review of involving patients in the planning and development of health care. *British Medical Journal*, 2002; **325**: 1263–1267.
- 8 Robert G, Hardacre J, Locock L, Bate P, Glasby J. Redesigning mental health services: lessons on user involvement from the Mental Health Collaborative. *Health Expectations*, 2003; **6**: 60–71.
- 9 Zuiderent-Jerak T, Strating M, Nieboer A, Bal R. Sociological refigurations of patient safety; ontologies of improvement and 'acting with' quality collaboratives in healthcare. *Social Science & Medicine*, 2009; **69**: 1713–1721.
- 10 Van de Bovenkamp H, Trappenburg MJ, Grit KJ. Patient participation in collective healthcare decision making: the Dutch model. *Health Expectations*, 2009; **13**: 6513–6526.
- 11 Arnstein SR. A ladder of citizen participation. *Journal of the American Planning Association*, 1969; **35**: 216–224.
- 12 Hodge S. Participation, discourse and power: a case study in service user involvement. *Critical Social Policy*, 2005; **25**: 164–179.
- 13 Fudge N, Wolfe CDA, McKeivitt C. Assessing the promise of user involvement in health service development: ethnographic study. *British Medical Journal*, 2008; **336**: 313–317.
- 14 Milewa T, Dowswell G, Harrison S. Partnerships, power and the "new" politics of community participation in British health care. *Social Policy & Administration*, 2003; **36**: 796–809.
- 15 Harrison S, Mort M. Which champions, which people? Public and user involvement in health care as a technology of legitimation. *Social Policy & Administration*, 2003; **32**: 60–70.
- 16 Carr S. Participation, power, conflict and change: theorizing dynamics of service user participation in the social care system of England and Wales. *Critical Social Policy*, 2007; **27**: 266–276.
- 17 Borg M, Karlsson B, Kim HS. User involvement in community mental health services – principles and practices. *Journal of Psychiatric and Mental Health Nursing*, 2009; **16**: 285–292.
- 18 Roberts M. Service user involvement and the restrictive sense of psychiatric categories: the challenge facing mental health nurses. *Journal of Psychiatric and Mental Health Nursing*, 2010; **17**: 289–294.
- 19 Martin GP. "Ordinary people only": knowledge, representativeness and the publics of public participation in healthcare. *Sociology of Health and Illness*, 2008; **30**: 35–54.
- 20 Titter JQ, McCallum A. The snakes and ladders of user involvement: moving beyond Arnstein. *Health Policy*, 2006; **76**: 156–168.
- 21 Schipaanboord A, Delnoij D, Bal R. Patient empowerment in the Netherlands. In: de Leeuw E, Lofgren H (eds) *Democratising Health. Consumer Groups in the Policy Process*. London: Edward Elgar, 2011: 111–126.
- 22 Gordon C. Governmental rationality: an introduction. In: Burchell G, Gordon C, Miller P (eds) *The Foucault Effect: Studies in Governmentality*. Chicago: Chicago University Press, 1991: 1–53.
- 23 Foucault M. The ethic of care for the self as a practice of freedom. An interview with Michel Foucault on January 20, 1984. In: Bernauer J, Rasmussen D (eds) *The Final Foucault*. Cambridge, MA: The MIT Press, 1988: 1–20.

- 24 Foucault M. Afterword: the subject and power. In: Dreyfus H, Rabinow P (eds) *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago, IL: University of Chicago Press, 1983: 208–226.
- 25 Foucault M. *An Introduction, the History of Sexuality I*. New York: Vintage Books, 1978.
- 26 Hui A, Stickley T. Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of Advanced Nursing*, 2007; **59**: 416–426.
- 27 Moser I. On becoming disabled and articulating alternatives. *Cultural Studies*, 2005; **19**: 667–700.
- 28 Contandriopoulos D. A sociological perspective on public participation in health care. *Social Science & Medicine*, 2004; **58**: 321–330.
- 29 Latour B. *Science in Action: How to Follow Scientists and Engineers Through Society*. Cambridge, MA: Harvard University Press, 1987.
- 30 Moser I. Sociotechnical practices and difference: on the interferences between disability, gender, and class. *Science, Technology & Human Values*, 2006; **31**: 537–564.
- 31 Kilo CM. A framework for collaborative improvement: lessons from the Institute for Healthcare Improvement's Breakthrough Series. *Quality Management in Healthcare*, 1998; **6**: 1–13.
- 32 Wilson T, Berwick DM, Cleary MPPPD. What do collaborative improvement projects do? Experience from seven countries. *Joint Commission Journal on Quality and Safety*, 2003; **29**: 85–93.
- 33 Schouten LMT, Hulscher MEJL, Everdingen JJE, Huijsman R, Grol RPTM. Evidence for the impact of quality improvement collaboratives: systematic review. *British Medical Journal*, 2008; **336**: 1491–1494.
- 34 Dückers MLA, Spreeuwenberg P, Wagner C, Groenewegen PP. Exploring the black box of quality improvement collaboratives: modelling relations between conditions, applied changes and outcomes. *Implementation Science*, 2009; **4**: 74.
- 35 Bate P, Robert G. Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *British Medical Journal*, 2006; **15**: 307–310.
- 36 Strating MMH, Zuiderent-Jerak T, Nieboer AP, Bal RA. *Evaluating the Care for Better Collaborative: Results of the First Year of Evaluation*. Rotterdam: Department of Health Policy and Management, 2008.
- 37 Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 1993; **16**: 11–23.
- 38 Deegan PE. Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 1988; **11**: 11–19.
- 39 Institute for Healthcare Improvement. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement*. Cambridge: Institute for Healthcare Improvement, 2003.
- 40 Arribas-Ayllon M, Walkerdine V. Foucauldian discourse analysis. In: Willig C, Stainton Rogers W (eds) *The SAGE Handbook of Qualitative Research in Psychology*. Los Angeles, CA: SAGE, 2008: 91–108.
- 41 Blommaert J, Bulcaen C. Critical discourse analysis. *Annual Review of Anthropology*, 2000; **29**: 447–466.
- 42 McLaughlin H. What's in a Name: 'Client', 'Patient', 'Customer', 'Consumer', 'Expert by Experience', 'Service User' — What's Next? *British Journal of Social Work*, 2009; **39**: 1101–1117.
- 43 Moser I. Against normalisation: subverting norms of ability and disability. *Science as Culture*, 2000; **9**: 201–240.
- 44 Foucault M. *Discipline and Punish: The Birth of the Prison*. London: Penguin Books, 1977.
- 45 Simon B. The return of panopticism: supervision, subjection and the new surveillance. *Surveillance & Society*, 2005; **3**: 1–20.
- 46 Broer T, Nieboer AP, Bal R. Quest for client autonomy in improving (long term) mental health care. *International Journal of Mental Health Nursing*, 2010; **19**: 385–393.
- 47 Broer T, Nieboer AP, Strating MMH, Michon HWC, Bal R. Constructing the social: an evaluation study of the outcomes and processes of a 'social participation' improvement project. *Journal of Psychiatric and Mental Health Nursing*, 2011; **18**: 323–332.