



Shaping Conditions for Recovery: A narrative on a Homeless Man with Severe Mental Illness in a Modern Welfare State

Coline van Everdingen · Peter Bob Peerenboom · Harry Gras · Philippe Delespaul

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Abstract Despite extensive research, interdependent problems such as severe mental illness and homelessness cause extreme disparities and health inequity. Handling complexity in careseeker–caregiver networks remains challenging. The local public health services in a Dutch city were enriched with a specialized team. An ethnographic policy evaluation was conducted to identify the essentials of an effective approach. We use the narrative of a homeless man who experiences psychoses for an in-depth analysis of the team’s functionality. The narrative data shows the challenges of caregiver networks and underlines the

need to integrate care. It demonstrates how normal behavior, personal skills, and a socio-ecological system strategy merge into collaborative networks with the ability to diversify care and keep focus on recovery. This paper demonstrates the failure of the linear handicap model and the costs of overspecialized care systems. Building on socio-ecological recovery literature, it provides insight how care networks successfully can foster recovery.

Keywords Severe mental illness · Homelessness · Health equity · Socio-ecological recovery approach · Integrating care · Recovery

C. van Everdingen (✉) · P. Delespaul
Department of Psychiatry and Neuropsychology,
Maastricht University, Postbox 616 (VIJV 1),
6200 MD Maastricht, The Netherlands
e-mail: coline.vaneverdingen@maastrichtuniversity.nl;
cve@vezc.nl

C. van Everdingen
Van Everdingen Health Care Consultancy, Sittard,
The Netherlands

P. B. Peerenboom
Tangram Health Care Consultancy, Doetinchem,
The Netherlands

H. Gras
Harry Gras Health Care Consultancy, Montfoort,
The Netherlands

P. Delespaul
Department of Adult Psychiatry, Mondriaan Mental Health
Trust, Heerlen, The Netherlands

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Introduction

Shaping conditions for recovery at the intersection of severe mental illness (SMI) and homelessness remains challenging (Rosen et al., 2020; Rhenner et al., 2018; MacNaughton et al., 2013). Local care networks advocate equal health chances for all, but well-defined recovery visions and proven effective models don’t offer a blueprint for successful dissemination. How can they better serve marginalized

populations with interdependent needs? What works to shape recovery enabling conditions effectively?

Essential conditions for recovery provide a natural, safe environment for growth (Deegan, 1988). Research widely endorses the need to operationalize recovery as an active, personal, non-linear journey (Leamy et al., 2011). The CHIME framework centers recovery processes around connectedness, hope and optimism, identity, meaning, and empowerment. It serves as a basement for building recovery practices around the world (Van Weeghel et al., 2019; De Wet & Pretorius, 2021). The key role of people with lived experience is undisputed. Dialogues on values related to social justice themes inspire change (Campbell, 2020; Luchenski et al., 2017). Scholars also recommended socio-ecological strategies and complex systems thinking to better face interdependent problems and promote recovery (Strauss, 2017; Rosen et al., 2020; Olvera Alvarez et al., 2018).

Ethnographic research revealed similar patterns in many countries, why interactions between users and services can go wrong. For instance, Moore-Nadler and colleagues (2020) explored the healthcare experiences of homeless people in the USA. Starting from the social determinants of health, and compromised systems, the narratives uncovered how professionalism, dehumanization, and engagement in care-seeker–caregiver relations cause instability and funnel into downward trajectories. This explains why, in the eyes of homeless careseekers, it is sound to withdraw from services. Complexity emerges from how we think about health, well-being, and care. Traditional care visions, dominated by individualism and reductionism, easily disregard the context and the nuances in individual stakeholder perspectives. Service specialization in siloed care systems underserves the neediest (Rosen et al., 2013; Van Everdingen et al., 2023). The powerful role of professionals, the focus on restoring control, and the assumption of the malleability of growth are detrimental to the human need for autonomy and relational engagement in caregiver networks (Johnstone & Boyle, 2018; Hui et al., 2021). Power imbalances and supposed public safety risks easily cascade into repression and control. Coercive treatment may further complicate the shaping of conditions for recovery.

In contrast, the recovery movement offers practice knowledge that potentially transforms downward

spirals into upward processes. Rooted in the antipsychiatry and the consumer/survivor movement, it builds on the longitudinal empirical recovery research (Voronka et al., 2014; Sweeney, 2016). The Vermont study is still a cornerstone (Harding et al. 1987a, 1987b; DeSisto et al., 1995). This three-decade study followed a hundred revolving door persons with schizophrenia after discharge into the community. Instigated by the dispute between community recovery leaders and the clinical establishment, it demonstrated that over time most of the ‘totally disabled, deadlocked cases’ recovered and participated actively in society. At present, separate recovery ingredients are still insufficient to counter inequalities and unfairness (Dzau et al., 2022). Recently, Ragins and Sunkel (2023) described why and how innovative caregiver networks build integrated recovery mental health programs. In addition to people with lived experience and formal caregivers, citizens and communities need to be engaged too. Three paradigm shifts are required: transforming illness-centered to person-centered care, shifting from professional-driven to consumer-driven care and from deficit-based practices to strength-based recovery.

This paper highlights an experiment in the local public health context of a Dutch city, aimed to improve local practices at the intersection of severe mental illness and homelessness. A debate about care quality and health equity incited to expand local public services with a special team, to better serve the interdependent needs of people with mental illness at the margins of society. The purpose was to facilitate mutual learning about what works to enable recovery. An ethnographic policy evaluation aimed to identify the essentials of an effective approach. Building on the socio-ecological recovery literature, this paper provides an in-depth analysis of the results. It uses a recovery narrative of a homeless man, who experiences psychoses, to answer two research questions:

1. Which elements facilitate engaging in care-seeker–caregiver relationships that open perspectives on recovery?
2. How does the approach of the special team impact on the abilities of careseeker–caregiver networks to adapt and to self-manage?

Methods

National Context

The Dutch healthcare and welfare system is extensive (Van Everdingen et al., 2021a). The social insurance system is designed to safeguard universal health coverage for all inhabitants. In practice, highly specialized services with dozens in- and exclusion criteria complicate care access. Services are fragmented, as illustrated by the differentiation between forensic, specialist, and long-term mental care. Ambulatory outreach for people with SMI is provided by F-ACT teams (staff-patient ratio 1:10). This is the de-facto mental health standard (Van Veldhuizen, 2007). Work support, welfare benefits, and homeless services are part of the welfare sector, structured by a different paradigm. Municipalities are responsible for service access, and for the connections between social and health services provided by local service networks.

Dutch peer support workers are instrumental in the recovery movement and are increasingly recruited throughout the fine-mazed network of institutional services. Peer support workers are found in all kinds of teams. Some are volunteers, others have marginally paid jobs. They develop services scattered over the country: drop-in centers, recovery colleges, Wellness Recovery Action Plans, Peer Supported Open Dialogues, and Resource Groups. The use of digital empowering instruments, such as the Experience Sampling Method, increases (Delespaul, 1995; Verhagen, 2020). Much remains low key. The public is unaware of the groundbreaking work of, for instance, the Dutch Voice Hearing movement (Corstens et al., 2014).

In daily care practices, cure and care services are provided in separate siloes (Dutch Safety Board, 2019; Muusse et al., 2021). Meanwhile, national austerity measures and municipal policy choices undermine the availability and quality of local assertive community treatment services (Sytema et al., 2007). The welfare budgets are also cut. Account-control measures induce bureaucracy. Attempts to reduce double payment undermine service quality and collaboration between services. As a result, integrating care for matching diverse needs of people with, for instance homelessness, depts, and psychosis or addiction, is difficult (Van Everdingen et al., 2021b, 2023). For long, mistrust is deeply rooted in the public and

political logic of society (Aupers, 2012). Despite certification, citizens and workers are unfamiliar with human rights (CESCR, 2017). Besides, the public poorly understands ‘confused people on the streets’ (Albers et al., 2018). Instigated by the public debate, a national policy for restoring mental health related safety in society became active in 2015. The debate on a national mental health recovery plan started in 2022.

A local Experiment

These policy choices and societal aspects significantly impact people with interdependent problems, such as homeless people with SMI (Van Everdingen et al., 2021b). To solve the care gap, a city called ‘City’ decided to enrich the local public health context with a new team: the ‘Special Assertive Outreach team’ (S-Team). The team was set up by a specialized housing service as an add-on to regional care networks. The S-Team targets ‘deadlocked cases’ of people with SMI, who are difficult to engage and continuously fall out of care. It provides both outreach care and long-term psychosocial recovery activities. It collaborates, for example, with regular and forensic multidisciplinary teams, organized by regional mental health trusts, providing in- and outpatient care for people with SMI. The latest teams remained responsible for the medication supply.

The S-Team is a small, versatile team of recovery coaches. It has a low caseload (staff-patient ratio 1:5), because of its assignment to facilitate conjoint learning at various ecosystem levels. The coaches can build on invaluable personal and professional expertise with the target group. Their professional background is nursing, system therapy, and experts by experience. All know the City very well, as this is the place where they grew up and live. The S-Team works along the ACT principles, with a shared caseload and a 24/7 availability. The S-team applies a dynamic approach of health and a 3D-approach of recovery, based on the positive health framework (Huber et al., 2011; Van Everdingen et al., 2021a). Its recovery approach is inspired by system therapy, community psychology, and psychotherapy (Mansell & Marken, 2015; Deci & Ryan, 2008; Collins & Ford, 2010; Mead & Bower, 2000; Olson et al., 2019; Ihm, 2012). The primary goal is to build working relationships at multiple ecological levels (Ward, 2017; Mezzina et al., 2019). The

S-Team collaborates with careseekers and caregivers to realize flexible, adaptive, trauma-responsive care, focusing on recovery.

Ethnographic Policy Evaluation

The initiating housing service commanded an ethnographic policy evaluation. The first author acted as participant–observer. She accompanied the S-Team in all kinds of activities. Contacts and observations were transcribed. Additional information sources consisted of interviews, management data, case files, and artefacts.

In the first year of the S-Team, the regional multidisciplinary consultation table referred 15 cases. At the individual level, personal autonomy failure resulted in personal and social loss. At network level, care failure resulted in inadequate, stagnating care processes. As a result, the cases were continually on top of the regional hotlist, but nothing happened anymore. In most cases, frustration and hopelessness in caregiver networks contributed substantially to the referral. After addition of the S-Team, all 15 cases showed similar patterns with a favorable course. Therefore, we utilize one single case for an in-depth qualitative demonstration of the research questions. It portrays the life and treatment course of ‘Simon’. The observations started when the S-Team was added to his caregiver network and cover about two and a half years. We first present Simon’s case history, reporting on the factual life events and his engagement with the S-team. Then, we inspect the care needs conceptions more carefully, to display meaningful nuances and changes in caregiver network interactions. Finally, we highlight the functioning of the careseeker–caregiver network in the light of recovery, to uncover relevant changes in the power dynamics and resources over time.

Case History

Youth

Simon’s life was unstable throughout his entire youth. As youngest child from regular substance users, he witnessed domestic violence. He used to stand up for the bullied and fight with the bullies; he had only two friends. Aged fifteen, he started experimenting with

drugs. He left school without diploma but achieved a craftsman certificate in a work study program. Then he entered on his career, joining his father as a craftsman.

Homelessness with Numerous Hospital Admissions: Stage Ia

After a clash with his parents, Simon ended up on the streets. He was hospitalized for the first time. Numerous (in)voluntary admissions would follow. For a decade, he was intermittently housed for few unbroken months. He was diagnosed with a psychosis spectrum disorder, intellectual impairments, and substance use. Therapies included social skills training, aggression regulation therapy, antipsychotic medication, and abstinence. Care providers considered him very dangerous, as he was repeatedly involved in verbal threatening and violent incidents. He spent a lot of time in seclusion. He had hardly any contact with his family. Sporadically, he got permission for meeting a hospitalized friend. Within 2 years, the police recorded dozens of aggressive incidents. These ultimately resulted in a court-ordered forensic admission. One year later, extending the admission was considered unnecessary and even contraindicated. Simultaneously, none of the regional stakeholders was willing to offer him a place to live.

Perspective on a New Home: Stage Ib

During a forensic admission, the S-Team was added to his caregiver network. They engaged in frequent visits, about three times a week:

In the beginning, Simon was quite paranoid. He exactly told you where to sit and how long to stay. It worked out well, when we started actively looking for a new home. Several weeks later, he had the prospect of a place to live on his own.

The S-Team focused on developing the contact. Simon was living on social benefits. He had administration support with an instalment plan. As financial issues recurrently caused distress, the S-Team helped providing clarity, enabling him to adjust his attitude towards the administration provider. Meanwhile, Simon explained his aggressive behavior as an expression of despair, frustration, and anger in

response to enforced treatment. He clearly articulated his needs:

Clinics make people go crazy. I don't want to be patronized; I want to be taken seriously... I need clarity because I want to know where I stand... I need rest; I don't want too much circus... Caregivers should not come too close to me. I don't want any injections.

When furnishing his new home, a coach witnessed his interaction with his parents:

His mother monopolized the attention. She kept on talking continuously, instructing him what to do. Simon felt oppressed; I could notice the tension and irritation in his sweating face. He clearly indicated what he was going to do. He asked her to leave him alone, but his mom was not giving him a moment's rest. Meanwhile, his dad detached himself from the situation. When he shortly came in, he directed his wife similarly as his mom tried to direct Simon.

Unstably Living at Home: Stage II

Simon left the clinic, 2 months after he started collaborating with the S-Team. For the first time, he was living on his own. He enjoyed his autonomy. He wanted to acclimatize himself to his new life. The S-team pro-actively intensified the contacts, yet respected that he didn't always open his door:

When he opens the door, his appearance informs me how to connect. When his hair is sticking out and he isn't dressed at noon, I don't push... Then I'm only present silently, alerted that he remained awake all night, while using cocaine and speed again... As soon as his hair and clothes are done neatly, he is open for coaching, for example on tidying and cleaning up. Overall, he moderately takes care of himself and of his home. Substance use is still an issue... It disrupts developing routines.

Simon's experience of being treated normal and finding out what's normal continued. He recognized his need to see his mother besides the need to do things on his own. He resumed his former hobby and looked forward to working as a craftsman with his father.

Sometimes his mother or former companions visited him. Still, loneliness and lack of activities ended in problems.

Shortly after the move, the treatment responsibility transferred to a Regular Assertive Outreach Team (R-Team). Simon's hostility towards antipsychotics and its prescribers remained. He wanted to show his capability to remain stable without any drugs. A recovery coach assisted him to express this desire in an adult manner to the psychiatrist, without any aggression. To his frustration, an answer failed to come. Influenced by former companions he started using hard drugs again, while throwing his antipsychotics away. Caregivers recognized the relapse, which decreased his self-care and increased the chaos at home. Simon's insight into the patterns and stressors eliciting psychotic episodes, his contacts with the R-Team, and peer-to-peer conversations with the S-Team could not prevent the psychosis. He started lodging former companions from the clinic. He became more and more agitated and paranoid, convinced he was tapped. The neighbors complained to the housing association, because of the screaming and nuisance at night. The police, estimating a public order risk, dispatched two patrol vans. At the psychiatric hospital, it became clear that Simon had not taken his antipsychotic drugs for months. Preceding to an evaluation meeting at the department, his mother and involved workers met:

Mom: My husband won't come. He doesn't stand the situation... But Simon remains our child. He is very anxious and desperate now. We're afraid he will terminate the rent of his apartment...

R-Team: The clinical department will fix the discharge date.

S-Team: We need a thorough action plan... We know him, we are convinced he is still psychotic now.

R-Team: At first sight, he looks normal.

S-Team: His paranoia only came out when I was sitting quietly with him for some time.

Besides his mother, two department workers, two R-Team workers, and two S-Team coaches participated in the evaluation. Simon was very tense when he joined. He loudly chanted his paranoid, psychotic perceptions:

I wouldn't harm a fly. But still, you lock me up in seclusion! That's what you like... I want rest. I need support. If I go back home now, I will put a knife in my neighbor's neck. I want to show that I can function without medication. If I get rest, I can go back in peace. I want to stop substance use and remain stopped.

The recovery coach looked him straight in his eyes, supporting to express his fears and needs towards his care providers. She negotiated how to meet his need for rest:

We will make a plan with you, Simon. What do you want?

Until then, the second coach was sitting close to Simon, silently. Now he confirmed:

What you want, that's the most important. We'll go for it!

At that moment, Simon's angry, hostile aura disappeared completely. He heaved a sigh of relief, smiling diffidently:

A weight is taken off my shoulders.

That admission, Simon took his antipsychotic drugs and found rest. Instead, at home the oral medication intake under supervision of the R-Team daily generated stress and dispute. Moreover, loneliness and empty time made life difficult. Again, visits of former companions incited him to use drugs. Neighbors started reporting agitation and nuisance to the S-Team. In presence of the police, the housing association informed him of the risk of eviction. Again, stress increased, and psychotic fear popped up. Four voluntary and forced hospital admissions later, all care providers conducted a conjoint medication review. Recognizing the recurrent patterns, the regional and the forensic mental health services requested a court order for compulsive medication.

Stably Living at Home: Stage III

One year after his first attempt to live on his own, Simon went back home again. A distant relative (a former health professional) started playing an explicit role in his caregiver network as a mentor. For instance, the relative actively monitored his weekly visits for depot administration. He organized that an acquaintance would irregularly stay over at night, acting as a fellow to prevent him from lodging companions. Consequently, Simon voluntarily removed all dealers from his cellphone. Further, the relative promoted Simon to participate in social family activities and work as a craftsman with his father. As a guardian, the relative also monitored that his income was allowed as extra pocket money in addition to his unemployment benefits. That allowed Simon to start practicing a new hobby.

At that time, the relative and the coaches explained their approach to the next-door neighbors and to the housing association. This resulted in a fruitful collaboration with Simon, his neighbors, caregivers, and other parties if necessary. The neighbors appreciated the prompt responses for each report of nuisance or agitation:

Simon is a decent boy. The nuisance was caused by his friends. It also gave nuisance when the police turned out with a special squad! We would have averted the risk if we had been able to reach him!

Simon's risk of being evicted was averted. He accepted his depot antipsychotic medication. He really enjoyed his new hobby and expanded his work commitment to 20 h a week:

My father is a craftsman. He taught me the tricks of his trade well!

His mother was happy too:

He behaves much nicer now. Sometimes, he even bakes bread or pancakes for me!

After regularly using depot antipsychotics, Simon was never hospitalized. At empty moments, he still was prone to substance use with companions, but no police records were filed. Reporting signals to the S-Team or the relative appeared effective. Besides, his pride in his work and new hobby boosted his self-esteem. He made significant progress to celebrate

Christmas and New Year with his family. When his fellow stayed over at night, he appreciated their “men’s talk”. He took care of his looks, hoping to meet a nice girlfriend.

Care Needs Conceptions

A Deadlocked Case: Stage Ia

Originally, information was confined to reports of the regional consultation table and to written summaries of personal files. For mental health caregivers, Simon was an adult man with a psychosis spectrum disorder, substance use, intellectual impairments and attachment problems related to childhood traumas. Their well-intended treatment plans were obstructed by his behavior, his refusal to use antipsychotics and his unwillingness to engage. Though prolonged intramural psychiatric care was considered contraindicated, putative danger and supposed difficulties excused them for discontinuing care. Therefore, the regional stakeholder network considered him a ‘deadlocked case’. Referral to the S-Team was a desperate attempt to shape new conditions for recovery.

Developing Contacts at Interpersonal and Network Levels: Stage Ib

Since regular forensic care was expanded with the S-Team, the heart of its coaching activities consisted of normal interhuman behavior combined with pragmatic support in daily life issues. An open-minded attitude, respect, clarity, and reliability resulted in reciprocal interactions and fostered developing confidence. Compassion, brotherhood, trust, and humor appeared important ingredients in their daily contacts. Using their own experiences, the coaches encouraged him to discover the meaning of ‘normal (healthy) behavior’:

Everyone has a right to live! We pace down to adjust optimally and flexibly to person’s needs. A substantial part of our work consists of treating people as normal and discuss ideas what is normal... Normal is to treat others as you want to be treated yourself. Normal behavior also implies to confine limits, for example to substance use or to other people.

The S-Team’s employs a similar approach towards careseekers and (in)formal caregivers. Starting from the careseeker needs, they first complimented people on their strengths, before exploring their vulnerabilities. They stimulated thinking in terms of solutions instead of impossibilities. They focused on developing shared visions of alternative strategies (of plan A and plan B). With respect for their roots and peculiarities, they invited careseekers and caregivers to mutual reflection how they fulfilled their roles. For instance, by inquiring why they not appeared at appointments or were absent in transfer meetings at discharge. For Simon, this strategy quickly resulted in the prospect on a new home. Colleagues in the regional consultation table noticed the positive impact of the S-Team’s approach.

Developing an Adult Identity: Stage II

After moving to a place on his own, the recovery coaches provided guidance to manage his home and organize his life. Simultaneously, they enabled Simon to behave and communicate in adult patterns towards family, neighbors, and professional caregivers. Meanwhile, they discovered that normal prosocial contacts were lacking. His unstable life and the numerous hospitalizations had impeded engaging in normal prosocial relations. Therefore, he was vulnerable to psychosis. His loneliness and plenty of free time made him prone to substance use with companions. They noticed that Simon still had clear ideas of normal social behavior. Normally, he was friendly and willing to help. His sensitivity towards caregivers’ treatment aimed to safeguard his autonomy.

Meanwhile, regular care focused on symptomatic treatment of his psychotic fear. The coaches accompanied Simon in formal and informal contacts. They supported him to articulate specific desires to his parents and to the R-Team. The increased understanding of his perspective facilitated collaboration. It eased his over-concerned mother in letting her pre-occupation with psychotic symptoms go. Besides, it enabled formal caregivers to extend symptomatic treatment aims with psychosocial aspects relevant to well-being and recovery.

After the conjoint decision for court-ordered depot antipsychotics, the psychiatrist reflects on his role:

I'm in charge of his Regular Assertive Outreach Team. The R-Team was set up for people with SMI. Simon's extremely threatening behavior fits what we expect from people with psychosis spectrum disorders. We are accustomed to hostility towards prescribers of antipsychotics. That's part of our job. Simon texts and calls my colleagues more easily. Overall, his relationship with the R-Team is functioning. If he is psychotic, he sometimes even calls me at night. Besides, I am the holder of his court order too. Simon does not want to be hospitalized anymore. He wants less medication. He wants to continue his work. He has a need for social contact. He hopes to find a girlfriend and build a steady relation... Fortunately, there was no need to hospitalize him since starting to administer antipsychotic drugs under constraint. His extreme rejection of antipsychotics is replaced by a much milder opposition to injections now.

Managing Environmental Accommodation to Changing Needs: Stage III

At the end of the last hospitalization, a relative started engaging explicitly as a personal mentor:

I'm a family member. Simon can always call me or come by. If he would be a boy living nearby, I would do the same. I look after his affairs...

'Give a little-take a little' was his device to get things done. The relative and the coaches collaborated actively. They supported Simon in all kinds of caregiver relations. The mutual engagement eased joint care coordination. This resulted in flexible, adaptive collaboration adjusted to mutual expectations and needs with Simon, family, next-door neighbors, formal caregivers, and other parties. Expansion of his family contacts resulted in emotional support, guidance, tangible support, and socializing. After one year of compulsory depot antipsychotics, the mentor, two coaches of the S-Team, and the psychiatrist of the R-Team joined in an evaluation meeting. They explained why their collaboration was working out well.

All caregivers: Together we shape the conditions!

Mentor: To manage care, one needs to know the rules and speak the language of each care sector. One needs to anticipate what can go wrong. I'm continuously managing chaos to get things done... Together we shape his environment to his needs. By doing so, we must bypass all kinds of bureaucratic obstacles.

S-Team: We combine normal, reciprocal human behavior with professional skills. We are alert to interfere if he continues spiraling down. Mostly, we're just present: respecting people's autonomy is fundamental to enable growth. Therefore, we coach him in his interactions with his environment. He is proud of his work with his father this strengthens his identity. Likewise, the changed relationship helps his parents to reconnect with normal parental roles. Similarly, we coach him to employ adult behavior towards other parties, such as his administrator, and the R-Team.

The mentor continues about the monitoring of psychosis signals:

Simon talks about his psychotic fear with the coaches, with his fellow and with me. We are continually present and alert to his psychotic fear. It changes all the time what needs to be done... If we would stop monitoring, we would lose to his fear.

As usually, Simon didn't want to be bothered with potentially stressful situations. He trusted his mentor and coaches. Therefore, he refrained from participating in the evaluation. The assessments on a quality-of-life questionnaire clearly expressed what he felt (Priebe et al. 1999). Overall quality of life was awarded a 4 on a 7-points Likert scale:

Not higher, because I need medication.

His living situation was also rated 4:

It's not ideal, but it could have been worse.

Assessment of social relations received a low 2-score. Broadly smiling, he commented:

If I had a girlfriend, it would be a 6!

Physical health was rated 7 and mental health 6. The overall score of received care was excellent: 7.

He still deeply mistrusted the R-Team, giving them a low 1-score. He clearly explained why received care of the S-Team was rated a 6:

Because you talk to the R-Team.

Since then, careseeker–caregiver interactions continued. Simon was happy with the improved family relationships. Ashamed of his substance use, he sought addiction treatment. Only his relative, the coaches and the psychiatrist were informed.

Recovery Dynamics

Table 1 summarizes the situation of Simon and his caregiver network over successive stages and provides insight in the dynamic interactions between both. Therefore, it provides insight in the conditions that enabled recovery.

In stage I, careseeker–caregiver interactions were characterized by sporadic opportunities and a lot of distrust from both sides. Simon described his life quality as poor with insufficient social, meaningful activities. In official caregiver’s reports, his dangerous reputation limited fulfillment of his care needs. Potentially, psychosis was disregarded as underlying cause of his threatening behavior. His role in violent incidents was repeatedly mentioned at the regional consultation tables, while frustration and missed opportunities of care providers to engage constructively were disregarded. The latest admission was court ordered. Desperate care providers hoped to create stability. The decision to involve the S-Team marks the onset of new dynamics. Within weeks, the S-Team files documented that the atmosphere changed. The regional consultation table also noticed that attention and pragmatic support decreased paranoia and fostered openness.

Table 1 Functioning of Simon and his caregiver networks in successive stages

Stage	Simon	Caregiver network
<i>Homeless and hospitalized</i>		
Ia	Start: 1st admission as a young adult Duration: a decade, >10 admissions	Hospitalized Lack of freedom, distress Little contact family/friends Recurrent threatening
Ib	Start: Addition of the S-Team Duration: 2 months	Hospital rules Forced treatment, seclusion Accumulation of police records Lack of alternative strategies
<i>Unstably living at home</i>		
II	Start: Move to own apartment Duration: 1 year	Continued clinical care Start regular visits S-Team Sincere attention, reciprocity Clear, pragmatic support
<i>Stably living at home</i>		
III	Start: Return at home after start of depot medication Duration: >1 year	Home Joy of personal autonomy Growing confidence Learning household skills Finding out what’s normal Start working as a craftsman Contact neighbors, parents Loneliness and lack of activities Irregular life Recurrent substance use Psychotic fear
		Treatment transfer to R-Team Daily supply antipsychotics Intensive coaching of S-Team Sincere attention, reciprocity Clear, pragmatic support Coaching normal adult behavior Giving voice to Simon’s perspective Increase network collaboration Decrease police records 4 admissions Start depot medication
		Explicit role relative Depot visits outpatient clinic Active collaboration of relative, neighbors, S-Team No police records No admissions Start addiction treatment

In stage II, Simon was living on his own for the first time in his life. The coaches consistently assisted him to express his perspective and exhibit adult behavior in all careseeker–caregiver interactions. This marked the onset of changes in his relationships to neighbors and formal caregivers. He started developing an adult identity.

At the start of stage II, symptom management and psychosocial treatment were part of separate care trajectories. Despite much coordination and improved collaboration, interactions failed to shape steady conditions for recovery in his irregular life. The daily intake of antipsychotics remained a recurrent source of irritation. With no social contacts or a regular job, Simon had a lot of unstructured free time. Psychotic fear and substance use continued to generate instability. Consequently, the pattern of recurrent admissions persisted. Repeatedly, the S-Team addressed the psychotic component in his agitation and aggression. Four admissions later, the decision was made to start depot antipsychotics.

In stage III, the caregiver network succeeded in offering integrating care, resulting in the shaping of stable recovery conditions. Two factors contributed to the change: starting (compulsory) depot medication and the mentoring by a relative. After 1 year, caregivers recognized the contribution of the depot antipsychotics and the dynamic informal–formal care coordination to the success.

Discussion

Severe mental health difficulties are still associated with extreme disparities. Extended longitudinal empirical recovery research has not changed this. The pervasive failure of societies to safeguard equal conditions motivated researchers to propose health equity as a quality aim (Nundy et al., 2022; Wyatt et al., 2016). This ethnographic policy evaluation paper highlights a Dutch experiment targeted at people living with SMI at the margins of society. The local public health services of a City were extended with a special team to facilitate conjoint learning and improve care. The paper follows the case history of ‘Simon’, to illustrate how caregiver networks can build recovery-enabling environments in communities.

Simon is a man living with psychoses. In Simon’s adolescence and young adulthood (stage I), care was dominated by an illness-centered, professional-driven,

deficit-based approach. It failed to preserve normal growth. Instead, it was one of the central causes of inequity. After all, the absence of stable housing prevented developing prosocial contacts or basic daily-life skills. The recurrent hospitalizations show how compromised systems, dehumanization, and disengagement in careseeker–caregiver relations resulted in downward spirals, as depicted by Moore-Nadler and colleagues. (2020). Consequently, the regional multidisciplinary consultation table considered Simon a ‘deadlocked case’.

So, the narrative underpins the need of the paradigm shifts described by Ragins and Sunkel (2023). In answer to question one, it discloses that the S-team works from a person-centered, consumer-driven, strength-based recovery approach. This approach affects the recovery processes described in the CHIME framework (Leamy et al., 2011). Table 2 provides an overview of the guiding principles underlying to the S-team’s functionality in the careseeker–caregiver network. The results show that normal behavior, mental health lived experience, and personal qualities (how to support recovery processes) constitute key elements to establish working relations and open new perspectives on recovery.

The narrative shows that the recovery coaches establish reciprocal relations and start easing normalization and growth. Yet in stage II, parallel care plans targeting on single recovery components were ineffective. Failure to adequately meet integrating care needs, repeatedly escalates care into more specialized solutions. The recurrent failure of the strategy leads to more coercion. In sum, the case substantiates the failure of the linear handicap model.

Regarding question two, frustration and hopelessness at the regional consultation table had motivated the referrals to the S-team. Targeting at long-term disabled, ‘deadlocked cases’ with SMI, the team was assigned to explore conjoint learning. The S-team started building working relationships at multiple ecological levels. As a result, the failures of previous strategies were countered. The experiment uncovered unexpected pathways to recovery, as demonstrated in the Vermont study. Care networks increasingly acknowledged that complexity originates from power dynamics in dealing with varying perspectives. This case accentuates that managing interdependent problems demands a robust, generic approach. Such

Table 2 Guiding principles, functions, and outcomes of the S-Team’s approach

	Guiding principles	Function and outcome
Normal behavior	Open attitude	Equality, confidence, trust Cultural sensitivity, room for diversity
	Slowing down	Being close and approachable
	Sincere attention	Respect, reciprocity
	Being straight	Clarity
	Patience and compassion	Mildness, forgiveness, 2nd (3rd, 4th...) chance
	Humor and love	Fun, joy, growth
Personal skills	Lived-through experience suffering and resilience	Modesty Inalienability of personal autonomy Open eye for attachment problems and identity development
	Personal qualities for assuming a process role	Self-knowledge, reflectiveness Ability to switch between perspectives Non-judging open attitude Ability to endure tensions and to demarcate responsibilities Having guts to be clear
	Ecosystem approach	Considering people in relation to their (ecosystem) contexts
	Evolutionary change and knowledge generation	Observing interactions in and between ecosystems in time Understanding universal, natural patterns of ecosystems to maintain and restore homeostasis Vulnerability—strength approach of individuals and networks Integrating knowledge of various sciences and sources broadens views and diversifies pathways to recovery
	Equality principle	Complex systems thinking Respect for dignity and autonomy Advocacy, promoting fairness, standing up for human rights
	Comprehensive, multi-dimensional approach of health and recovery	Transdomain health approach: going beyond diagnoses Recognizing the non-linear, unpredictable course of SMI 3-D vision of recovery, related to the positive health model: symptomatic (mental and physical), social (daily functioning and participation), and personal (quality of life, meaning) recovery
Socio-ecological system strategy	Collaborative approach	Flexible and dynamic interactions: room for creativity, inventiveness Negotiating power and resources: interpersonal collaboration to expand degrees of freedom Regarding sustainability related to boundaries: The dignity of failure, good enough governance Narrative skills and techniques, such as lifelines and metaphors

an approach assists careseekers and caregivers to develop dynamic relations and consistently focus on the varying dimensions and conditions for recovery. Involving others diversifies possible care solutions. The case underscores the power of collaborative

informal–formal care. The active engagement of a relative in Simon’s caregiver network and the start with depot antipsychotics mark the transition to a successful approach, offering perspective on sustainable recovery. In close interplay with Simon, the

collaborative network succeeds in the shaping of a dynamic, recovery-enabling environment. For Simon, this is the onset into more steady recovery processes, learning how to adapt and to self-manage.

So, answer two accentuates the relevance of socio-ecological system principles for developing collaborative relations focusing on recovery (Strauss, 2017; Rosen et al., 2020; Olvera Alvarez et al., 2018). It shows how the rights-based ecosystem approach of the S-Team incites attention to different voices and power balances in careseeker–caregiver interactions. Such strategies allow divergent care strategies and enable normalization and growth in a sustainable way. The varying backgrounds of the S-team members contribute to the success, as they increase the team’s ability to adapt continuously to changing circumstances and needs. These results match authors in the field of public and community health who recommend socio-ecological strategies to understand recovery trajectories using complex systems, such as Strauss (2017). Littmann and colleagues (2021) confirmed that values are an important guide to ‘negotiate power and resource realities’. ‘The dignity of failure’ allows collaborative learning to enable growth (Deegan, 1988). Pragmatism and realism should prevail, as the ‘good enough’-rule allows to diversify potential pathways (Grindle, 2011).

Metaphors can help us to understand transitions in recovery dynamics and provide a shared language in careseeker–caregiver networks (Strauss, 2017; Rosen et al., 2020). Examples are the notion of ‘Tipping point’ (borrowed from mathematics) or ‘Woodshedding’ (from art). Tipping points are apparently unpredictable transitions from an existing slow change process through sudden disruption towards a new equilibrium (Nelson et al., 2017). Applying this metaphor to the recovery process of Simon, shows that despite the stabilizing effect of the depot antipsychotics (slow progressive change), psychotic fears and substance use remained disruptors of real change. It resulted in chaos and unpredictability. The tipping point metaphor helps to recognize that chaos and stagnation do not indicate that recovery is beyond reach. Likewise, the woodshedding metaphor allows us to ease therapeutic restlessness and accept the seemingly intolerable stagnation. The metaphor

indicates an apparent stagnation which imperceptibly enables growth allowing people to reach another stage (Sparrow, 1985; Shiers et al., 2009). Simon was able to use stage III to build trust and pick up his prior job and hobbies. Since his care needs were met in integration, he was stably living on his own, and hospital admissions stopped. Hallmark changes were observed in work mastery, increased self-esteem and a subtle but distinct increase of autonomy within the family. The woodshedding metaphor encourages caregivers to respect careseekers as the key persons and owners of their life and recovery process.

Finally, the concurrent use of coercive treatment with a recovery approach is problematic. It complicates the shaping of conditions for recovery, as it sets people apart and artificially limits their room for growth. Conversely, essential conditions for recovery require natural, safe environments for growth. Such social environments enable lifelong learning, assisting people and communities to develop adequate, adult responses to adapt and to self-manage for dealing with (un)common stressors. Then, exploration of different strategies can harvest recovery knowledge and foster mutual learning. Based on the dignity to fail, everyone deserves countless chances for growth. The Convention of the Rights of Persons with Disabilities underscores that everyone has equal rights to these countless chances for growth (WHO, 2022).

In the City, the cases referred to the S-team proved that mutual interpersonal relations in a recovery approach can safely reduce the use of coercive treatment. In this case, the success of the recovery approach questions the need for coercive medication monitoring. The defensive choice reflects the actual dominance of symptom and risk management over recovery goals. Apparently, after many hospitalizations, coercive treatment appeared unavoidable for the mental health trusts. Taking stock of the over-regulated care system makes the choice more comprehensible. After all, the City is located in a modern welfare state, which just decided to transform ‘care systems’ into ‘health systems’. Mutual learning processes will help innovative recovery teams to embrace the three paradigm shifts comprehensively and continue exploring alternative strategies. That gives hope that success stories as Simon’s one will contribute to future reduction or even abolishment of coercive care.

Conclusions

Essential conditions for recovery make up a natural, safe environment for growth. Simon's case history confirms that they go beyond care and touch all dimensions of life. Such conditions enable lifelong learning. They foster the development of adequate, adult responses to adapt and to self-manage for dealing with (un)common stressors. Recovery-enabling environments help individuals and communities to improve health and well-being and fulfill meaningful roles in society.

This policy evaluation demonstrates the need of integrating care strategies for populations with interdependent problems, often found in people with SMI. The narrative data shows the failure of the illness-centered, professional driven, deficit-based care model, and the costs of overspecialized, separate, specialized healthcare and social service systems. It demonstrates how a recovery approach centered around normal behavior, lived experience, personal qualities, and using a socio-ecological system strategy can create recovery-enabling environments. It underscores the power of collaborative informal–formal care. It shows that combined resources can expand the necessary degrees of freedom for successful recovery processes. Developing alternatives generated in a mutual, person-centered recovery dialogue can substantially reduce or even totally abolish the need for coercive care. To better understand these recovery processes, we need to create and adopt new metaphors, such as the tipping points, and woodshedding. They form an important antidote for the assumed quick-fix interventions of the linear reference frame of care. They acquire an invaluable place in the language of recovery narratives and help us to better communicate about the time related processes that open new perspectives for recovery.

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Author Contributions CvE, and PD participated in the conceptual design of the study. CvE drafted the manuscript, collected the data, and performed the analyses. PBP and HG participated in focus groups to identify the essentials of the

approach. All the authors critically revised the manuscript and contributed to interpretation of the data. All authors read and approved the final version of the manuscript.

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Data Availability The first author includes the data of this multiple case study to make a PhD. When the PhD is finished, the data will become available in a public repository. Until then, we are open to data requests within the scope of collaborative projects.

Declarations

Conflict of interests No financial or non-financial interests declared.

Ethics Statement The research ethics committee of Maastricht University Medical Centre/Maastricht University approved that our research plan for the scientific use of the management data does not fall within the remit of the Medical Research Involving Human Subjects Act (record number 2021-2689). Therefore, our research plan can be carried out in the Netherlands without an approval by an accredited research ethics committee and without explicit written informed consent of the participants. Oral consent to participate was obtained.

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