Good telecare: on accessible mental health care

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***Abstract* — Mental health care is increasingly given at a distance, supported by technology. In this article, we focus on whether care, when technology comes in, still counts as good care. Therefore, we looked into a mental health nursing telecare practice for patients that live at home. The telecare team offers 24/7 unplanned webcam contact. We observed and interviewed nurses whilst they were having webcam contact. In our analysis we focused on frictions in care. We found different examples, that relate to an overall dilemma in mental health care: how does the policy of reinforcing self-reliant patients relate to 24/7 care? The dilemma is reinforced through the webcam, as it makes care much more accessible. We used theories on good care, which show how good care is situational and established when enacted. We think professionals should look for complex examples and confer on frictions in order to improve good care. Exchange and discussion between care professionals, derived from their understandings with patients, will lead to applied knowledge, or even better, artisanal knowledge of good care.**

Keywords - good care; e-mental health; nursing telecare; ethnography.

I. INTRODUCTION

Telecare provides an alternative form of contact between patients and nurses [1]. It is part of a growing movement of technology in mental health care, in which web-based systems like serious games, self-management instruments and online therapies have become regular interventions [2][3][4][5][6]. For mental health care institutions, telecare is mostly used to introduce new care interventions, enhance flexibility and reduce face-to-face contacts [7][8]. Flexibility is regarded as an important asset and the online interventions are often available for patients to use at their convenience. This fits the prevailing views on self-managing patients: request for support at the moment you need it or when it fits you. Not all 'e-mental health' technologies make use of a webcam, but they do share the capacity for care at a distance. The webcam has an extra feature: it makes the care professional accessible to patients in sight and sound at the push of a button.

The webcam is bringing obvious changes to care. How to know if this care through a webcam is good care? Let us start with what comes to mind first: care at a distance leads to absent care professionals (or if you wish: absent patients). We can safely state that care at a distance will not be the same as care in person. There is the absent body, which can be cared for at a distance using information on the body that the patient provides through the technology [9]. Mental health care has more focus on non-physical care, with nurses guiding and supporting patients. For mental health care organizations, telecare seems a good alternative or addition to regular care, based on the presupposition that bodily presence might not always be necessary in mental health care [8][10][11].

The webcam does not only make the bodies absent, the webcam itself comes into the caring relationship: it is a technological object that asks for operation [12][13][14][15]. There is a rich literature in Science and Technology Studies on dealing with technology. Buttons need to be pushed, results read out, numbers configured and settings tailored for individual patients [16][17]. The work that needs to be done before the technology works, becomes part of the caring relationship, as technology is worked together, but is also a form of relationship with the technology. People get attached to devices, as technology becomes part of their day-to-day life [18][19][20][21]. Technology takes hard work and subtle tinkering to make it fit in daily practices. In the process of tinkering, relations are established. The technology becomes part of the caring relation, bringing along changes.

And that is our main concern: if care changes with the technology, is that care still good care? Good care is a widespread, presumably understandable idiom. We all have ideas on what good care is. Some are easy to name, but many aspects of care are in our actions. Care is about patients, but often also about the patients' spouses and everything that surrounds them. Care is for houses, pets, administration, food, plants and trinkets [22]. That we care not 'just' for patients, but also for what surrounds them (and us), shows how infinite care is and also how difficult to define. Care is not only about who and what we care for, but also why. Care is also about the relation and responsibilities of caregivers and caretakers. In prevailing health care policy, self-management is seen as a form of good care. The ideal of self-management is about patients who are in the lead, controlling their own lives, instead of being led by health care organizations. In day-to-day lives of patients though, a lot of practical stuff needs care, in which patients are often very dependent, next to dependency on physical care [23][21]. Care is also about rituals, in which the good is

established [24].What binds the various aspects of care we just named, in which we were far from complete, is the establishment of the good along the way. Nurses and patients, patients by themselves, spouses, pets and stuff: in shared practices, or in the practice they are in, they all define good care by doing it. They make good care along the way, so to speak. The outcomes of the 'good' in care are different of course: in different practices good care will be establish in different ways. As the 'good' is constituted when care is given and depends on its environment, the 'good' is extremely fluid [25][23][26].

There is no uniform description of the good in care, but there is some agreement: care should be experienced as good by all involved. Therefore, good becomes something that needs to be negotiated. But will that what is negotiated as good, be renegotiated for its goodness when parts of it change? Or will this lead to the idea that the care is still good, because its seems the same, when in fact its merits might have changed? Making good care therefore demands tuning between nurses and patients, to discuss and adjust care when and where necessary. However, to know if there is something to discuss, nurses have to watch out for where the tuning fails. Following Mol [26] this means searching for moments and situations, for circumstances or signals that show the 'bads'. Often patients will be very capable of saying so themselves, but many cases they are not. Nurses have to look for those bads, because part of making care good (again) is to be sensitive to friction and to be able to fix it. Nurses should therefore search for friction to maintain good care.

In this article, we want to add to knowledge on how good telecare can function in a changed practice. We studied a mental health nursing care practice that uses a webcam to give patients the opportunity to make video contact with a nurse whenever they feel it is necessary. We specifically wanted to learn about the limits and constraints of good care and posed the following research question: What dilemmas and frictions on good care arise in a mental health nursing telecare practice?

II. METHOD

This article is based on our data collected from a nursing telecare team. This team consists of case managers from 18 different FACT teams. FACT stands for Flexible Assertive Community Treatment. The members of these multidisciplinary teams are mainly case managers (almost all nurses) as well as psychiatrists, psychologists and sometimes social workers [27]. FACT teams supply care to patients with severe mental illnesses who live at home. Home care varies from daily visits to once every month. FACT teams aim to be able to scale up care very quickly when necessary, and likewise to scale care down as well, therefore adapting the care to the patient's situation. The 18 FACT teams are part of one organization for mental health care that covers one region. Each team makes one case manager available to take one shift a week (from 8 am till 8 pm) at a health care post that provides care at a distance with a webcam. The telecare team handles all unscheduled webcam contacts ('calls') from patients throughout the region. After hours, calls are routed to various clinics in the region, which also have a webcam. Patients have a dedicated computer with touch screen and webcam. The system's hardware and software is very user friendly: patients can talk to the case managers at a push of a button. The telecare team is available 24/7, but most calls take place during office hours.

We followed the telecare team for nine months, conducting ethnographic research [28][29][30] to open up the practice, see and recognize changes and discuss these with nurses. In the process, we sought to become part of the care practice, or at least to get as close to it as possible so that we could recognize and understand it better. We became acquainted with the telecare practice by talking with and observing case managers in various mental health care settings [31][32]. We read project documents on various telecare projects and participated in team meetings. Our field work then concentrated on the telecare team. We joined case managers on their shift. We took field notes while observing webcam contacts of case managers and patients. We conducted interviews after the webcam calls, asking case managers to reflect on the call, and these interviews were taped and transcribed verbatim. We also interviewed two patients, and observed webcam calls from their homes. Patients were informed of our presence in writing beforehand and the researcher left the room if they had not consented. The independent ethics committee judged this project to be exempt from review [33]. The quotes in the results section of this article were translated from Dutch. We joined the team 27 times, for two to four hours each. We observed and talked to 11 case managers, who were in touch with 30 patients, some of them multiple times. Twice we were asked by patients to leave the room, as they did not consent to our presence.

The observations and analyses were led by sensitizing concepts, which were shaped by the theoretical notions on good care we discussed in the introduction, guiding the notes and the coding process. The researchers articulated these notions during the analytical process, and applied them in the second round of observations and interviews with the case managers [34]. Data analysis focused on what work is done in the telecare practice and how the case managers talk about it. We used theories on good care to interpret the findings and reveal the areas of friction in good care in the practice of telecare.

III. RESULTS

We will discuss three practices in which webcam use has changed care. We show how this has led to frictions concerning good care.

A. What care do case managers address?

This section deals with how telecare leads to uncertainty about who needs to follow up on particular questions from patients.

When a patient's call on the telecare system is not answered, the system registers the call and gives an engaged signal. There are two kinds of unanswered calls: the ones that arrive when a case manager is busy talking to another

patient and the ones that come in after hours. For the first kind the custom is to return the call as soon as possible. Patients know that when there is no answer during daytime, this probably means the line is engaged. After hours calls are diverted to various clinics, but sometimes the staff in the clinic are too busy to answer. At the start of a working day, especially on Monday morning, when the team has been away for the weekend, the system shows a list of missed calls:

Rien contacts one of the patients on the list of missed calls.
Anja answers: I know you, but your hair looks different. They joke about hair gel. Then Anja asks: What's up?
Rien: I saw a missed call and knew you'd tried to reach the clinic.
Anja: Yes, I felt depressed. I worry about my cat a lot and it takes up my mind. The cat needs meat twice a day and I can't handle that. I've got to take it out of the fridge and give it at room temperature. I am all taken up by that cat.
Rien: Well, all the best.
Anja: Thanks. What's your name again?
Rien spells his name and tries to end the conversation. Anja talks a bit about the weather and finally says: Thanks for your interest in me and for returning my call.

There is no protocol for missed calls after hours. Rien feels he should find out what the matter was. After all the patient tried to reach a care professional. Some colleagues disagree, like Taco:

The telecare team doesn't do scheduled care. If you promise one [caller], you have to promise them all. Then we have to call back a lot. You'll see.. when you're returning one of those calls, you're in the middle of that conversation and then a new call comes in, so you have to return that one, and so on. So you're actually creating calls.

There are two routines for missed calls. The first is about returning only daytime missed calls, the ones caused by an ongoing call with another patient. This routine is not in dispute. The other one, returning after hours missed calls, is carried out very differently. Some case managers feel that each missed call needs following up. The idea is that telecare will 'only work' when it does as promised: provide a way to contact a care professional 24 hours a day. For Rien, good care means acting on the list of missed calls; for Taco only when the missed call appears when he engaged with an unplanned call.

Telecare conversations tend to be diverse. Sometimes, as soon as the technology establishes the connection through image and sound, patients tell their stories:

Case manager Taco talks about patient Tobias, who told very dark stories after his last admittance. For example, Tobias claimed that one of the nurses at the clinic had instructed him to 'go grab that borderline bitch'. Taco tells how much such calls affect him and how difficult these conversations are on a webcam. We discuss this for a bit, but do not seem to get to the heart of the matter. Taco says such contact seems like a stopgap, like it is not part of the process. I ask Taco if it would have been different if he were Tobias' case manager. Taco ponders on this, on how telecare is a part of the care offer and how it is part of the treatment, but that does not seem right to him after all…. It seems clear though that calls like the one with Tobias have more effect on Taco because they are by webcam.

The immediate contact established by the webcam and the fact that he is not Tobias' case manager make this situation hard for Taco to deal with. In some situations his colleagues find other solutions:

Wende: They [patients] should arrange these things with their own therapist. [A call] can get very substantive on medication as well. Then I say: I can't answer these questions!

The case managers on the telecare team feel that they should not be replacing the patient's regular care team (in which case they might feel obliged to answer all questions), but that the purpose of the telecare unit is to provide a first contact in (unscheduled) times of stress or social need. In the event of a crisis, the telecare team alerts the patient's regular case manager. A non-crisis situation is just recorded on the electronic system and patients are referred to their action plan or their own case manager. This demonstrates that not all questions can be asked, or put better, will be answered.

Another example of the issue on who takes care of what kind of questions from patients is the case of Maartje, one of the patients we interviewed. Case manager Hella told Maartje to use the webcam whenever she feels it is necessary. Maartje has a recurring belief that a man enters her house and leaves blood everywhere. Whenever she is frightened, she calls the team on screen and discusses her feelings and behavior. This service is very important for her, even when she is not delusional, because she can talk about what is going on in her life. A few times Maartje has discussed her delusion with the person on duty in the health care post, who in turn has called or mailed Hella, her regular case manager. Maartje's story about blood and violence is upsetting to case managers who do not know her, and that makes them mobilize Hella.

Maartje: I'm not supposed to go into details with other case managers, you know? When I do, Hella complains because she gets all these messages from her colleagues at the station. They report my questions and remarks, and then Hella gets telecare questions later on. So then the world's upside down.

Besides receiving the regular appointments at home, which steadily deal with her important issues, Maartje can mobilize help via telecare whenever she feels she needs it. This has a down side, though, as the issues that bother Maartje lead the case managers to warn Hella. Apparently Hella knows that these issues, although very serious, make the case managers undertake understandable, but mostly unnecessary, follow up. Hella might be used to regulating Maartje in their weekly

talks at home, but now she feels she has to coordinate her telecare calls too. Maartje has noticed that Hella intervenes, because Maartje's questions are not supposed to come through the back door, as it were, and she even thinks that the telecare option upsets the logical process of care for Hella: it is an 'upside down' world.

Hella structured the logistics of Maartje's webcam use without consulting others. There is no clear rule and no communication on the practice:

Maartje called while Taco was engaged with another a screen call. Afterwards, he returns Maartje's call. Maartje immediately states that she 'does not want to go into the deep end'. She just wants to discuss social relations. 'I met someone at the fellow sufferers group. And I ate with this person I met at church'. Maartje talks about her plans.

After the call ends, Taco says he needs to examine whether it was Maartje's initiative 'not to go into the deep end' and not talk about everything that is bothering her. He respects her choice, but states that she used to discuss everything. Maartje and Hella's understanding on the content of telecare conversations has not traveled far.

We saw how telecare contact (or lack of contact in the case of missed calls) raises questions on who needs to follow up on what. What questions need answers and which ones can be passed on? Are telecare case managers supposed to answer all questions and deal with all issues that stem from the technology (like missed calls) just because they offer availability? Underneath these practical questions lies the issue if it is good care to address all questions. Unanswered questions create friction in the telecare situation, as presumably the system was installed for patients to use whenever they feel the need to talk about any and every subject and it turns out they cannot..

B. A familiar difference in a new case

Care professionals, of course, differ in their approach, opinions and knowledge. This section deals with the differences in webcam practices, revealing a dilemma related to good care.

Many patients use the webcam regularly and are thus known to all the case managers. Bob is one such patient, a middle-aged man with an anxiety disorder. Sometimes, when he is having a tough day, Bob calls several times:

Interviewer: What do you think is the purpose of telecare for people like Bob?
Mary (case manager): Well, it's for when people get stuck, for example. People who can't start the day by themselves, they call their case manager every five minutes. With the screen, I feel they can learn to give themselves a signal, like: I'm stuck, I have to do five things and I don't know where to start. Structuring your day, that's a perfect way of using it.

For Mary, Bob exemplifies the benefits of telecare. Bob is very insecure about many things, including organizing his days. The screen gives him an easy way to get in touch with a care professional so that he can ask for support for whatever is bothering him at that moment. However, there are other sides to this story too:

Bob calls. He says: I want to talk a bit.
Daniel: Why do you want to talk?
Bob: I want to get rid of my tension.
Daniel: You always do, but you have to talk to your psychiatrist, I can't help you.
Bob: I want to know what I can do about it.
Daniel: What do you think?
Bob: I think I'll go for a ride on my bike.
Daniel: Good idea!
Bob, terminating the call: I'm hanging up now.

Daniel has a different way of handling Bob's recurring requests for support. Daniel's intervention is based on the aim of letting patients develop their own resources. Bob has written an action plan of steps he can take when he is not feeling well. In this example, Bob suggests a bike ride, just as his action plan might indicate.

For case manager Rudi even this might not be enough, as Bob seems unable to use the plan as intended. Rudi says that Bob's frequent calls show that he cannot rely on his own resources. In Rudi's opinion telecare is not supporting Bob, but therapy might:

Field note: Bob has already called in once this morning. He knows what to do, but needs confirmation. Rudi thinks that Bob should be taught how to handle his thoughts himself, without the continuing intervention of others, for example with the help of cognitive behavior therapy. He does not know if that would be an option for Bob or if anything like that has been tried yet.

We learn from the example of Bob, Mary, Daniel and Rudi how a familiar issue in mental health care is reinforced by the webcam. It questions whether Bob should be allowed to call in whenever he feels it is necessary or should he be encouraged to rely on other resources than nursing care? The issue is not new, but the webcam renews it, as it makes care more accessible. Bob can ask for help whenever he likes; he just has to press a button and someone is there to support him. With telecare the team is available for unplanned contacts. The webcam puts forward a normative question related to telecare: should care be accessible on demand?

C. Good platforms?

In the wake of the issue of care on demand is the question whether patients can vent about anything on their mind? Is it important to share everything? And is therefore each call equally important, including ones that do not seem to be about care? This section explores a specific aspect of telecare: social talk.

Because most calls are unplanned, often the patient and care professional are unfamiliar with each other. Most case managers of team E find this unfamiliarity an asset in their work. It is a change from daily routine, they meet new

patients and being separate from regular care gives them the chance to participate in social talk. The case managers recognize that many patients are very lonely and understand that some need to chitchat regularly. Case manager Wende:

Well, you've got the time to listen, you see, as you're here anyway. And because you are not in a therapeutic relationship, you don't have to do so much with these patients… That's what they do with their therapist, with their own care professional.

Wende regards telecare as an extra option for social talk, as patients do not have to 'work' with the members of the telecare team. Her colleague Taco adds another level of meaning to this. He actually sees that patients actively bond:

Some callers appeal to us differently than to their own case managers. They do more … or sometimes less… It's definitely different. You can tell that they know they can ask us questions. Some have great confidence in us, they know us, our faces. They discuss everything. But some don't, they are more reluctant.

Not all case managers find social talk not part of their job though, or as Rudi puts it:

And what I do here, with telecare, is just show my face, chat a bit and listen to what someone says or wants. So that's more like, well, it's like being very understanding and not giving any old advice…. I don't fully understand the situation nor do I know where the patient is heading, so it's more like being available for a talk… Methodically it's not much… Perhaps it'll go somewhere, but that would still take a lot of work.

The question this raises is whether social talk is a pastime or a therapeutic intervention? For Rudi a webcam conversation without a care context becomes chitchat, while Wende and Taco feel that providing social contact is important as patients can be very isolated.

The matter of social talk is further complicated by an issue on the platform telecare offers. Is it a form of good care when patients get the opportunity of recurring conduct? Case manager Taco talks about the issue of handling the reappearing chitchats of the same patients:

Yes of course, it gives patients an opportunity to complicate things. Give an extra option and people will take it. Maybe not to the extent we want, but you do give people…When you look at it from the recovery perspective telecare is actually quite nice. That people can decide for themselves whether they want to talk to someone or not.

Sometimes it is difficult for case managers to handle, repeatedly listen to, or even look at the recurring stories. Taco tells about patient Sonja:

Taco: Sonja calls whenever she hears voices. She uses telecare to tell us how she used her own interventions successfully. But it's always the same conversation. Also, she always sits in the same way at her table. Always the same notification. Sometimes I find it a bit silly.

On one of the shifts we attended, patient Titia called at least a dozen times. It turned out that she had had a lot to drink and Rudi, who was on duty, cut off every subsequent call until she stopped calling. During the conversations, Titia complained about mental health care. Rudi knows her concern is exacerbated by alcohol, something he sees more often:

Rudi: You generate dysphoria with the screen… It becomes online grumbling.
Interviewer: So the screen paves the way to that?
Rudi: Yes, I think so. Many frequent users have an endless need to externalize everything without having any awareness of the part they play themselves. So with this lady, you can wonder if telecare is useful… But you don't know.

When is a call useful? Some case managers say that every form of contact is useful, whenever patients find it necessary. Others, like Taco and Rudi, have their doubts. Patients with a borderline disorder form a special group under debate. These patients often demand a great deal of attention and should be able to cope by themselves. Therefore, some case managers wonder if such patients benefit from a seemingly endless offer of care. Case manager Ab stresses this point by reminding us that the general vision of the organization is that caregivers should stimulate clients to undertake more things by themselves:

And then what do we do? We give them 24/7 [tele]care.

We have seen different ideas on the function of social talk in telecare. Some case managers find telecare a very good instrument for engaging in the important asset of social talk to prevent loneliness. Others find that talking without a care context, such as an action plan, is not very relevant. With the social talk comes a deeper friction: should telecare be a space in which everything can be discussed freely whenever necessary? And does telecare give stage to endless unnecessary chats, leading to a main dilemma: does 24/7 telecare relate to the self-recovery perspective on care that drives the care organization? Some case managers define social talk as good care, but they have not discussed this with others. The same goes for the dilemma of round-the-clock care.

IV. CONCLUSION

In this article we looked for dilemmas and frictions on good care that arise in a mental health nursing telecare practice and we discussed three different practices. In this section we discuss our main findings and relate them to theories on good care. We end by discussing how care professionals can deal with frictions in good telecare.

Telecare leads to frictions on what questions can be asked at what moments. According to some nurses, just

because telecare makes care available, that does not mean that all questions need (or should) be answered. In fact, it might even be necessary to prevent some questions, which takes place when missed calls are not returned or particular topics are prohibited in telecare conversations. The moral questions are on when you offer 24/7 care, should you regulate or even answer every call that comes in? And is it good care to follow up missed calls, as they might represent unanswered questions for help. Or in other words: if a patient calls, missed or answered, does it represent self-control or does the stream of calls need any regulation? Case managers act differently in this situation, which can lead to uncertainties for patients.

The webcam renews a familiar issue while it makes care more accessible: should patients rely on themselves or on care? For Bob, the question of what good telecare is, depends on whether it supports his need to be self-reliant. Self-reliance is an important theme in mental health care. Patients are encouraged to solve things for themselves as much as possible. Does telecare, through its constant availability, really help Bob to develop self-reliance, when he can call for help whenever he wants? Or will Bob lean on (tele)care more, because it is constantly available? Does telecare create a missed opportunity for Bob to find his own solution first (on his action plan or his own social network)?

Social talk, which has always been an aspect of care practice, becomes more extensive when telecare is used. Whether or not social talk is good care is not a new question. Care professionals and patients usually handle this in their daily practices. However, the webcam adds friction to the practice, as it takes social talk out of the context of prevailing care and turns it in a care practice on its own. For some case managers it is unclear if this is a good care practice. The availability of telecare plays quite a role here, leading to questions on the amount or frequency of contact. Is a daily webcam chat about the weather a form of support or should that not be part of care? And what about its ceaseless accessibility? That can lead to uninhibited expression of feelings and ideas, even when that is not good for a patient. The webcam might facilitate a free space for unbridled expression, which some case managers think is the actual benefit of social talk.

We have seen patients using telecare to ask diverse questions or discuss subjects they regard as essential, whenever they feel it is necessary. Along the way they encounter care professionals with differing views on whether or not their needs should be met. Here we see where good care comes into being. The different practices described here could count as good care, as we stated that good care is situational and fluid. So why are the differences that we encountered a problem? Why do we call them dilemmas and frictions? Let us look at the case of Bob again. Let us say that nurse A and Bob have determined that for Bob good care means that he may call whenever he likes. Everything is fine during nurse A's shift but a few hours later, nurse B is on duty. She thinks differently and treats Bob differently. So Bob will not get good care, or he has to renegotiate it with every new shift. And even when he has established this with all the team members, he now needs a system to remember what he has agreed with whom (whomever is on duty). Differences between care professionals are not unusual, but Bob now encounters them far more often than he ordinarily would, had the care been given only by his regular case manager and a sole replacement during holidays. If we take this a bit further: how would this practice look like if Bob decided that good care means he wants to call in every three minutes? Mostly likely, all nurses would agree that is not feasible, and they would not think it is good care. The example of Bob is exemplary for all frictions and dilemmas we have seen. They are not the same, but they share that good care could be established, but is not, as the changes in the practice through the technology, are not in favor of the patients. Moreover, for all of them counts that outcomes are not discussed.

In the introduction we discussed how good care is established as it is being carried out. Conditional for good care is the intention, as care professionals strive for good care, as we saw when observing the case managers. When the telecare case manager on duty redirects a patient with queries about medication to his regular case manager, it is not because the case manager does not want to help. It is because she thinks she might not be the best person to answer these questions. Instead, she offers him contact and the opportunity to talk about other things, to give something extra to his day. She strives for good care, but it becomes a friction when the patient needs something else. Or when the dynamics of the telecare team, with an occupancy of two different case managers a day, creates too many differences.

In our examples the frictions are not discussed between either case managers and patients, nor between case managers. It is difficult to discuss what the 'bad' of care is [26], but not discussing it at all, risks aggravation of frictions. Just because the 'good' in care is not uniform (as we not share all our ideas, convictions, passions, experiences or desires), it is important to discuss what patients need when striving for the good [23]. To reestablish good care when the circumstances change, patients, professionals (by themselves and together) and society at large have to think and talk about, strive for, and provide the good of care while trying to limit the bad.

The different dilemmas and frictions on good telecare we have seen, all relate to an overall dilemma in mental health care: how does the policy of reinforcing self-reliant patients relate to 24/7 care? The webcam reinforces the dilemma as it enhances the accessibility of care. With the webcam come all new forms of the same dilemma to the front, leading to frictions on good care. It is difficult to recognize changes in good care in the changed care practice of telecare. In what way does this new practice contributes to what patients need and want?

Good care is complex, as it consists of various goods [26] that rely on each other or are at least bound to each other. As good care is situational and established when enacted, it is also subject to some consensus, and so it might be best to be discussed often. Following the ideas on the importance of discussing ethical issues [35] and alongside the continuing development of empirical ethics [36], we would encourage professionals to deliberate on the care they give. Case

managers should look for complex examples, confer on the frictions, dilemmas and issues. In discussion the subject could be that following up on missed calls might turn out to be one of the goods of care. Or not. If it turns out not to help make care good, then it might as well be skipped. Case managers can also discuss if any boundaries for social talk are necessary. And for whom they are important. Taking into account the workload of most care professionals, we want to stress that discussing good care can be done in workable solutions, fitting the case managers' daily routines (think of phone calls, team meetings, forums, coffee breaks, corridor chats and lunches) and deliberate on the care given in daily telecare practices. The aim is to strive to uncover the (potential) frictions, in order to give good care. Exchange and discussion between care professionals, derived from their understandings with patients, will lead to applied knowledge, or even better, artisanal knowledge of good care.

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REFERENCES

[1] A. van Hout, R. Janssen, and M. Hettinga "Performing Telecare: Recognizing New Nursing Care Practices," Proc. eTELEMED 2016, Feb. 2016, pp. 247-251.

[2] L. van der Krieke, L. Wunderink, A.C. Emerencia, P. de Jonge, and S. Sytema, "E-mental health self-management for psychotic disorders: state of the art and future perspectives," Psychiatric Services. 2014 1:33-49.

[3] S. Lal and C. Adair, "E-Mental Health: A Rapid Review of the Literature," Psychiatric Services. 2014 1: 24-32.

[4] D. Ekers, R. Murphy, J. Archer, C. Ebenezer, D. Kemp, and S. Gilbody, "Nurse-delivered collaborative care for depression and long-term physical conditions: A systematic review and meta-analysis," Journal of Affective Disorders. 2013 149: 14–22.

[5] G. Clarke and B. Yarborough, "Evaluating the promise of health IT to enhance/expand the reach of mental health services," General Hospital Psychiatry. 2013 35: 339–344.

[6] F. A. Moreno, J. Chong, J. Dumbauld, M. Humke, and S. Byreddy, "Use of StandardWebcam and Internet Equipment for Telepsychiatry Treatment of Depression Among Underserved Hispanics," Psychiatric Services. 2012 12: 1213-1217.

[7] GGZ Nederland (Dutch Association of Mental Health and Addiction Care), "Een analyse van de verwachte kosten en baten van eHealth. Blended behandelen en begeleiden (An analysis of expected costs and profits of eHealth. Blended therapy)," Amersfoort. 2013.

[8] F. Garcia-Lizana and I. Munoz-Mayorga, "What about telepsychiatry? A systematic review," Prim Care Companion J Clin Psychiatry 2010: DOI 10.4088/PCC.09m00831whi.

[9] B. Lindberg, C. Nilsso, D. Zotterman. S. Söderberg, and L. Skär, "Using information and communication technology in home care for communication between patients, family members and healthcare professionals: a systematic review," International Journal of Telemedicine and Applications. 2013: DOI 10.1155/2013/461829.

[10] L. Barnes and T. Rudge, "Virtual reality or real virtuality: the space of flows and nursing practice," Nursing Inquiry.2005 12: 306-315.

[11] K. England and I. Dyck, "Managing the body work of home care," Sociology of Health and Illness. 2011 33: 206-219.

[12] B. Latour, Science in Action. Cambridge (MS): Harvard University Press, 1987.

[13] J. Law, "Actor-network theory and material semiotics," In: The New Blackwell Companion to Social Theory. BS Turner Ed. Oxford 2009: Blackwell, 141-158.

[14] M. Akrich, " The De-Scription of technical objects," in Shaping technology/building society. Studies in sociotechnical change. W.E. Bijker and J. Law, Eds. Cambridge (MS), London (GB) 1992: The MIT Press, 225-258.

[15] B. Latour, "Where are the missing masses? The sociology of a few mundane artefacts," in Shaping technology / building society. Studies in sociotechnical change. W.E. Bijker and J. Law, Eds. Cambridge (MS), London (GB) 1992: The MIT Press, 225-258.

[16] M. Winance, "Trying out the wheelchair: The mutual shaping of people and devices through adjustment," Science, Technology, & Human Values. 2006 31: 52-72.

[17] J. Pols, Care at a Distance: On the Closeness of Technology. Amsterdam, The Netherlands: Amsterdam University Press, 2012.

[18] I. Kamphof, "A Modest Art: Securing Privacy in Technologically Mediated Homecare," Foundations of Science. 2015: DOI 10.1007/s10699-015-9448-5.

[19] J. Pols, "How to Make Your Relationship Work? Aesthetic Relations with Technology," Foundations of Science. 2015: DOI 10.1007/s10699-015-9449-4.

[20] J. Pols and I. Moser, "Cold technologies versus warm care? On affective and social relations with and through care technologies," ALTER, European Journal of Disability Research. 2009 3: 159-178.

[21] I. Moser and J. Law, "Good passages, bad passages," in Actor Network Theory and After. J. Law and J. Hassard Eds. Oxford. 1999: Blackwell Publishers, 196-219.

[22] A. van Hout, J. Pols, and D. Willems, "Shining trinkets and unkempt gardens: on the materiality of care," Sociology of Health & Illness. 2015: 1-12.

[23] A. Mol, The logic of care. London: Routledge, 2008.

[24] J. Pols, "Washing the citizen: washing, cleanliness and citizenship in mentalhealth care," Culture, Medicine & Psychiatry. 2006 1: 77-104.

[25] J. Pols, "Chapter 7: Conclusion: Enacting improvement," in Good care. Enacting a complex ideal in long-term psychiatry. Utrecht 2004: Trimbos-reeks, 149-55.

[26] A. Mol, "Care and its values. Good food in the nursing home," in Care in Practice. On tinkering in clinics, homes and farms. A. Mol, I. Moser and J. Pols Eds. Bielefeld. 2010: Transcript Verlag, 215-34.

[27] J.R. van Veldhuizen and M. Bähler, "Manual Flexible Assertive Community Treatment," Groningen, 2013.

[28] T. Scheffer, "Event and Process: An Exercise in Analytical Ethnography," Human Studies. 2007 30:167–197.

[29] J. Law, "Seeing like a Survey," Cultural Sociology. 2009 2: 239-256.

[30] S. Hirschauer, "Putting Things into Words. Ethnographic Description and the Silence of the Social," Human Studies. 2006 29-4:413-441.

[31] A. Mol, "Missing Links, Making Links. The Performance of some Atherosclerosis," in Differences in Medicine: Unraveling Practices, Techniques and Bodies. M. Berg and A. Mol Eds. Durham, London. 1998: Duke University Press, 144-65.

[32] J. de Lange, "Vergeten in het verpleeghuis (Forgotten in the Nursing Home)," Utrecht. 1990: Trimbos-instituut.

[33] Central Committee on Research Involving Human Subjects, "Your research: does it fall under the WMO?," Available from: http://www.ccmo.nl/en/your-research-does-it-fall-under-the-wmo.

[34] H. Boeije, Analysis in qualitative research. London: Sage, 2010.

[35] T. Abma, B. Molenwijk, and G. Widdershoven, "Good Care in Ongoing Dialogue. Improving the Quality of Care Through Moral Deliberation and Responsive Evaluation," Health Care Analysis. 2009 17: 217-235.

[36] D. Willems, "Varieties of goodness in high-tech home care," in Care in practice. On tinkering in clinics, homes and farms. A. Mol, I. Moser and J. Pols Eds. Bielefeld 2010: Transcript Verlag 257-277.