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PARTICIPATION FOR INDIVIDUALS WITH A SEVERE MENTAL ILLNESS: CAN SUPPORT THEREIN BE ACTUALLY SUPPORTIVE?

A qualitative study into the supportiveness of traditional and socially innovative measures aimed at stimulating participation

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Summary

The aim of this research is to determine the supportiveness of socially innovative and traditional approaches focused on (the progression towards) participation of individuals with a severe mental illness (SMI) in Amsterdam. A cross-sectional research design has been employed, as part of which interviews were conducted with both counselors and clients of these initiatives. It can be concluded that the supportiveness of the initiatives does not differ between traditional and socially innovative approaches as initiatives of both approaches are considered supportive by counselors and clients, with the most important determinant of this supportiveness being the degree of person-centeredness maintained within the initiatives. There are however considerable barriers to achieving the participation of individuals with a SMI, the most prominent being the SMI and the consequent issues arising from it. Relief from these barriers can however be found in the possibilities which participation provides, as coping is widely present among individuals with a SMI and once clients are participating they come to see the value of it. Limitations of the research are insufficient interviews with clients from a day center and the incomplete standardization of the interviews. It is recommended that further research be conducted into processes occurring before individuals with an SMI receive support for their participation. An additional practical recommendation is that person-centeredness should permeate into all facets of society.

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1. Introduction

Recently, participation has been receiving an impetus in Dutch society. Participation is "the fulfillment of social and societal roles, with or without support, in a for the individual useful manner" (Nivel, 2005, p. 5) within areas such as education, employment, social participation, functioning in social relations and recreation (Nivel, 2005). This shift towards a participation society is part of a wider movement in which the character of the welfare state is being transformed. Welfare states saw the urgency of becoming more entrepreneurial, while simultaneously having to reduce the size of government to be able to compete with other states, as a result of globalization (Osborne & Gaebler, 1992; Marsland, 1996). To tackle these issues, national governments have resorted to three distinctive strategies: privatization of government services, strengthening of civil society (meaning society and the citizens living in it) and decentralization (EC, 2004; Van Ewijk, 2006). These strategies can be seen as part of social innovation, which entails "innovation in meeting social needs of, or delivering social benefits to communities – the creation of new products, services, organizational structures or activities that are 'better' or 'more effective' than traditional public sector, philanthropic or market-reliant approaches in responding to social exclusion" (Moulaert, MacCallum, Mehmood & Hamdouch, 2013, p. 1). Social innovations are comprised of three features: fulfillment of needs, transformation of social relations and empowerment or political mobilization (Moulaert et al., 2013). However, competing conceptualizations of social innovations have also been brought forward, but for the sake of clarity the previous definition will be maintained (Rüede & Lurtz, 2012; Moulaert et al., 2013; Cajaiba-Santana, 2014). Concurrently occurring with the move towards a participation society is the "socialization of care". This entails that individuals with a disability are to become integral parts of society by enabling them to live independently and participate within society, they are to become part of the "normal" majority (Koops & Kwekkeboom, 2005; Verplanke et al., 2008; Marks, 1997). Consequently, care is increasingly taking place within the environment of individuals with a disability where their needs are leading (Penninx, 2005).

These two parallel developments, meaning the move towards a participation society and the "socialization of care", are particularly important in light of the purpose

of this research. Policy goals such as participation and activation on the labor market are focal points in Dutch social policy (OECD, 2007). However, the most vulnerable groups in society tend to benefit the least from activating policies (Van Hal, 2013) which makes it worthwhile to gain more insight into the process towards it. Individuals with a severe mental illness (SMI) is the vulnerable group which this research focuses on. Individuals with a SMI require long-term care and experience issues on a variety of social domains (EPA, n.d.). The participation of individuals with a SMI is not optimal on a variety of participation domains. In a panel study conducted in 2010 by the Netherlands Institute of Mental Health and Addiction, 17% had paid employment, as opposed to 67% in the general population. About 30% does not have structural day activities which may involve paid employment, volunteer work or education. Additionally, the majority of the panel members rarely to never has contact with family and neighbors, whereas one in six rarely to never has contact with friends (Overweg & Michon, 2012).

Thus, a transformation within the Netherlands has been set in motion, which is a longstanding process in which all involved organizations and persons have to adjust to a new culture and content in which they have to operate (Transitiebureau, 2012). What remains unclear is how this transformation is and will be given shape on the local level. It is therefore important to have knowledge of their consequences and what they might mean for stimulating participation and also for the value of the concept of social innovation. To contribute to the available knowledge, this research will look at various expressions of traditional, philanthropic and public sector approaches in relation to more socially innovative approaches towards stimulating the participation of individuals with a SMI. This research is located at the intersection between the transition and transformation that are taking place within the Netherlands in that it will look at institutionalized approaches towards stimulating societal participation and at community-based approaches. To the best of the researcher's knowledge, no research has compared these different approaches. Additionally, the scientific literature specifically focuses on the movement of individuals with a disability towards "regular" employment, it might however be that this is not feasible for everyone and therefore it is wise to have more research focusing on other domains of participation.

To guide this study, it is structured as follows. First, a theoretical exploration will be conducted. Second, the research design will be set out. Third, the results of the empirical research will be described and elaborated upon on the basis of the three sub-questions. Fourth, conclusions will be drawn on the basis of the conducted research.

2. Theoretical exploration

2.1. Participation

Participation is an important goal of the rehabilitation of individuals with a SMI (Brown et al., 2004). Participation can encompass a wide variety of social life domains. The social life domains of interest for this research are "domestic life", "interpersonal life (including formal relationships and informal social relationships, family relationships, and intimate relationships)", "education (informal, vocational training, and higher education) and employment (with and without payment, excluding domestic work)" and "community, civic and social life (including religion, politics, recreation and leisure" (Dalemans, De Witte, Wade, Van den Heuvel, 2008, p. 1073). However, taking the perspective of individuals with a disability, it becomes clear that participation can entail a variety of values for a variety of individuals and not necessarily a range of activities. Values which came to the fore are being actively involved in something worthwhile and a sense of belonging, having a choice and being able to exert control, being able and having the right to take part in something, responsibilities of an individual towards his- or herself and towards society, being able to make a difference and being able to offer support to others and connection with others, being included in society and being a member of something. Additionally, respect and dignity were also indispensable for participation (Hammel et al., 2008). It is thus important to take a broad approach towards participation.

Participation and the stimulation towards it can initially occur within mental health care. Exemplary approaches are individual track support (ITS), which focuses on helping individuals with a SMI find and maintain employment, and the individual-demand oriented approach (IDA), which focuses on unpaid activities which ultimately should help long-term unemployed individuals in finding employment. Within ITS the client remains central and the necessary provisions are secured in the personal environment of the client. ITS involves the determination of goals, ensuring that a client is

able and motivated to participate, enabling education, training, gaining work experience and placement at a job with continuous support of the counselor. IDA involves the determination of the extent of, reasons for, and possibilities of participation, assessment and a consequent track plan, mediation between client and supplier of activities, stimulating active contribution, providing support and helping to develop the clients' control and self-sufficiency. Another approach is Individual Placement and Support (IPS) which entails that after an employment profile and employment plan are developed, the search for employment starts as soon as possible. Intensive support, for both client and employer and encompassing the clients' social network and social and physical work environment, are provided at the clients' workplace (Verschelling-Hartog, 2009). The role of counselors and their (educational) background are at play also in that peer support is considered to establish a reciprocal relationship, whereas "expert worker support" is considered to establish a less symmetrical relationship of a "giver" and "receiver" of care (Repper & Carter, 2011).

Clubhouses, which are more community-based, involve clients whom are members over the course of their lifetime and are actively involved in decisions made concerning the program and their individual treatment. Internal work opportunities and transitional employment are provided (Burt, Duke & Hargreaves, 1998). Day centers can be a meeting place where people socialize with each other and play games, they can provide a variety of productive activities such as doing maintenance and crafts, or they can be a combination of both (Tjörnstrand, Bejerholm & Eklund, 2011).

Participation can also be given shape in new and (socially) innovative ways. The newly introduced local and contextual approach towards social services provision (Van Ewijk, 2006) can be given shape through social innovation, particularly for individuals with a SMI. To reconcile the different views (Rüede & Lurtz, 2012; Moulaert et al., 2013; Cajaiba-Santana, 2014) on what constitute social innovations, Rüede & Lurtz (2012, pp. 10-22) have distinguished seven components of social innovation, of which these five will be focused upon: (1) "to do something good in or for society", (2) "to change social practices or social structure", (3) "to contribute to urban and community development", (4) "to reorganize work processes", (5) "to make changes in the area of social work". Social innovations can also be social enterprises (Carajba-Santana, 2014).

Social enterprises have between a quarter and half of their workforce consist of individuals with a disability, necessary support to employees is provided, are commercially viable, and workers' participation ranges from full ownership to basic workplace participation (Grove, 1999; Warner & Mandiberg, 2006; Aldridge, 2000, as cited in Paluch, Fossey & Harvey, 2012).

2.2. Important support-related factors

Social innovation can be a means through which individuals with a SMI are empowered as it allows them to change from a position of being excluded, directed into by their SMI limiting their functioning in society, to a position of being empowered (Moulaert et al., 2013; Sendi, 2014). Empowerment can be defined as "a process by which people, organizations and communities gain mastery over issues of concern to them" (Zimmerman, 1995, p. 581). Empowerment is also a particularly important outcome for successful rehabilitation (Frain, Bishop & Tschopp, 2009). However, in order for individuals with a SMI to be rehabilitated, individuals have to be engaged in efforts aimed at facilitating that. The focus in this research lies on participation as a goal of rehabilitation. It is important to distinguish between recovery and rehabilitation: "recovery is the process that the consumer-survivor undergoes, and rehabilitation is the process that practitioners use to facilitate recovery" (Farkas, 1996, p. 6). In mental health care, the working alliance and patient-centeredness are important for engagement with a recovery-oriented perspective of individuals with a SMI in treatment (Dixon, Holoshitz & Nossel, 2016). Thus, it can be said that to facilitate participation of individuals with a SMI as a goal of rehabilitation a recovery-oriented approach will be beneficial. As the working alliance and patient-centeredness are important for engagement in recovery-oriented approaches and achieving the recovery of individuals with a SMI, these concepts will be applied to initiatives stimulating (the progression towards) participation for individuals with a SMI. The term working alliance describes the "trusting, collaborative relationship" that can exist between a counselor and client in psychiatric and vocational rehabilitation, and is important for certain outcomes in psychiatric rehabilitation (Martin, Garske & Davis, 2000; McCabe & Priebe, 2004; Kukla & Bond, 2009). According to Bordin (1979) this working alliance comprises three components: goals of the patient and agreement thereon with the professional, tasks of the patient and the professional, and bonds existing between patient and professional. Clients with

schizophrenia were employed longer when supported by case managers having higher expectations of them (O'Connell & Stein, 2011). Successful employment specialists successfully manage to advocate for their clients and keep sight of the recovery of their clients, and achieve a strong working alliance (Glover & Frounfelker, 2011a). Regarding the manner of providing services, successful employment specialists worked efficiently, achieved equality with clients and worked well together with their clients (Glover & Frounfelker, 2011b).

The degree of empowerment of the client is considerably affected by the attitude of the professional (Kendall, Buys & Larner, 2000). Views of professionals about their clients are important for the extent of needs fulfillment of clients as these views determine the leading principles in professionals' service provision to clients (Nelson et al., 2002). A distinction can be made between paternalism and maternalism, which have a prescriptive nature, and are contrary to autonomy and empowerment (Hawks, 1997; Taylor, Pickens & Geden, 1989; Taylor, 1995, as cited in Sandström, Lundborg, Axelsson & Holmström, 2007), and patient-centeredness, which makes the client an active participant in improving his or her wellbeing, in addition to the professional (Berwick, 2005; Coulter, 1999; Morath, 2003, as cited in Sandström et al., 2007). Patient-centered care within mental health care can be defined as "a comprehensive approach to understanding and responding to each individual and their family in the context of their history, needs, strengths, recovery hopes and dreams, culture and spirituality… assessments, recovery plans, services and supports, and quality of life outcomes are all tailored to respect the unique preferences, strengths, vulnerabilities (including trauma history) and dignity of each whole person" (Adams & Grieder, 2014, pp. 5-6). Shared decision-making can be seen as aiming towards incorporating this patient-centeredness in the field of mental health care in order to empower individuals with a SMI (De Las Cuevas & Peñate, 2014). Person-centered engagement for men facing housing instability and a SMI involved: empowerment and autonomy, empathy, compassion and sincerity, dignity and respect, and tailored and holistic life plans tailored to their circumstances and the changing thereof (Guilcher et al., 2016).

2.3. Barriers and possibilities

Barriers to employment which have been identified among individuals with a SMI are a lack of control of symptoms, not partaking in supported employment and a lack of control of general medical issues (Milfort, Bond, McGurk & Drake, 2015). Another prevalent barrier is the stigma attached to individuals with a SMI. Stigma may affect them by limiting their opportunities as a result of structural/institutional mechanisms and legal restrictions, they may be discriminated against and their awareness of the present stigma might result in them regarding themselves differently (Link & Phelan, 2001). In an evaluation of ITS, it was found that mental health care has to be more involved. Participants contribute by not always continuing the support after employment was found because they feel that the support is no longer necessary. If participants had negative experiences, support was discontinued altogether (Dankers & Wilken, 2007). IDA has been implemented in the context of Supported Employment, there are however no effect studies available (Duijvestijn, 2012). Day centers were found to make individuals with a SMI feel disconnected from society (Bryant, Craik & McKay, 2004). Barriers to the supportiveness of clubhouses are the inability to provide onsite psychiatric services and promoting service dependence (Raeburn, Halcomb, Walter & Cleary, 2013). In an evaluation of a participatory return to work program, barriers for professionals were time limitations, lack of employment opportunities and type of (experienced) health issues (Lammerts, Schaafsma, Van Mechelen & Anema, 2016).

Participation within society can offer many possibilities to individuals with a SMI. Work status, adjustment to disability, functional ability and quality of life are important outcomes (Frain et al., 2009). For individuals with a SMI, important factors contributing to their recovery are work, employment, engagement and meaningful roles. IPS has shown its effectiveness in improving chances of employment for individuals with a severe SMI (Michon et al., 2014). Additionally, participation in IPS programs or participation in education have been associated with increased self-esteem, relieving of psychiatric symptoms, decrease in dependency and preventing a relapse (Kehyayan, Hirdes & Perlman, 2014). Learning, whether it be practical and social skills or ways to recover, is important for the recovery of individuals with a SMI, as are social relations and their willpower to achieve recovery (Petersen et al., 2015). Day centers were shown to provide structure and offer a supportive social environment (Bryant, Craik & McKay,

2004). Social enterprises, in turn, provide possibilities through decreased use of mental healthcare services and medication, decreasing social isolation and increased confidence and motivation (McKeown et al., 1992, as cited in Svanberg, Gumley & Wilson, 2010). Clubhouses offer possibilities such as being in a safe environment, supportive relationships and opportunities of engaging in supported employment (Raeburn et al., 2013). Professionals can support themselves as well to better support clients: successful employment specialists were well-equipped to deal with people, manage time, network with others and work together with others (Glover & Frounfelker, 2011a). The theoretical framework is depicted in figure 1.

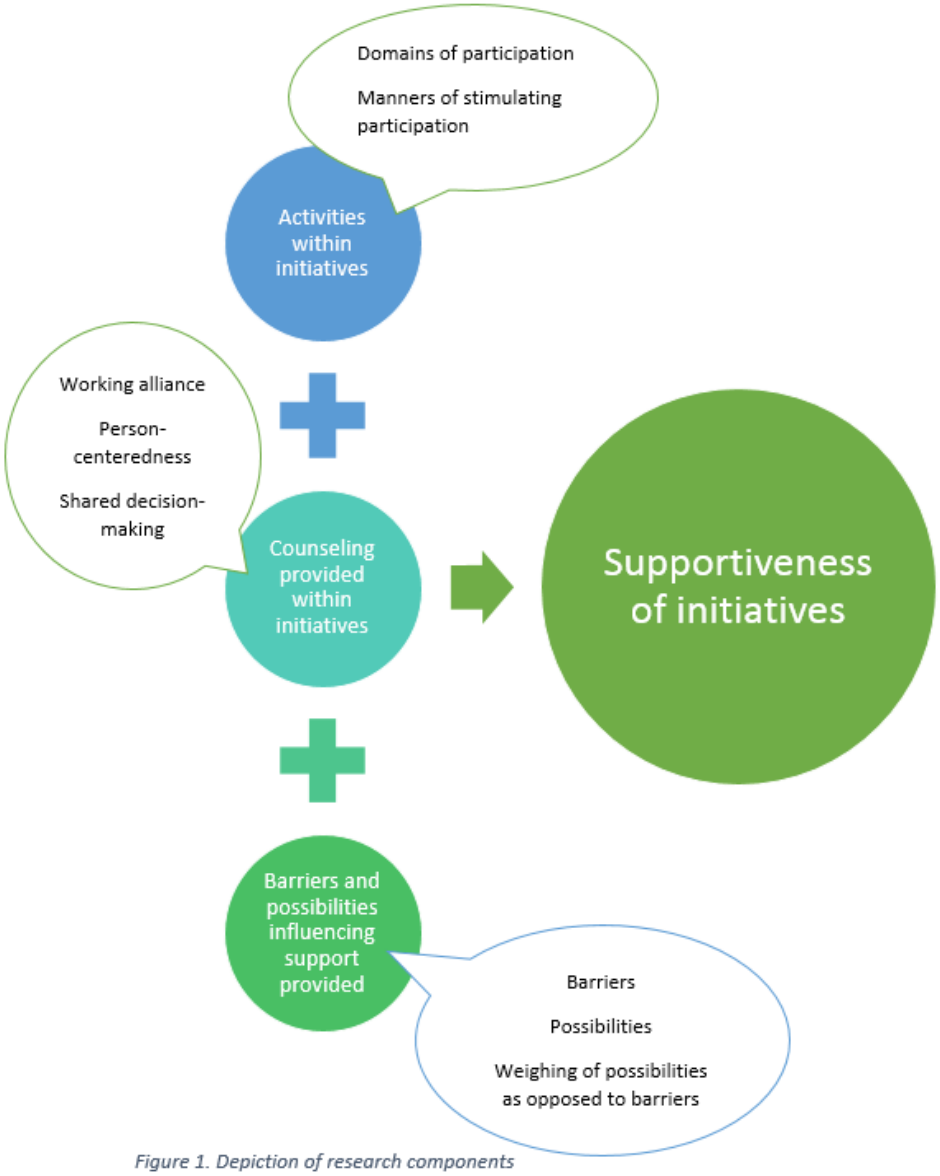

Figure 1. Depiction of research components

2.4. Research question

The main research question is "To what extent are socially innovative on the one hand and traditional, public sector and market-reliant approaches on the other hand which are aimed at stimulating societal participation among individuals with a SMI supportive for these individuals in Amsterdam?". Consequently, the following sub-questions were formulated:

1. How does the support provided to individuals with a SMI differ between socially innovative and traditional, public sector and market-reliant approaches which are aimed at stimulating societal participation of these individuals?
2. Which support-related factors are important to individuals with a SMI for them to be supported within socially innovative and traditional, public sector and market-reliant approaches to participate within society?
3. To what extent do individuals with a SMI experience barriers and possibilities within socially innovative and traditional, public sector and market-reliant approaches which influence the extent to which use can be made of the support provided by these approaches?

3. Research design

3.1. Population

Initiatives aimed at stimulating the societal participation of individuals with a SMI are divided into two sub-groups: the traditional, public sector and philanthropic initiatives and the socially innovative (SI) initiatives. To allow an equal comparison, the amount of respondents and the amount of initiatives being part of the research was balanced. The components of social innovation defined by Rüede & Lurtz (2015) served as the guideline for determining the initiatives in each of the two subgroups while making use of the theory and the internet, where the SI initiatives had to incorporate minimally two of these components and the traditional initiatives one or less. To provide a holistic perspective of participation initiatives, a total of six initiatives, identified in cooperation with the internship provider and through searching the internet, were focused upon: a day center, a clubhouse, a social enterprise, two initiatives within the context of general mental healthcare and a community-based initiative. Counselors were approached directly via e-mail and telephone, and the selection of clients was determined by

counselors, as they know who can answer questions, or clients were approached personally. Of each of the approaches, one or two counselors who directly provide support to individuals with a SMI were interviewed. One or two individuals with a SMI whom are participating in the initiatives have also been interviewed. IPS is an exception as it was impossible to interview clients due to the undesired additional pressure for clients. For both groups of respondents there is a wide variety in gender and age groups, and in the extent to which the clients were in recovery.

	Traditional	**Socially innovative**
Actual participation	Day center (A)	Clubhouse (B)
		Social enterprise (C)
Progression towards participation	Individual track support (D1)	Community-based initiative (E)
	Individual Placement and Support (D2)	

Table 1. Types of initiatives

3.2. Methodology

The research has been carried out through the use of a cross-sectional research design, which collects data at one point in time (Babbie, 2010). This design has been chosen as the purpose of the research is not to measure the supportiveness of participation measures over time, but to measure the supportiveness of these measures while individuals with a SMI are making use of these measures. Interviews were chosen as the aim is to discover what is important for enabling people with a SMI to participate (in society). The interviews are semi-structured (Robson, 2002) to allow the respondents to have sufficient space to provide their personal input, and as there is limited research available on the role of support in stimulating the societal participation of individuals with a SMI.

The theoretical concepts have been integrated to achieve a composite measure of supportiveness. Due to the limited research on this topic, the interview questions have been formulated on the basis of the theoretical exploration and have been adjusted to reflect the particular purpose of the research. The interview protocol is generally the same for both the counselors and the individuals with a SMI, but it has

been adjusted to reflect the knowledge of the person being interviewed to ensure that the respondent could answer the questions. In advance to the interviews, the interview strategy and protocols have been assessed on their validity and reliability by a fellow researcher due to it being uncertain whether a sufficient amount of respondents could be interviewed and respondents being both vulnerable and busy. Respondents varying in gender and age group were interviewed to achieve a certain degree of external validity, despite being bound by the initiatives which could be studied and the uncertainty of finding a sufficient amount of respondents. To clarify certain topics and increase content validity (Dooley, 2009), questions and components for a particular topic were specified based on the theory. It was also asked whether respondents had any additions after the pre-determined questions were posed, and the interview protocol was let go of to the extent that the answers applied to the subject of the research, to increase content validity. During the interview reliability was strengthened by limiting the interviews to one respondent being interviewed simultaneously, and the researcher providing a summary of what the respondents stated and asking for confirmation.

A total of twenty-one interviews, including an expert, were conducted in Dutch and lasted between ten minutes and one and a half hours due to the varying reflective abilities of the respondents. Interviews were held at the location where the client participates or is stimulated to participate, and for counselors and the expert at their workplace. This was done to not inconvenience the counselors and to see the circumstances in which clients are supported. The interviews were recorded, and afterwards transcribed by an external party.

3.3. Conceptualization and operationalization

The concept of supportiveness of approaches towards stimulating the societal participation of individuals with a SMI has three dimensions. The first dimension is the types of approaches towards stimulating the participation of individuals with a SMI. The indicators for this dimension are the areas of participation in which support is offered to individuals with a SMI and the activities which are undertaken to stimulate the participation of individuals with a SMI. The indicator of areas of participation is measured by one open-ended question which asked the respondent to indicate in which areas

they are supported. The indicator of activities of participation is measured by one open-ended question which asked the respondents to indicate in which ways they are supported (clients) or support clients (counselors). The respondents were also asked in another question to indicate what their opinion is on what can be done to support individuals with a SMI to participate.

The second dimension is the internal stimulation of societal participation of individuals with a SMI. The indicators for this dimension are the working alliance and person-centeredness. As both these indicators consist of several aspects, the decision has been made to formulate the questions based on the attributes. The attributes of the indicator of working alliance are goals, tasks and bonds. For the attribute of goals, two open-ended questions were asked. The first question asked the respondent to indicate whether goals are being set with the client. The second question asked the client to indicate their opinion on the setting of goals, and the counselor was asked to indicate whether the setting of goals supports clients to participate. For the attribute of tasks, four open-ended questions were asked. The first question asked the respondents to indicate which tasks the counselor performs to support the client and consequently, the client was asked to indicate their opinion on this, and the counselor was asked to indicate whether the tasks they perform supports the client's participation. The second question asked the respondents to indicate how it was determined which tasks are being performed by the counselor and consequently, the client was asked to indicate their opinion on this, and the counselor was asked to indicate whether the determination of the tasks they perform supports the client's participation. The client was also asked to indicate which tasks they perform themselves to participate and consequently they were asked to indicate what their opinion was on this. For the attribute of bonds, four open-ended questions were asked. The clients were first asked to indicate how the relationship with counselors is and if necessary to describe the relationship in more detail, and consequently were asked to indicate their opinion on this. The counselors were first asked to indicate how they aim to build a relationship with their clients, and were asked to describe the relationship with their clients. Both clients and counselors were asked to indicate how successes and adversity of the client are dealt with. The attributes of the indicator of person-centeredness are content and approach. The indicator was measured by two open-ended questions for the counselors, and four

open-ended questions for the clients. The first question asked both types of respondents to indicate the extent to which they are central within the support offered. If necessary, the respondents were asked more detailed questions on certain content-related components of person-centeredness and consequently were asked to indicate their opinion on this. The second question asked both types of respondents to indicate the manner in which they are approached (clients) or approach clients (counselors). If necessary, the respondents were asked more detailed questions on certain components of the person-centered approach and consequently were asked to indicate their opinion on this. Lastly, the respondents were asked to indicate whether there are any other important factors for the stimulation of participation of individuals with a SMI.

The third dimension is external factors influencing the support for the stimulation towards societal participation of individuals with a SMI. The indicators of this dimension are barriers which are experienced by individuals with a SMI, the possibilities which are experienced by individuals with a SMI and the weighing of the possibilities as opposed to the barriers. The attributes for the barriers and possibilities indicators are environmental barriers/possibilities and personal barriers/possibilities. The indicator of barriers was measured by one open-ended question for the clients, and two open-ended questions for the counselors. The first question asked both types of respondents to indicate whether individuals with a SMI experience barriers which influence the support offered. The second question asked the counselors to indicate whether they themselves experience barriers which influence the support offered. The indicator of possibilities was measured by one open-ended question for the clients, and two open-ended questions for the counselors. The first question asked both types of respondents to indicate whether the support given offers individuals with a SMI possibilities to participate. The second question asked the counselors to indicate whether the support given offers themselves possibilities to support individuals with a SMI. The third question asked both types of respondents to indicate whether the possibilities of the support weigh up against the barriers for individuals with a SMI. The fourth question asked counselors to indicate whether the barriers weigh up against the possibilities for themselves. For clients, the attribute of the weighing of the possibilities as opposed to the barriers is the personal weighing. For the counselors, the attributes of the weighing of the possibilities as

opposed to the barriers are the personal weighing and the client's weighing. The exact wording of the questions can be found in Appendices 1 to 3.

3.4. Data analysis

The coding scheme was developed according to the research questions and the consequent interview questions posed to answer the research questions, and indirectly also through the consequent literature. Initially, the data were coded according to the interview questions for which they provided an answer. Categories were added if they provided new data applying to the purpose of the research. Consequently, the coding scheme was specified and adjusted on the basis of the data in order to better reflect it. The coding categories can be found in Appendix 4. Lastly, patterns were aimed to be detected on the basis of the coded data, and with assistance of the coding program NVivo (Robson, 2002). The analysis of the data has been done with the help of matrices in which the coded data was displayed according to the coding categories and the amount of data which has been coded within those categories. This allowed the analysis of the data to be done on a cross-case basis according to the type of approach (socially innovative or traditional). It allowed distinctions to be made between the two types of approaches in order to see what the similarities and differences are on the dimensions under study, and to determine what the most striking findings are which warrant further discussion. On the basis of these most striking discussions, conclusions were drawn in relation to the literature.

4. Results

4.1. Participation

For work-focused initiatives B and C, the manners in which support is offered relate more to gaining the necessary skills to be able to work. In these initiatives, work is a means through which an individual can develop him- or herself. Being included in society (Hammel et al., 2008) becomes particularly apparent within SI initiative B as one counselor notes that the ultimate goal is that clients can be part of society. A client of initiative B was enabled to offer support to others and connect with others (Hammel et al., 2008). Traditional initiative D2 is similar in that it also supports to gain the necessary skills on the job, but the counselor is not an employee just as the client and offers support on a more individual basis. Within traditional initiative A clients are actively

encouraged to do productive and creative activities to allow them to regain structure in their lives. Initiative A differs from SI initiatives B and C, and from traditional initiative D2 that clients are actively encouraged to participate by directing clients to activities, whereas in the three other initiatives participation is more on a voluntary basis as in SI initiatives B and C clients do not have to participate when they feel unwell, and in traditional initiative D2 clients have chosen to participate and are made aware that they have to actively contribute. Traditional initiative D1 focuses primarily on recreation and stimulates participation by remaining close to the wants and needs of the client. However, in the literature it was indicated that the focus within initiative D1 is work (Verschelling-Hartog, 2009) and although it can be, it is not the main goal. SI initiative E is an exception in that the domains of participation can be anything the client wants them to be, but it has in common with traditional initiative D1 that it remains close to the wants and needs of the client, as do all the other initiatives albeit to different degrees. Within traditional initiatives D and SI initiative E, much attention is paid to provide individuals with competences and tools to be able to participate: ensuring motivation, discovering necessary participation conditions and providing job application training for example, which are also described in the literature for all the initiatives except for initiative E (Verschelling-Hartog, 2009). Initiative B is exemplary of a clubhouse (Burt et al., 1998): membership lasts a lifetime, equality is central, internal work opportunities and transitional employment are offered. Initiative A offers both productive and creative activities (Tjörnstrand et al., 2011) to enable clients to lead structured lives, according to a counselor. Initiative C allows individuals with a SMI to work in a restaurant to prepare them for a job on the "regular" job market, while taking into account the clients' SMI allowing them to stay home when they have a bad day, in line with the literature (Grove, 1999; Warner & Mandiberg, 2006; Aldridge, 2000, as cited in Paluch et al., 2012). The domains of participation and the manners in which the participation on these domains is stimulated have no negative effect on the opinion on support in general, as both counselors and clients of the socially innovative and traditional initiatives are in general (very) positive about the support offered.

4.2. Important support-related factors

4.2.1. Working alliance

4.2.1.1. Goals

Goals, the first component of the working alliance (Bordin, 1979), for (the progression towards) participation are formally or informally set by every initiative. All clients, except for two who could not answer this question, are positive that goals are set, four clients directly indicated that they prefer to work goal-oriented. Counselors also see positive effects of the setting of goals. Goals are primarily determined by clients themselves, but also in cooperation with them. The primary concern of goal setting within the initiatives is that they correspond with the wants and needs of the clients, and this also involves making (the progression towards) participation manageable for the clients: small steps, small goals and taking the time to allow the client to participate at his/her own pace. A client from SI initiative B expressed this aptly:

´What I particularly like here is, most day activities initiatives offer [creative activities], and I can do more than that. And because you can do more than this here but do not have to, a lot more comes out of you and it is better also for your recovery because you let your brain work."

This quote shows that it is good to offer more participation activities on a voluntary basis, but it can lead to annoyance as another client of initiative B notes: ***"But there are also people who only come here to get things"***.

The previous quotes show that perhaps it is more about knowing that you can do something, rather than actually doing it which stimulates participation. A solution might be giving clients time to aim to progress towards participation, as endorsed by a counselor of SI initiative E.

4.2.1.2. Tasks

Both client and counselor perform tasks, the second component of the working alliance (Bordin, 1979). Clients are actively aiming towards participation and are actually participating. Some clients do more than others, but that also depends on the personal situation of a client. A client of traditional initiative A was just as satisfied with picking paper outside than the client who does activities ranging from vacuuming to conducting meetings with new members within SI initiative B. Two clients of traditional

initiatives D1 and SI initiative E think about and plan to participate but do not always manage to follow through on it. The client of initiative E does mention that she sometimes feels things are not moving fast enough, but in hindsight she says to herself that it is better to take things slow. This shows that it is important within similar initiatives to support clients to learn how to deal with their inherent hurdles to stimulate their participation, as factors in their personal situation hinder them in satisfyingly participating. One counselor of traditional initiative D1 might have a solution by encouraging clients to try participation activities a few times before they can determine whether it suits them or not.

Within SI initiative B both clients and counselors do the same tasks and these are determined in cooperation. This cooperating in the determination of tasks can also be seen in the other initiatives, but is not that apparent in SI initiative C. However, when clients of initiative C have a bad day, they are given the space to not come to work. A client of SI initiative B also touches upon this by indicating that when she has a good day she wants to get everything she can out of it. Clients are generally satisfied with the types of tasks done by counselors, and counselors, in turn, see positive effects for clients of the tasks they do.

4.2.1.3. Bonds

The bonds between counselors and clients, the third component of the working alliance (Bordin, 1979) can be generally characterized as good, and particularly as personal. Clients are thus satisfied with the relationships. The best relationship between counselor and client does not mean that those clients are most easily supported as a counselor of traditional initiative D2 states: ***"The person with whom I have the best click can have the most difficult work wish. And someone who may have everything in order, but who is more distant, that goes well in a completely different way. Both situations have something (positive aspects)"***. Clients share much with their counselors, and this is shown by the personal nature of the bonds. A counselor of traditional initiative D2 expressed the necessity of this personal bond in the following manner:

"That is necessary because otherwise I cannot determine with someone what he/she needs"

Counselors encourage this personal relationship by sharing their own personal experiences. They dedicate particular attention to careful development of bonds by keeping it light and positive and creating trust and clarity. Setbacks and successes of clients are mainly positively reinforced: successes are celebrated and complimented, and setbacks are heard and move on from.

4.2.2. Person-centeredness

One aspect of patient-centered care, or person-centeredness maintained here, which is unequivocally part of support provided to clients is the centrality of their wants and needs. Of interest here is that support is "tailored to respect the unique preferences, strengths, vulnerabilities and dignity of each whole person", as originated from the concept of patient-centered care (Adams & Grieder, 2014, pp. 5-6). Particularly within SI initiatives B, E and traditional initiatives D this is clearly seen. Within SI initiative B it even entails that no work from third parties will be done within the clubhouse because then the focus will be on the work that needs to get done, and it may result in a different treatment of clients. Incorporating clients' wishes is easier because clients are asked what they want to do within the clubhouse. Person-centeredness can be seen within SI initiative E by one counselor indicating that she aims to determine what a client needs to feel well, and within IPS it can be seen by counselors following the wishes of the client and not trying to say what a client can and cannot do regarding work.

Support can also be provided by not explicitly focusing on it, as evidenced by one counselor of initiative E:

"At the [activity related to initiative] we do not have the task of wanting or having to help people. Because we do not have that task, people can be themselves."

This implicit support is apparent in initiative B also, as clients are given the space to sit behind a computer and not contribute to the running of the clubhouse.

Clients are approached as an individual: a counselor within initiative D1 calls her clients after her workday to ask how their participation activity has been, for example. Within SI initiative B and traditional initiatives D, the autonomy of clients is stimulated by encouraging them to call or e-mail when they need support, or go to forms of participation by themselves. Clients are respectfully approached as well, and are

stimulated to be respectful of others as well, particularly in SI initiatives B and C. On the whole, clients are generally positive about the degree of person-centeredness.

4.2.3. Other important support-related factors

The supportiveness of the working alliance can also be influenced by other factors. One such factor is supportive relationships: it is important for finding and making use of work opportunities in traditional initiative D2, and for being able to be who you are within a community in SI initiatives B and E. Supportive relationships are conducive to recovery, and particularly within the clubhouse (Tanaka & Davidson, 2015), therefore they should be stimulated both within and outside the working alliance. A counselor of SI initiative E emphasized the importance of conveying to clients that there is hope for better times, and hope has also been found to be an essential component of recovery (Dunstan, Falconer & Price, 2017).

4.3. Barriers to and possibilities of participation

For five of ten clients the possibilities do outweigh the barriers which they experience within the support offered for (the progression towards) participation. It is found to be that clients learn to better cope with the barriers and do not let barriers overshadow the possibilities, and thus are able to see the possibilities irrespective of the barriers. There are however considerable barriers: six of ten clients experience considerable barriers which affect the provided support for their (progression towards) participation which primarily originate from their SMI and its consequent barriers in other areas of life such as a difficulty concentrating and not wanting or being able to be in the presence of people. A lack of control of symptoms (Milfort et al., 2015) as a barrier to participation was particularly apparent with a client of traditional initiative D1 who stated ***"I want a lot, only my thoughts do not allow it, (…) only you are being pushed back by your feelings"***. A lack of control of general medical issues (Milfort et al., 2015) has been found among two clients of SI initiative B and traditional initiative D1. Within initiative B two counselors noted that more individual support would be beneficial, as also indicated by Raeburn et al. (2013), but it was not specifically defined as a barrier. Stigma is a prevalent barrier in the literature (Link & Phelan, 2001), and three counselors of traditional initiatives D and a client of SI initiative B have noted this. However, open questions were posed so it might be that the other respondents did not immediately think of stigma or other barriers described in the literature as barriers. Other external barriers are bureaucracy, lack of

cooperation of external organizations with clients regarding participation efforts and budget cuts within general mental healthcare. Most of the possibilities for clients of the support are participation-related. The support also offers clients possibilities personally: they grow as a person, are proud of themselves and are distracted from their issues. Learning, whether it be practical and social skills or ways to recover, is important for individuals with a SMI to recover (Petersen et al., 2015) and takes place in almost every initiative: from the clubhouse where both practical and social skills are learned, to learning how to write a CV within IPS. Social relations and the willpower to achieve recovery are important also (Petersen et al., 2015), and the former is focused upon by counselors in SI initiatives B and C, while the latter is indirectly present in traditional initiative D2 by counselors encouraging the client to actively contribute towards participating.

For counselors the possibilities unanimously outweigh the barriers. Counselors experience considerably less barriers than clients. One prominent barrier for counselors is time, and to a lesser extent a lack of employment opportunities, which is in line with Lammerts et al. (2016). There are possibilities for the counselors as well: they see that as a result of the provided support that their clients can be better supported, for instance in the case of SI initiative C counselors can support clients in more advanced areas of his/her life because there is more space for these areas as the focus is not so much on the SMI. Networking with others (Glover & Frounfelker, 2011a) has been noted by a counselor of traditional initiative D2 as important for the success of the support which she can offer a client.

5. Conclusion

5.1. Discussion

The main research question, being *"To what extent are socially innovative on the one hand and traditional, public sector and market-reliant approaches on the other hand which are aimed at stimulating societal participation among individuals with a SMI supportive for these individuals in Amsterdam?"* can now be answered in reference to the theoretical framework. Both socially innovative and traditional, public sector and market-reliant approaches are supportive. The supportiveness does not differ between the initiatives focusing on actual participation or the progression towards participation,

despite their varying accents in the support which they provide. Both the traditional and socially innovative approaches provide support for both participation activities and give meaning to a person's life, as emphasized in the literature (Dalemans et al., 2008; Hammel et al., 2008). The manners of stimulating participation also differ between the two types of approaches concerning the actions of counselors, but they are similar in their focus on the empowerment of individuals with a SMI (Zimmerman, 1995). However, some counselors, such as of initiative A and D1 do accelerate the process towards participation, and indirectly also empowerment, by doing certain tasks for clients which they ideally would have done themselves when they deem it important for the clients' benefit.

The supportiveness of the two types of approaches is related to the counselor and the method he/she maintains to support clients, rather than whether the initiative can be characterized as socially innovative or traditional. The working alliance, described in the literature as the "trusting, collaborative relationship" between counselor and client (Martin et al., 2000; McCabe & Priebe, 2004; Kukla & Bond, 2009) is present and appreciated by clients and counselors, irrespective of the domains of participation and the manners in which participation is stimulated. A high degree of person-centeredness as defined in the literature (Adams & Grieder, 2014, pp. 5-6) is also present and appreciated in the provided support, and is most important in determining the supportiveness of participation initiatives, as adhering to the wants and needs of the client is omnipresent in the support provided within the participation initiatives, and clients are also positive about this person-centeredness. Initiatives B, C and E, in turn, also encourage clients to incorporate this person-centeredness in their interactions with others, by letting others be central as well, consequently preparing them for participation in society.

There are a wide range of barriers experienced by primarily clients, the most important one being the mental illness and the consequent issues arising from it. Possibilities of the provided support are experienced as well, primarily regarding involvement in forms of participation. However, for clients to see and make use of these possibilities, the SMI has to be under control to such an extent that it does not dominate a person's life and consequently affect the supportiveness of participation initiatives.

5.2. Limitations

A limitation of the research is that for the day center the respondents could not be sufficiently interviewed because of their limited recovery of their SMI and/or related issues. This could be mitigated by applying purposive sampling and not convenience sampling (Dooley, 2009), and more time could be devoted to selecting respondents by the researcher. Both were not possible as the respondents were approached out of a need by an external organization and it was deemed wise to follow the counselors in who is best to interview as the researcher lacked those insights. Another limitation of the research is that the interviews were not entirely standardized. This could be mitigated by conducting the interviews in similar environments and free from intrusion and would improve the reliability of the data collection process (Dooley, 2009). It was not possible to do this differently as it was deemed wise to not burden the respondents by interviewing them outside of a safe environment for the clients, and the work environment for counselors.

5.3. Recommendations

In order to contribute to the knowledge available regarding the (societal) participation of individuals with a SMI, more research could be devoted towards the processes which occur before these individuals receive support for their participation. If the aim is to ensure the participation of individuals with a SMI who can and want to participate, then the conditions determining whether they have access to these initiatives should work with them and not against them. What this research has shown is that counselors and clients are highly motivated. However, clients have difficulty receiving the necessary care as they experience poverty both regarding money and social exclusion, according to the expert. In addition, social innovation has permeated into institutionalized initiatives, although they remain bound by bureaucracy, thus hindering the completion of the transformation towards social innovation. Therefore, further research on social innovation can incorporate these initiatives, and devote attention to researching these hindrances and resolving them.

On the basis of this research, there are some practical applications which can be advised. From the research it can be concluded that within the initiatives counselors and clients are satisfied with what is being done. Thus, concerning what is currently

done within the initiatives under study, the recommendation is: Keep up the good work. However, perhaps not surprisingly, there are considerable external factors such as a high degree of bureaucracy and high work pressure of counselors which hinder the efforts spent on the support of individuals with a SMI, and which should be mitigated. The client should be central in allowing them to determine their extent of participation, and these factors hinder that. Some simply are not able to participate. And that should be sufficient.

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Appendices

Appendix 1. Interview protocol counselor

Interview begeleider

Ik wil u allereerst bedanken voor het feit dat u de tijd kon vinden voor dit interview. Het doel van het interview is om erachter te komen wat ondersteunend is in het vergroten van participatie. Het interview bestaat uit drie delen. Als eerste ga ik u vragen hoe u mensen met psychiatrische problematiek ondersteunt om mee te gaan doen (in de samenleving) of om (maatschappelijk) te gaan participeren zoals het ook wel wordt genoemd. Bij meedoen kunt u denken aan het hebben van contact met mensen, het hebben van werk, het hebben van een plek om te wonen, het volgen van een opleiding en het doen van activiteiten in vrije tijd. Hierop volgend gebruik ik meedoen (in de samenleving) in plaats van (maatschappelijke) participatie. Daarna wil ik graag wat vragen stellen over factoren die belangrijk zijn voor mensen met psychiatrische problematiek om zich gesteund te voelen om (maatschappelijk) te gaan participeren. Als laatste wil ik u graag vragen naar belemmeringen en mogelijkheden die u ziet van de ondersteuning naar (maatschappelijke) participatie van mensen met psychiatrische problematiek. Heeft u er bezwaar tegen als het interview wordt opgenomen? De antwoorden zullen anoniem worden behandeld. U kunt op elk moment stoppen met het interview mocht u dit nodig vinden. Heeft u voordat we beginnen nog vragen en/of opmerkingen? Mocht u tijdens het interview vragen hebben, dan kunt u die gewoon stellen.

A. Participatie

Vraag A1: Op welke gebieden biedt u mensen met psychiatrische problematiek ondersteuning om mee te gaan doen (in de samenleving)? Kan betrekking hebben op bijvoorbeeld:

a. Activiteiten
    i. Gezinsleven
    ii. Interpersoonlijk leven (formele en informele relaties, familie relaties en intieme relaties)
    iii. Opleiding (informele opleiding, beroepsopleiding, hbo, wo)

iv. Beroep (betaald en onbetaald)
v. Gemeenschap, burgerlijk en sociaal leven (godsdienst, politiek, recreatie/ontspanning en vrije tijd)

b. Zingeving/Waarden
i. Betrokkenheid,
ii. Thuishoren
iii. Keuzemogelijkheid
iv. Controle
v. (Kunnen en mogen) deelnemen
vi. Verantwoordelijkheid (voor hem- of haarzelf en tegenover maatschappij)
vii. Verschil maken
viii. Steun aan anderen
ix. Verbinding met anderen
x. Onderdeel uitmaken van
xi. Respect
xii. Waardigheid

Vraag A2: Op welke manieren ondersteunt u mensen met psychiatrische problematiek op de hiervoor genoemde gebieden?

a. Hoe bepaalt u in hoeverre de persoon die u ondersteunt kan meedoen (in de samenleving)?
b. Wat voor activiteiten doet u voor mensen met psychiatrische problematiek om hen te ondersteunen om mee te gaan doen (in de samenleving)?
c. Hoe ondersteunt u mensen met psychiatrische problematiek zodat zij actief werken aan hun meedoen (in de samenleving)?
d. Wat zijn voor u aandachtspunten binnen de ondersteuning naar het meedoen (in de samenleving) voor deze mensen?
e. Welke rol speelt uw (opleidings-)achtergrond in de ondersteuning die u mensen met psychiatrische problematiek biedt om hen te ondersteunen mee te doen (in de samenleving)?

Vraag A3: Wat vindt u van datgene wat u kunt doen om mensen met psychiatrische problematiek te ondersteunen om mee te gaan doen (in de samenleving)?

B. Manieren waarin participatie wordt ondersteund

Werk alliantie

I. Doelen

Vraag B1: Stelt u doelen samen met de mensen met psychiatrische problematiek die u ondersteunt?

a. Zo ja:
   - Waarom stelt u doelen?
   - Hoe worden deze doelen bepaald?
   - Probeert u ervoor te zorgen dat u en diegene die u ondersteunt hetzelfde doel of dezelfde doelen hebben? Waarom wel of waarom niet?

b. Zo nee:
   - Waarom stelt u geen doelen?
   - Heeft dit gevolgen voor de ondersteuning die u mensen met psychiatrische problematiek kunt geven? Zo ja: Welke gevolgen heeft dit?

Vraag B2: Ziet u dat dit mensen met psychiatrische problematiek ondersteunt om mee te gaan doen (in de samenleving)?

- Positief: Hoe merkt u dat? Kunt u voorbeelden noemen?
- Negatief: Waar denkt u dat het aan ligt? Wat zou beter kunnen?

II. Taken

Vraag B3: Welke taken neemt u op u om mensen met psychiatrische problematiek te ondersteunen om mee te doen (in de samenleving)?

Vraag B4: Ziet u dat dit mensen met psychiatrische problematiek ondersteunt om mee te doen (in de samenleving)?

- Positief: Hoe merkt u dat? Kunt u voorbeelden noemen?

- Negatief: Waar denkt u dat het aan ligt? Wat zou beter kunnen?

Vraag B5: Hoe worden deze taken bepaald?

Vraag B6: Ziet u dat dit mensen met psychiatrische problematiek ondersteunt om mee te doen (in de samenleving)?

- Positief: Hoe merkt u dat? Kunt u voorbeelden noemen?
- Negatief: Waar denkt u dat het aan ligt? Wat zou beter kunnen?

III. Banden

Vraag B7: Hoe probeert u een relatie op te bouwen met mensen met psychiatrische problematiek om hen te ondersteunen om mee te doen (in de samenleving)?

Vraag B8: Hoe gaat u om met tegenslagen die de personen met psychiatrische problematiek die u ondersteunt ervaren?

Vraag B9: Hoe gaat u om met successen die de personen met psychiatrische problematiek die u ondersteunt ervaren?

Vraag B10: Hoe zou u de relatie met de mensen met psychiatrische problematiek die u ondersteunt om mee te gaan doen (in de samenleving) over het algemeen beschrijven?

Persoon centraal

I. Inhoud

Vraag B11: In hoeverre stelt u de persoon die u ondersteunt centraal? Kunt u daarvan voorbeelden noemen?

- In hoeverre ondersteunt u de zelfstandigheid van mensen met psychiatrische problematiek te vergroten?
- In hoeverre ondersteunt u mensen met psychiatrische problematiek hun leven weer in eigen handen te nemen?

- In hoeverre houdt u rekening met de eerdere ervaringen van mensen met psychiatrische problematiek (inclusief trauma)?
- In hoeverre houdt u rekening met de behoeften van mensen met psychiatrische problematiek?
- In hoeverre houdt u rekening met de krachten van mensen met psychiatrische problematiek?
- In hoeverre houdt u rekening met de wensen van mensen met psychiatrische problematiek (wat betreft hun herstel)?
- In hoeverre houdt u rekening met het gedrag en normen en waarden (cultuur) van mensen met psychiatrische problematiek?
- In hoeverre houdt u rekening met spiritualiteit van mensen met psychiatrische problematiek?
- In hoeverre neemt u beslissingen binnen de ondersteuning samen met mensen met psychiatrische problematiek?

II. Benadering

Vraag B12: Hoe benadert u de personen die u ondersteunt? Kunt u voorbeelden noemen?

- Als iemand die zijn/haar leven in eigen handen mag nemen (autonomie)?
- Als iemand die zijn/haar leven in eigen handen kan nemen (empowerment)?
- Met begrip?
- Met medeleven?
- Met oprechtheid?
- Met waardigheid?
- Met respect?

Vraag B13: Zijn er nog andere dingen die belangrijk zijn om mensen met psychiatrische problematiek te ondersteunen om mee te doen (in de samenleving)?

C. Belemmeringen en mogelijkheden die ondersteuning naar participatie beïnvloeden

I. Belemmeringen

Vraag C1: Ervaren mensen met psychiatrische problematiek belemmeringen die van invloed zijn op de ondersteuning die u kunt bieden om hen te ondersteunen om mee te doen (in de samenleving)?

a. Zo ja:
   Wat voor belemmeringen ervaren mensen met psychiatrische problematiek die van invloed zijn op de ondersteuning die u kunt bieden om hen te ondersteunen om te participeren (in de samenleving)? Betrekking hebbende op:

1. Belemmeringen in omgeving
2. Persoonlijke belemmeringen (cliënt en begeleider)

a. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaren ze geen belemmeringen in de ondersteuning?

Vraag C2: Ervaart u zelf belemmeringen in de ondersteuning die u mensen met psychiatrische problematiek kunt bieden om hen te ondersteunen om mee te doen (in de samenleving)?

a. Zo ja:
   Wat voor belemmeringen ervaart u zelf in de ondersteuning die u mensen met psychiatrische problematiek kunt bieden om hen te ondersteunen mee te doen (in de samenleving)? Betrekking hebbende op:

1. Belemmeringen in omgeving
2. Persoonlijke belemmeringen (cliënt en begeleider)

b. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaart u geen belemmeringen in de ondersteuning?

II. Mogelijkheden

Vraag C3: Biedt de ondersteuning mensen met psychiatrische problematiek mogelijkheden om mee te doen (in de samenleving)?

a. Zo ja:
   Wat voor mogelijkheden biedt de ondersteuning mensen met psychiatrische problematiek om mee te doen (in de samenleving)?

1. Mogelijkheden in omgeving
2. Persoonlijke mogelijkheden (cliënt en begeleider)

a. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaren ze geen mogelijkheden van de ondersteuning?

Vraag C4: Biedt de ondersteuning die u mensen met psychiatrische problematiek geeft u zelf mogelijkheden om deze mensen te ondersteunen mee te doen (in de samenleving)?

a. Zo ja:
   Wat voor mogelijkheden biedt de ondersteuning die u mensen met psychiatrische problematiek geeft u zelf om deze mensen te helpen mee te doen (in de samenleving)?

1. Mogelijkheden in omgeving
2. Persoonlijke mogelijkheden (cliënt en begeleider)

b. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaren ze geen mogelijkheden van de ondersteuning?

Als er zowel mogelijkheden als belemmeringen benoemd zijn voor mensen met psychiatrische problematiek:

Vraag C5: Wegen de mogelijkheden van de ondersteuning voor mensen met psychiatrische problematiek op tegen de belemmeringen voor deze mensen om mee te doen (in de samenleving)?

Als er zowel mogelijkheden als belemmeringen benoemd zijn voor begeleider:

Vraag C6: Wegen de mogelijkheden van de ondersteuning die u mensen met psychiatrische problematiek biedt op tegen de belemmeringen voor u zelf om hen te ondersteunen om mee te doen (in de samenleving)?

Bedankt voor uw tijd! Wilt u dat ik u het uitgeschreven interview nog toestuur voordat ik het in mijn verslag gebruik? Wilt u het uiteindelijke verslag nog toegestuurd krijgen?

Appendix 2. Interview protocol client

Interview cliënt

Ik wil u allereerst bedanken voor het feit dat u de tijd kon vinden voor dit interview. Het doel van het interview is om erachter te komen wat ondersteunend is in het vergroten van jouw meedoen (in de samenleving). Het interview bestaat uit drie delen. Als eerste ga ik u vragen hoe u wordt begeleid om mee te doen (in de samenleving). Bij meedoen (in de samenleving) kunt u denken aan het hebben van contact met mensen, het hebben van werk, het hebben van een plek om te wonen, het volgen van een opleiding en het doen van activiteiten in uw vrije tijd. Daarna wil ik graag wat vragen stellen over dingen die belangrijk zijn voor u om zich gesteund te voelen om mee te gaan doen (in de samenleving). Als laatste wil ik u graag vragen naar belemmeringen en mogelijkheden die u ervaart van de ondersteuning naar meedoen (in de samenleving). Heeft u er bezwaar tegen als het interview wordt opgenomen? De antwoorden zullen anoniem worden behandeld. U kunt op elk moment stoppen met het interview mocht u dit nodig vinden. Heeft u voordat we beginnen nog vragen en/of opmerkingen? Mocht u tijdens het interview vragen hebben, dan kunt u die gewoon stellen.

A. Participatie

Vraag A1: Op welke gebieden krijgt u ondersteuning? Kan betrekking hebben op bijvoorbeeld:

c. Activiteiten
    vi. Gezinsleven

vii. Interpersoonlijk leven (formele en informele relaties, familie relaties en intieme relaties)
viii. Opleiding (informele opleiding, beroepsopleiding, hbo, wo)
ix. Beroep (betaald en onbetaald)
x. Gemeenschap, burgerlijk en sociaal leven (godsdienst, politiek, recreatie/ontspanning en vrije tijd)

d. Zingeving/Waarden
xiii. Betrokkenheid,
xiv. Thuishoren
xv. Keuzemogelijkheid
xvi. Controle
xvii. (Kunnen en mogen) deelnemen
xviii. Verantwoordelijkheid (voor hem- of haarzelf en tegenover maatschappij)
xix. Verschil maken
xx. Steun aan anderen
xxi. Verbinding met anderen
xxii. Onderdeel uitmaken van
xxiii. Respect
xxiv. Waardigheid

Vraag A2: Op welke manieren krijgt u ondersteuning op de hiervoor genoemde gebieden? (activiteiten)

a. Wat voor activiteiten worden er gedaan?
b. Hoe wordt ervoor gezorgd dat u actief meedoet?
c. Waar wordt veel aandacht aan besteed?

Vraag A3: Wat vindt u van datgene wat wordt gedaan om u te ondersteunen mee te gaan doen (in de samenleving)?

B. Manieren waarin participatie wordt ondersteund

Werk alliantie

IV. Doelen

Vraag B1: Heeft u doelen gesteld (met diegene die u ondersteunt) die u graag wilt bereiken?

a. Zo ja:
   - Wat zijn deze doelen?
   - Hoe worden deze doelen bepaald?
   - Heeft u het gevoel dat u en uw begeleider allebei hetzelfde doel of dezelfde doelen hebben? Waarom wel of waarom niet?

b. Zo nee:
   - Weet u waarom niet?
   - Heeft dit gevolgen voor de ondersteuning die u krijgt? Zo ja: Welke gevolgen heeft dit?

Vraag B2: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat? Kunt u voorbeelden noemen?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen? Wat zouden doelen moeten zijn naar uw mening?

V. Taken

Vraag B3: Welke taken neemt uw begeleider/nemen begeleiders op zich om u te ondersteunen mee te doen (in de samenleving)? (begeleiding)

Vraag B4: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen? Welke taken zou uw begeleider/zouden begeleiders op zich moeten nemen?

Vraag B5: Hoe worden deze taken bepaald?

Vraag B6: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?

- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen? Hoe zouden deze taken bepaald moeten worden?

Vraag B7: Welke taken neemt u zelf op u om mee te gaan doen (in de samenleving)?

Vraag B8: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen? Welke taken zou u op u moeten nemen?

VI. Banden

Vraag B9: Hoe is de relatie met uw begeleider?

Vraag B10: Kunt u de relatie beschrijven?

Vraag B11: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen? Hoe zou de relatie met uw begeleider moeten zijn?

Vraag B12: Hoe wordt er omgegaan met tegenslagen die u ervaart?

Vraag B13: Hoe wordt er omgegaan met successen die u ervaart?

Persoon centraal

III. Inhoud

Vraag B14: In hoeverre staat u als persoon centraal? Kunt u voorbeelden noemen?

- In hoeverre helpt de ondersteuning u uw zelfstandigheid te vergroten?
- In hoeverre helpt de ondersteuning u uw leven weer in eigen handen te nemen?
- In hoeverre wordt er rekening gehouden met uw eerdere ervaringen (inclusief trauma)?
- In hoeverre wordt er rekening gehouden met uw behoeften?

- In hoeverre wordt er rekening gehouden met uw krachten?
- In hoeverre wordt er rekening gehouden met uw wensen (wat betreft uw herstel)?
- In hoeverre wordt er rekening gehouden met uw gedrag en normen en waarden (cultuur)?
- In hoeverre wordt er rekening gehouden met spiritualiteit?
- In hoeverre worden beslissingen binnen de ondersteuning samen met u genomen?

Vraag B15: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen?

IV. Benadering

Vraag B16: Hoe wordt u behandeld? Kunt u voorbeelden noemen?

- Als iemand die zijn/haar leven in eigen handen mag nemen (autonomie)?
- Als iemand die zijn/haar leven in eigen handen kan nemen (empowerment)?
- Met begrip?
- Met medeleven?
- Met oprechtheid?
- Met waardigheid?
- Met respect?

Vraag B17: Wat vindt u daarvan?

- Tevreden: Waarom vindt u dat?
- Ontevreden: Waarom vindt u dat? Wat zou beter kunnen?

Vraag B18: Zijn er nog andere dingen die u belangrijk vindt om u te ondersteunen om mee te gaan doen (in de samenleving)?

C. Belemmeringen en mogelijkheden die ondersteuning naar participatie beïnvloeden

I. Belemmeringen

Vraag C1: Ervaart u belemmeringen die van invloed zijn op de ondersteuning bij het meedoen (in de samenleving)?

b. Zo ja:
   Wat voor belemmeringen ervaart u die van invloed zijn op de ondersteuning bij het meedoen (in de samenleving)? Betrekking hebbende op:

1. Belemmeringen in omgeving
2. Persoonlijke belemmeringen (cliënt en begeleider)

c. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaart u geen belemmeringen in de ondersteuning?

II. Mogelijkheden

Vraag C2: Biedt de ondersteuning u mogelijkheden om mee te gaan doen (in de samenleving)?

b. Zo ja:
   Wat voor mogelijkheden biedt de ondersteuning die u wordt geboden u om mee te gaan doen (in de samenleving)? Betrekking hebbende op:

1. Mogelijkheden in omgeving
2. Persoonlijke mogelijkheden (cliënt en begeleider)

c. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaart u geen mogelijkheden van de ondersteuning?

Als er zowel mogelijkheden als belemmeringen benoemd zijn voor mensen met psychiatrische problematiek:

Vraag C3: Wegen de mogelijkheden van de ondersteuning op tegen de belemmeringen voor u om mee te gaan doen (in de samenleving)?

Bedankt voor uw tijd! Wilt u dat ik u het uitgeschreven interview nog toestuur voordat ik het in mijn verslag gebruik? Wilt u het uiteindelijke verslag nog toegestuurd krijgen?

Appendix 3. Interview protocol expert

Interview expert

Ik wil u allereerst bedanken voor het feit dat u de tijd kon vinden voor dit interview. Het doel van het interview is om erachter te komen wat ondersteunend is in het vergroten van participatie voor mensen met psychiatrische problematiek. Specifiek hoor ik dan graag over uw kennis over en ervaringen met deze doelgroep en hun toeleiding naar participatie in het algemeen, maar ook in het kader van het Groot Maatschappelijke Opvang (MO)/Geestelijke Gezondheidszorg (GGZ) Overleg. Daarnaast wil ik het graag hebben over wat mensen met psychiatrische problematiek ondersteunt om te gaan participeren (in de samenleving). Bij participeren kunt u denken aan het hebben van contact met mensen, het hebben van werk, het hebben van een plek om te wonen, het volgen van een opleiding en het doen van activiteiten in vrije tijd. Heeft u er bezwaar tegen als het interview wordt opgenomen? De antwoorden zullen anoniem worden behandeld. U kunt op elk moment stoppen met het interview mocht u dit nodig vinden. Heeft u voordat we beginnen nog vragen en/of opmerkingen? Mocht u tijdens het interview vragen hebben, dan kunt u die gewoon stellen.

Vraag 1: Kunt u me iets meer vertellen over uw (opleidings-)achtergrond wat betreft maatschappelijke opvang en geestelijke gezondheidszorg in Amsterdam?

A. Participatie in het algemeen

Vraag A1: Op welke gebieden ondersteunen maatschappelijke organisaties mensen met psychiatrische problematiek om (maatschappelijk) te gaan participeren in Amsterdam?

Vraag A2: Op welke manieren ondersteunen maatschappelijke organisaties mensen met psychiatrische problematiek om (maatschappelijk) te gaan participeren in Amsterdam?

Vraag A3: Wat vindt u van datgene wat wordt gedaan door maatschappelijke organisaties om mensen met psychiatrische problematiek te ondersteunen om (maatschappelijk) te gaan participeren in Amsterdam?

B. Participatie in context van het Groot MO/GGZ Overleg

Vraag B1: Op welke gebieden ondersteunt het Groot MO/GGZ Overleg mensen met psychiatrische problematiek om (maatschappelijk) te gaan participeren in Amsterdam?

Vraag B2: Op welke manieren probeert het Groot MO/GGZ Overleg de (maatschappelijke) participatie van mensen met psychiatrische problematiek te ondersteunen in Amsterdam?

Vraag B3: Wat vindt u van datgene wat het Groot MO/GGZ Overleg doet om mensen met psychiatrische problematiek te ondersteunen om (maatschappelijk) te gaan participeren in Amsterdam?

C. Participatie voor mensen met psychiatrische problematiek

Vraag C1: Wat ervaart u dat mensen met psychiatrische problematiek nodig hebben om (maatschappelijk) te gaan participeren?

a. Doelen
b. Taken van begeleider en cliënt
c. Band tussen begeleider en cliënt
d. Cliënt centraal

Vraag C2: Ziet u dat mensen met psychiatrische problematiek belemmeringen ervaren die van invloed zijn op de ondersteuning die zij krijgen om (maatschappelijk) te gaan participeren in Amsterdam?

d. Zo ja:
   Wat voor belemmeringen ervaren mensen met psychiatrische problematiek die van invloed zijn op de ondersteuning die u kunt bieden om hen te ondersteunen om te participeren (in de samenleving)? Betrekking hebbende op:

3. Belemmeringen in omgeving
4. Persoonlijke belemmeringen (cliënt en begeleider)

Vraag C3: Ziet u dat mensen met psychiatrische problematiek mogelijkheden ervaren van de ondersteuning die zij krijgen om (maatschappelijk) te gaan participeren in Amsterdam?

d. Zo ja:
   Wat voor mogelijkheden biedt de ondersteuning mensen met psychiatrische problematiek om mee te doen (in de samenleving)?

3. Mogelijkheden in omgeving
4. Persoonlijke mogelijkheden (cliënt en begeleider)

b. Zo nee:
   Wat is daar de oorzaak van? Waarom ervaren ze geen mogelijkheden van de ondersteuning?

Vraag C4: Wegen de mogelijkheden van de ondersteuning voor mensen met psychiatrische problematiek op tegen de belemmeringen voor deze mensen om (maatschappelijk) te participeren?

Bedankt voor uw tijd! Wilt u dat ik u het uitgeschreven interview nog toestuur voordat ik het in mijn verslag gebruik? Wilt u het uiteindelijke verslag nog toegestuurd krijgen?

Appendix 4. Coding scheme with categories

- Domains of (societal) participation
  - Education
  - Living situation
  - Personal
  - Recreation
  - Relationships
  - Work
- Stimulating societal participation
  - (Educational) background
    - Combination of personality and education
    - Considerable role
    - No considerable role
    - Undetermined
  - Actively contributing

            - Befitting needs of client
            - Being positive
            - Direct involvement
            - Encourage self-determination
            - Familiarization with forms of participation
            - Inherent motivation present
            - Mobilize social environment
            - No expectations
            - Not possible because of voluntary nature
            - Open discussion
            - Through assignment of activities
        - Extent of (societal) participation
            - Adjusting to clients' wants and needs
            - Advising
            - Befitting interests and established activities
            - Difficult to determine
            - Discretion of clients
            - Pre-determined motivation
            - Small steps
            - Within society
        - Participation activities
            - Creating necessary prerequisites for (progression towards) participation
            - Participation
            - Progression towards participation
        - Points of concern
            - Clients' situation
            - Needs and wants
            - Positive environment
            - Practical activities
            - Self-determination
            - Tempo
- Opinion on support in general
    - Positive
    - Very positive
- Working alliance
    - Bonds
        - Description of bonds
            - Both personal and professional
            - Boundaries of relationship
            - Depending on client
            - No expectations

                - Personal
                - Positive
                - Professional
                - Stimulating
                - Opinion of client
                    - Negative
                    - Positive
                    - Very positive
            - Development of bonds
                - Creating clarity on process
                - Creating trust
                - Depending on client
                - Focus is wants and needs
                - Immediate involvement
                - Keep it light
                - Maintain positive conditions
                - No expectations
            - Setbacks
                - Client changes outlook of others
                - Client's process is leading
                - Discussion
                - Limited extent of paying attention to it
                - Lower expectations
                - Maintain availability
                - Move on
                - No discussion
                - Positively reinforcing
                - Sympathize
                - Opinion of client
                    - Positive
                    - Very positive
            - Successes
                - Keep it neutral for clients with personality issues
                - Learning experience
                - Positively reinforcing
                - Opinion of client
                    - Positive
    - Goals
        - Determination of goals
            - Determined by clients
            - Determined by professionals
            - Formal determination of goals

- In cooperation with client
- Informal determination of goals
- Effects for clients
    - Positive
    - Undetermined
- Opinion of client
    - Positive

- Process
    - Corresponding with wants and needs
    - Counselor as facilitator
    - Discretion for fulfillment up to client
    - Value of goals
        - Opportunities
        - Threats

- Tasks
    - Client
        - Actively aiming towards participation
        - Engaging in forms of participation
        - Motivating others to participate
        - Opinion of client
            - Negative
            - Positive
            - Varying
    - Professional
        - Determination of tasks
            - Both counselor and client
            - By professionals
            - Completely up to client
            - Dependent on client
            - Effects for clients regarding determination of tasks
                - Negative
                - Positive
                - Varying
            - Opinion of client
                - Positive
                - Varying
        - Types of tasks
            - Build positive relationship
            - Coach clients
            - Participation
            - Personal development of client
            - Effects for clients

        - Negative
        - Positive
        - Varying
    - Opinion of client
        - Positive
        - Undetermined
        - Varying
- Person-centered
    - Approach
        - Boundary setting
        - Dependent on client
        - Personal
        - Relaxed
        - Self-determination
        - Opinion of client
            - Positive
            - Undetermined
    - Content
        - Being present
        - Independence
        - Limit to person-centeredness
        - Publicly celebrating successes
        - Respect
        - Sensing and understanding client
        - Strengths
        - Suggesting manners of participation
        - Taking seriously
        - Talents
        - Wants and needs
- Other important support-related factors
    - Awareness
    - First priority wants and needs of client
    - Focus on recovery
    - Involving social environment
    - More individual support
    - Normalizing otherness
    - Sense of community
    - Support should be cooperation between counselor and client
    - Sweet people
    - Taking time
- Barriers
    - Client

        - Access to healthcare
        - Characteristics of person
        - Counselors
        - External
        - Gender
        - Medication
        - Mental issues
        - No barriers
        - Participation
        - Physical
        - Poverty
        - Social
        - Stigmatization
        - Substance dependency
        - Transport
    - Professional
        - Attitude organizations public domain
        - Bureaucracy
        - Characteristics of clients
        - Combination of day activities and business
        - Counselors
        - Lack of individual support
        - Lack of job vacancies
        - Prejudice and stigma
        - Time
- Possibilities
    - Client
        - Access to forms of participation
        - Care
        - Participation
        - Personal
        - Recovery
        - Social interactions
    - Professional
        - Varying
        - Yes
- Weighing of possibilities as opposed to barriers
    - Client
        - No
        - Yes
        - Varying
        - Matter of coping

        - Worsening of symptoms
    - Professional
        - Within control of counselor
        - Yes
- Consequences of support
    - Client
        - Negative
        - Positive
        - Varying
    - Professional
        - Negative
        - Positive
        - Varying
- Characteristics of clients
    - Needs
    - Opportunities
    - Threats
- Specific initiative in relation to another initiative
- Memorable quotes
    - Participation
    - Working alliance
    - Person-centeredness
    - Barriers
    - Possibilities