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# THESE DE DOCTORAT DE

NANTES UNIVERSITE

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*Sciences économiques et sciences de gestion - Pays de Loire*

Spécialité : Science de gestion

Par

**Mme.Yuna LI**

## **Medical-social care to child mental health and neoliberal surveillance**

**Thèse présentée et soutenue à Longyan, P.R. China, le lundi 6 février 2023**

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**Titre :** Les services médico-sociaux de la santé mentale des enfants et la surveillance néolibérale

**Mots clés :** santé mentale des enfants, surveillance néolibérale, processus d'industrialisation

phénomène de réification, approche dialogique d'*accountability*

**Résumé :** Au cours des dernières décennies, les réformes néolibérales en France ont considérablement affecté le secteur médico-social. Cet impact est multidimensionnel et profond, impliquant une série de transformations dans la gouvernance des soins, la professionnalisation du personnel médical, l'évaluation des établissements et le rapport social entre la profession et le public. Cette thèse vise à comprendre le rôle que peut jouer la mise en place de mécanismes d'*accountability* dans la reconfiguration, la reconstruction et l'exercice du pouvoir en contexte organisationnel.

Pour atteindre cet objectif, la thèse a) s'appuie sur une étude de la littérature relative au Nouveau Management Public et à la conception managériale de la responsabilité,

b) prend une illustration empirique extensive des techniques managériales contextuelles et des moteurs qui les sous-tendent, c) développe un cadre théorique foucauldien pour étudier les mécanismes de responsabilité en tant que technologies de domination et de pouvoir dans les contextes organisationnels et d) examine l'impact de l'introduction des mécanismes de responsabilité. La collecte de données qualitatives pour la recherche est menée dans plusieurs institutions médico-sociales françaises où les professionnels sont interviewés. Elle comprend 250 heures d'observation non-participante et 35 entretiens semi-structurés.

**Title:** Medical-social care to child mental health and neoliberal surveillance

**Keywords:** child mental health, neoliberal surveillance, industrialization process, reification phenomenon, dialogical approach accountability

**Abstract:** In recent decades, neoliberal reforms in France have significantly affected medical-social sector. This impact is multidimensional and profound, involving a series of transformations in healthcare governance, medical staff professionalism, assessment of establishments and the social relationship between the profession and the public. This dissertation aims to understand the role that the implementation of accountability mechanisms can play in the reconfiguration, reconstruction and exercise of power in organizational context.

b) takes extensive empirical illustration on contextual managerial techniques and the drivers behind them, c) develops a Foucauldian theoretical framework to study accountability mechanisms as technologies of domination and power in organizational contexts and d) examines the impact of the introduction of the accountability mechanisms. Qualitative data collection for the research is conducted at several French medica-social institutions where the professionals are interviewed. It includes 250 hours of non-participant observation and 35 semi-structured interviews.

To achieve the aim, the dissertation a) draws from literature study related to New Public Management (NPM) and managerialist conception of accountability,

## **AUTHOR'S ACADEMIC CONTRIBUTIONS**

### **DURING THE COURSE OF THE PHD**

Li, Y. (2018). Children mental health and new public management: the rise of industrial order in France. Paper presented at the 10<sup>th</sup> International EIASM (European Institute for Advanced Studies in Management). Lund, Sweden, September 4-6.

Li, Y. (2018). Industrialization in the French Social & Health Care Services: a critical perspective. Paper presented at the 7<sup>ème</sup> Colloque AIRMAP (Association Internationale de Recherche en Management Public) Un management public innovant? Biarritz, France, June 1-2.

Li, Y. (2017). Towards a communicative understanding of organizational capability building in non-profit organization. Paper presented at the 6<sup>ème</sup> Colloque AIRMAP (Association Internationale de Recherche en Management Public) Un management public universel? Nice, France, June 1-2.

Li, Y. (2016). Les Pâtes au Beurre, un modèle vertueux du prendre soin? Paper presented at the conference of Mouvement pour l'Accompagnement et l'Insertion Sociale(M.A.I.S). Régional de Bretagne et Pays de Loire, December 2.

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## ABSTRACT

In recent decades, neoliberal reforms in France have significantly affected medical-social sector. This impact is multidimensional and profound, involving a series of transformations in healthcare governance, medical staff professionalism, assessment of establishments and the social relationship between the profession and the public. This dissertation aims at understanding the role that the implementation of accountability mechanisms can play in the reconfiguration, reconstruction and exercise of power in organizational context.

To achieve the aim, the dissertation a) draws from literature study related to New Public Management (NPM) and managerialist conception of accountability, b) takes extensive empirical illustration on contextual managerial techniques<sup>1</sup> and the drivers behind them, c) develops a Foucauldian theoretical framework to study accountability mechanisms as technologies of domination and power in organizational contexts and d) examines the impact of the introduction of the accountability mechanisms. Qualitative data collection for the research is conducted at several French medical-social institutions where professionals are interviewed. It includes 250 hours of non-participant observations and 35 semi-structured interviews. The dissertation answers the following research questions:

1. How are various forms of exercise of power and control enacted through the managerial techniques implementation and use in clinical practices and medical-social establishments?
2. How do these enactments reconfigure power relations and reconstitute the regime of truth?
3. What is the role of the accountability mechanisms in such a process of power reconstruction?

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<sup>1</sup> The research is particularly centered on contextual managerial devices which are compulsorily introduced by the reform 2002-2.

The empirical analysis reveals the outcomes of the application of managerial techniques do not only result in the perception of accountability mechanisms misfit, but more importantly spring from mutual constitution of the accountability-based mechanisms and the human actors leading to reconfiguration of power relations. This process is complex, involving the materiality of managerial techniques, the discourse, knowledge and power techniques embedded in the mechanisms, the existing social and power structure, the power/knowledge nexus and the dominant discourses in the organization, which would be described as an emergence of power-technology nexus. We will argue them in the following two points:

First, the study of chapter five argues that documentation plays a vital role in disciplinary control. Documentation produces corresponding knowledge and establishes truth for managerial devices informed practices. In the case of patient files, the depth of information (patient's condition, diagnosis, clinical practices etc.) is required to constitute and displays the chain of accountability. The standards of treatment (documenting clinical process and self-examination with indicators) seek to establish norms of behavior which make individuals differentiable, comparable and manageable. It brings into play the "binary opposition of the permitted and the forbidden" (Foucault, 1984), which becomes the basis for normalizing judgement and examination possible by overseeing authorities. It aims to turn multi-ways of doing things into a unique one, which imposes homogeneity of behaviors in different medical-social establishments. In other words, these contextual managerial techniques (for strategic purpose to be accountable) seek to develop internalized self-disciplining culture in an organization. Moreover, the emergence of the power-technology nexus limits human actors' ability (especially care staff's creativity) to exercise power within the accountability mechanisms. The contextualize analysis of chapter six<sup>2</sup> examines that organizational culture, clinical practices and working methods are shaped by the technology of domination as

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<sup>2</sup> The study of chapter six is enlightened by economies of worth (Boltanski & Thévenot, 2006).

means of domination (i.e. accountability mechanisms as technologies of domination). It results in the industrialization process in the medical-social sector. Meanwhile, the empirical study of chapter seven<sup>3</sup> traces the way in which care profession's work is increasingly mediated by standardized treatment. Our study reveals how standards-based accountability is a form of reification, threatening to replace the notion of community and human relations in the healthcare sector by relations between things.

Second, in view of Foucault, power is not plain oppression of the powerless by the powerful. It is not the binary opposition. Power is more a strategy. Foucault sees power coexistence with resistance, as a productive factor, because power makes creative use of space for self-construction, i.e. empowering human actors to constitute themselves. The study of chapter eight argues that care staff are not willing to settle for a power structure because they do not accept the accountability mechanisms and internalized surveillance. The association A provides an alternative strategy in face of the technical-managerial accountability. The focus of study is on care profession and their struggles to recognize different possibilities of power. One such possibility is clearly offered in relations with others who share the same discomforts. The case study describes that healthcare workers whose struggles are shared and common experiences recognized seek to develop non-normalizing organizational practices and an alternative form of "care of the self". Rather than presenting itself narrowing as a science of healing, the care of the self is more concerned with the day-to-day practice of living and a relational governance.

Keywords: child mental health, neoliberal surveillance, industrialization process, reification phenomenon, dialogical approach accountability

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<sup>3</sup> The study of chapter seven is made in the light of Honneth's reification (2008).



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# 1 INTRODUCTION

## 1.1 Research Background

From the end of 1970s to the beginning of 1980s, in the influence of globalization and information technology, OECD countries have set off the wave of government reform. The reform ideas are basically through the introduction of market competition mechanism and the business management concept, in order to improve the quality of public service and the level of public management, which is New Public Management (NPM) movement. The core sense of accountability means “being called to account for one’s actions”. Greatly influenced by NPM, accountability is possible favorite to make public managers realize their objectives. That accountability is making public servants responsible to public wishes other than calling them to account. In doing so, it is necessary to develop a mechanism through which the government could enhance the effectiveness and efficiency of public governance. Managerialism is seen an ideology and is more than a concern for effective and efficient management of institutions. The main element of managerialism is the economic rationality of neo-liberals. According to Pollitt (1993), a key concept of managerialism is to provide a “technical” solution, i.e. a technical or instrumental rationality to the political problem of increasing the labor productivity and efficiency of public services. Thus, it involves a series of “neo-Taylorian” management practices, such as setting standards and targets through planning system, performance measurement and public reporting of performance, as well as introducing competition and incentives for better performance.

France has also taken part in NPM reforms. In our paper, we will be focus on the medical-social establishments for child mental health. A battery of reforms in health care have been greatly influenced by NPM, such as LOLF<sup>4</sup>, RGPP<sup>5</sup> and MAP<sup>6</sup>. Those attempts are made in public health-care sector in order to increase the

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4 La loi organique relative aux lois de finances (LOLF)

5 Révision générale des politiques publiques (RGPP)

6 Modernisation de l’action publique (MAP)



managerialist of accountability. They aim at: i) introducing formal evaluation mechanism and enhancing organizational transparency; ii) training official and civil servant for skills in scientific management (or recruit more professional manager specialized in management and management techniques); iii) increasing to use of evidence-based and contractual relationships between politicians and public.

The increasing focus is on performance through which local authorities hold accountable for what they do. As we know, the reliance of traditional control is on hierarchical authority relationship. But nowadays it has been progressively replaced by quasi-market and contractual relationships. Henkel (1991) points that we are in the “new Evaluative State” in which performance evaluation is underlined through a battery of means: in terms of outputs through performance measures and indicators; in terms of managerial systems and process through inspections and quality audits; and in terms of contract performance through supervising of standards. The traditional faith in professionals’ commitment has been challenged, thus managerialist form of accountability becomes increasingly tied to a synonym of surveillance, control even sanction. The reform 2002-2 is considered as one of the most important reforms for medical-social sector. It develops a compulsory introduction of internal and external control based on evaluation approach. Since then, there is a rising number of regulations implemented into the sector. The aim is to develop accountability mechanisms in which care staff should be self-disciplined their performance. This culture suggests strong tendency towards normalization with the pressure for compliance that is mimical with the traditional values of critical engagement and the exercising of professional independence.

## **1.2 Research Motivations**

There are two motivations for this study on accountability regime and power dynamics. In the first place, the study seeks to develop deep understanding of the role of technical-managerial accountability mechanisms in power exercising, reconfiguration and reconstruction. We will make a deeper study to examine the

implementation of contextual managerial techniques and its strategic direction to desired destination. The accountability mechanisms are chosen as the major research target for its profound organizational implications and the interesting assumptions and drivers behind the mechanisms. The enactment of the power techniques embedded in the accountability mechanisms enable the restructuring of the existing clinical processes and work practices. In this sense, the emergence of power-technology nexus gradually transformed social-material practices in the medical-social sector. The accountability mechanisms have become embedded in the organizational processes and decision-making exercises, which gains “power” over medical processes and operations. In doing so, our study will be centered on the accountability mechanisms as technologies of domination.

The second motivation for this study is that development of deep understanding of accountability mechanisms implementation and its impact requires consideration of the embedded complex power relations. This can enable a rich exploration and understanding of power dynamics during the accountability mechanisms implementation. The existence of resistance does not mean the discipline, control and governance system are threatened. Resistance to accountability mechanisms that derive from the flows of neoliberalism is different from past struggle. In Foucault’s term- “care of the self” plays an important role under neoliberal surveillance. Our case association A highlights a “different” approach to the issue of resistance through Foucault’s notion of “the care of the self”. The focus of study will be centered on care profession’ s struggles to recognize different possibility of power. One such possibility is clearly offered in relations with others who share the same discomforts. These others might available in the association A and develop a dialogical approach over what it means to be a clinician and what it means to be treated to children with mental disorder.

### **1.3 Research Objectives**

The primary objectives of this dissertation are as follows:

1. To explore the underlying mechanisms by which the contextual managerial techniques are implemented and used within the existing social and power structures.
2. To provide deeper understanding of the role of the technical-managerial accountability mechanisms in reconfiguring, reconstruction and exercise of power in the medical-social sector.

To achieve the aim, the dissertation a) draws from literature study related to New Public Management (NPM) and managerialist conception of accountability, b) takes extensive empirical illustration on contextual managerial techniques<sup>7</sup> and the drivers behind them, c) develops a Foucauldian theoretical framework to study accountability mechanisms as technologies of domination and power in organizational contexts and d) examines the impact of the introduction of the accountability mechanisms. The dissertation answers the following research questions:

1. How are various forms of exercise of power and control enacted through the managerial techniques implementation and use in clinical practices and medical-social establishments?
2. How do these enactments reconfigure power relations and reconstitute the regime of truth?
3. What is the role of the technical-managerial accountability mechanisms in such a process of power reconstruction?

## **1.4 Thoughts on research and thesis framework**

### **1.4.1 Thoughts on research**

Our research begins with an analysis of the burnout of staffs working in the public health sector. It is a qualitative approach from verbal data and exploratory well situated in situations where we (as researchers) do not have preconceived ideas. The working map is as follows. First of all, we conduct an observation and

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<sup>7</sup> The research is particularly centered on contextual managerial devices which are compulsorily introduced by the reform 2002-2.

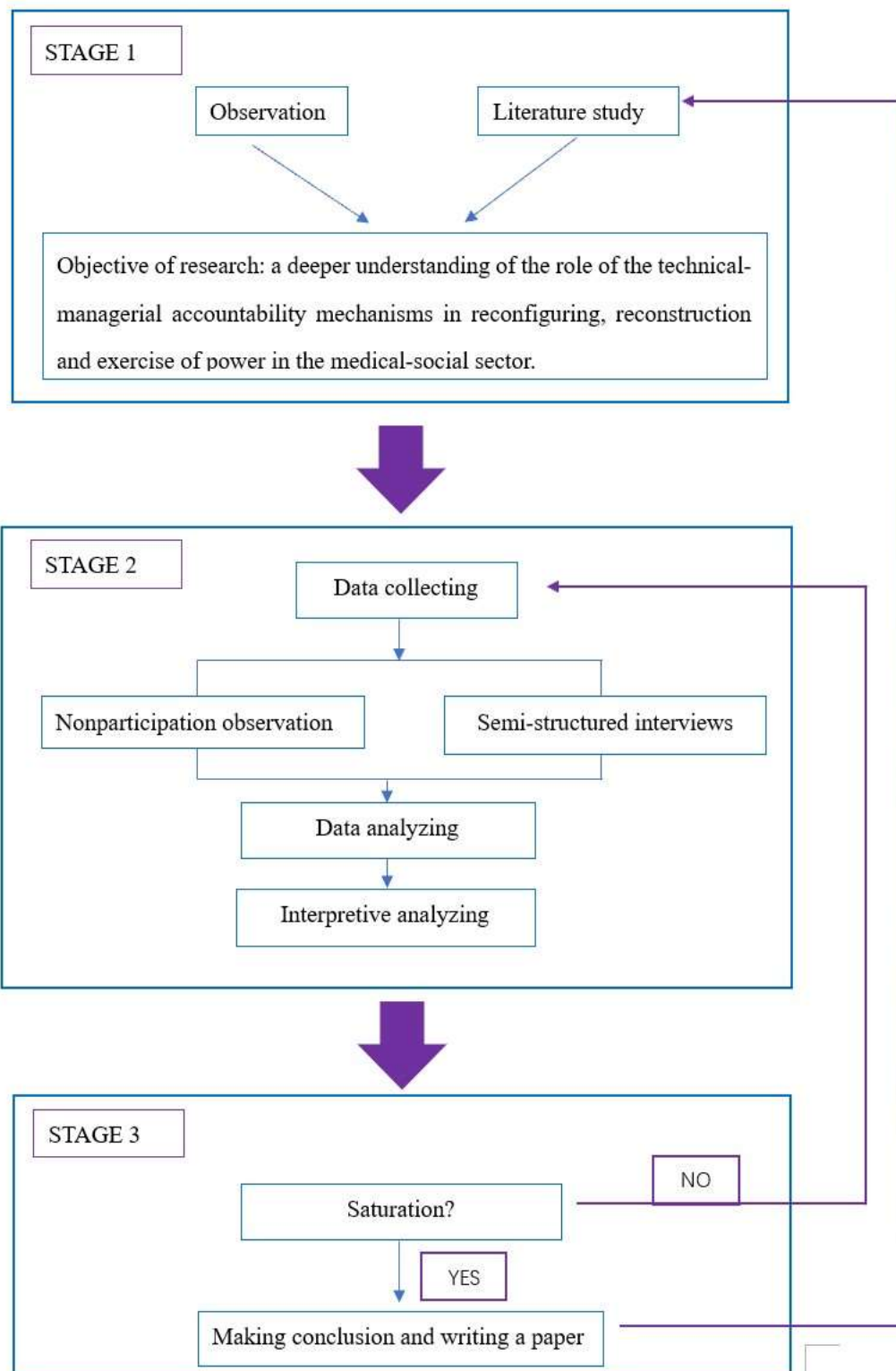
semi-structured interviews in the association A<sup>8</sup> in order to understand a series of questions: a) why does the founder “escape” from the public institutions (mainstream mental-health sector) and found in the association A? b) why the increasing number of parents come to the association A and prefer to be treated there? c) why are the rising quantity of professionals eager to found the association A in their regions? d) why is the association A not transferred into a bureaucratic structure, in the situation of the soaring number of the association A founded in France? Then the third and fourth question guide us to a much broader vision, i.e. the whole public health sector and the reinforcing impact of auditing and evaluation. A Chinese saying goes, “miss the forest for the trees!” At earlier stage we spent a large amount of time in focusing on the standpoint of management of every staff working in the association A, while missing the macro-analysis of social background. Secondly, we conduct a series of semi-structured interviews in other French cities. The interviewees are composed of many professionals working for or fully accepting the concept of the association A. Most of them worked or have been working in the mainstream child-mental care for more than ten years. At the same time, some parents<sup>9</sup> are interviewed in order to develop another angle to see our care sector. As a researcher, we come and go between field and theory to collect data and check saturation. At last stage, we use Nvivo 11 to deal with data, develop data-open codes-axial codes and finally put a focus on the importance of dialogue between the various actors involved. The working map is in the following figure 1.

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8 A is the name of an association and the place investigated in our field study. We will precisely talk about it in the following chapter.

9 Most of them are mothers. Their kids usually have varying degrees of mental health problem.

**Figure 1: Working map**



(Source: Author's conceptualization)

### **1.4.2 Thesis framework**

The study is composed of ten chapters:

The general introduction of paper is to introduce research questions, working map and framework, as well as theoretical and practical value.

Chapter two is a part of methodology. It attempts to explain why we chose qualitative rather than quantity approach, how to design research, as well as how to collect and analyze data.

Chapter three is to present about the background of research. It will be centered on NPM reform introduced in public sector, especially its great impact on French healthcare. The emphasize on the logic of details based on neo-liberal economics is in conflict with the logic of self-governance in relation with autonomy, trust and human relations. The rise of managerialist accountability reconstruct the organizational structure and relationships. The decline of trust in professionals in public service has resulted in new forms of control based upon contractual forms of relationships and upon “surveillance” through performance measurement (reward or sanction). In doing so, this section is composed on two parts. It is composed of two sections. From the historical perspective (the first section), we have reviewed the origin and reason for NPM reforms, the translations of NPM reforms in French healthcare sector. Those reforms are growing at a time of tightening governance and control system. The second section is a focus on the accountability requirements in the public sector. Greatly influenced by “New Managerialism” (Wilson, 1996), the managerialist accountability attempts to make public service more accountable for the efficient and effective use of resources through technical solutions to performance evaluation. There is no way this could be done without accountability mechanisms (measuring and managing performance).

Chapter four presents Michel Foucault’s views on power as a theoretical framework for this research. In the first place, the relevant concepts of power relation, power/knowledge and regime of truth, resistance, disciplinary control, etc., are investigated. The relevance of Foucault's perspective on power to managerial

devices and accounting is also discussed. In the second place, Foucauldian applications within accounting are reviewed and critiqued. Thirdly, the adoption of Foucault's theoretical foundation on power is indicated. Finally, research questions are formulated based on the literature review and the objectives of research.

Chapter five will review the implementation of contextual managerial techniques in the medical-social sector, which is analyzed through the theoretical lens of Foucault's perspective on power/knowledge. The implementation of managerial techniques develops accountability mechanisms. The emergence of the power-technology nexus limits care profession's ability to exercise power. In other words, the regime of truth is transformed through the disciplinary power enabled by the technical-managerial accountability mechanisms.

Chapter six will continue to examine the impact since the accountability mechanisms implementation, through the voices of medical-social professionals. Healthcare sector is previously dominated by professional and political logic in management. Neoliberal reforms result in the introduction of two combined but different logics: an increasingly dominant logic of details and a minor logic of self-governance (Hood, 1991; Dahl, 2009). The two logics present a major contradiction for staff in medical-social sector, both reshaping their sense of professionalism and proving their resistance. The study will be made in the light of the economies of worth by Boltanski and Thévenot (2006) to analyze care profession's perceptions of new methods of working, which presents a small window to see the phenomenon of an industrialization process in care sector.

Chapter seven is to review the phenomenon of reification in care sector. The study traces the ways in which medical-social professionals' work is increasingly being mediated by standards-based accountability to show how these professionals grapple with the tensions between policy and a sense of their professional responsibility for their patients.

Chapter eight will characterize our case study the association A, investigate its relational governance and coproduction process of public values. As argued by

Foucault (2000), as soon as power manifests itself, it should expect resistance. Individuals do not directly accept and apply new systems. Rather they can critically and reflectively detach themselves to these systems and modify them. In other words, they will make creative use of the space for self-construction. In light of this point, we argue a language-based nature of accountability (i.e. a dialogical approach) may be an alternative strategy in face of evaluate society. In our view, this approach could cope with the complexity of the social world and of the effects of public services. The language-based nature of accountability proposed could provide a much richer scope of accountability relationship between government, medical-social establishments and care service users.

Chapter nine will discuss the findings enlightened by Foucault's work, especially his notion of power, the concept of power/knowledge nexus, the theorizing of disciplinary control, and the "care of the self".

Chapter ten will make a brief summary of the thesis and outline its major theoretical contributions and practical implications to the accountability regime in healthcare organizations. It also outlines the suggestions for possible research directions.



## **2 RESEARCH METHODOLOGY**

### **2.1 Introduction to the chapter**

This chapter describes the rationale for the design of our research. Research design should place careful consideration because it is an overall plan for relating a conceptual research problem to relevant and practicable empirical research. (Ghauri & Grønhaug, 2002). Research design involves a series of strategy to collect data, obtain the information, and finally investigate research questions. That is to say, the study requires a research design that should be appropriate and in the best possible way to answer research issues. Furthermore, research design must be aligned with the research paradigm. In doing so, the chapter 2 will firstly present the epistemological and methodological positions of research. To undertake the research, a qualitative research methodology is employed with an approach of Stake's case study. Secondly, the chapter then describes data collection and analysis. Observation and interviews are employed in data collection. In an analysis of data, we present how to transcribe interviews and data coding.

## 2.2 Research Position and Research Design

In this section, we discuss our rationale for using qualitative methods over quantitative methods for this study.

### 2.2.1 Qualitative or quantitative?

The paper reports on a case study of the association A, a mental healthcare facility for children and their family. The study firstly seeks to understand why and how the association is increasingly important for children mental illness and for mental health professionals. In other words, we will examine what inspires numbers of mental health professionals to work at the association, and what alternative strategy to improve the mental care service quality. With the increasing number of interviews, we could then investigate in-depth in care sector. As outline above, the central objective of the study is not to measure the parts and test a hypothesis in an issue, but to comprehend the issue under study in a complex and detailed level. In doing so, qualitative design is used in the paper in order to understand the participants' actual context which is directly related to the phenomenon.

In contrast to quantitative research, with its aim at explanation, prediction and broader generalization, qualitative research is intent on generation deeper understanding the whole as well as of the specific and particular (Stake, 1995). Qualitative research methods could directly provide an in-depth and interpreted understanding the experiences, histories, perspectives and other social world of research participants. In this such, qualitative study is a focus on the interpretation of the world. The qualitative approach is in great efforts to make sense of our world. In the Sage *Handbook of Qualitative research* by Denzin and Lincoln, the latest definition of qualitative research is

*a situated activity that locates the observer in the world. Qualitative research consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They turn the world into a series of representations including filed notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of,*

*or to interpret, phenomena in terms of the meanings people bring to them.  
(Denzin & Lincoln, 2011, P.3)*

Creswell incorporates the elements of Denzin and Lincoln's definition: he considers the qualitative research that

*begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for a change. (Creswell, 2013, p. 40)*

There exists considerable diversity in qualitative study (see Table 1), yet it is possible according to those two definitions to define a set of core characteristics, such as interpretation, addressing the meanings of the social problems, naturalistic approach or natural setting. As an applied research methodologist, Creswell (2013) emphasizes on the process of qualitative research. It begins with assumptions, and then by means of inquiry (data collection procedures) the issues or problems are to be explored. Before going further into the investigation, we should also clarify what the assumptions are in qualitative research? Why do we begin with assumptions in the qualitative research according to Creswell (2013). In fact, qualitative researchers often have access to the field at the site where they collect the data with philosophical assumptions. In quantitative studies, investigators use hypothesis to shape the purpose of the study. Quantitative hypothesis are the predictions the researchers seek to investigate the relationships among variables. Webster's Dictionary presents the following definitions for the terms of assumption and hypothesis:

- Assumption: the act of taking for granted, or supposing a thing without proof
- Hypothesis: something not proved, but assumed for the purpose of

argument, or to account for a fact or an occurrence.

**Table 1: Diversity in qualitative study**

<b>Characteristics</b>	<b>Schensul &amp; Lecompte (1999)</b>	<b>Hatch (2000)</b>	<b>Marshall &amp; Rossman (2014)</b>
Is conducted in a natural setting (the field), a source of data for close interaction?	Yes	Yes	Yes
Relies on the researcher as key instrument in data collection		Yes	
Involves using multiple methods	Yes		Yes
Involves complex reasoning going between inductive and deductive	Yes	Yes	yes
Focuses on participants' perspectives, their meanings, their multiple subjective views	Yes	yes	
Is situated within the context or setting of participants/sites (social/ political/ historical)	Yes		Yes
Involves an emergent and evolving design rather tightly prefigured design		Yes	Yes
Is reflective and interpretive (i.e., sensitive to researcher's biographies/social identities)			Yes
Presents a holistic, complex picture		Yes	Yes

(Source: Creswell, 2013)

Assumption and hypothesis could be thus generally viewed as the supposition, the question or the issue. Both qualitative and quantitative researchers initiate their study with assumption or hypothesis, yet qualitative research has often been differentiated from quantitative as hypothesis generating rather than hypothesis testing (Maudsley, 2011). Another point is highlighted that why qualitative researchers begin with “philosophical” assumptions, whether those should also be explored in quantitative studies, and why it is important to begin by thinking about “philosophical” assumptions. In fact, ontological and epistemological assumptions are the branches of the philosophical assumptions. The ontology deals with the nature of reality while we discuss about how we reach to reality in epistemology. Table 2 shows that philosophical approaches (ontology & epistemology) have influence on research design (qualitative & quantitative) in different ways.

**Table 2: Philosophical approach and research design**

	<b>Qualitative Research Design</b>	<b>Quantitative Research Design</b>
<b>Ontological Aspect</b>	<ul style="list-style-type: none"> <li>• Ends with hypothesis and grounded theory</li> <li>• Emergence and portrayal</li> <li>• Researcher as instrument</li> <li>• Naturalistic</li> <li>• Inductive</li> <li>• Searches for pattern</li> <li>• Seeks Pluralism, complexity</li> <li>• Descriptive language in reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Begins with hypothesis and theories</li> <li>• Manipulation and control</li> <li>• Used formal instruments</li> <li>• Experimentation</li> <li>• Deductive</li> <li>• Component analysis</li> <li>• Seeks consensus</li> <li>• Reduces data to numerical indices</li> <li>• Abstract language is reporting</li> </ul>
<b>Epistemological Aspect</b>	<ul style="list-style-type: none"> <li>• Reality is socially constructed</li> <li>• Primacy of subject matter</li> <li>• Variables are complex, interwoven and difficult to measure</li> <li>• Takes an insider’s point of view</li> </ul>	<ul style="list-style-type: none"> <li>• Facts have an objective reality</li> <li>• Primacy of method</li> <li>• Variables can be identified and relationships measured</li> <li>• Takes an outsider’s point of view</li> </ul>
<b>Research Purpose</b>	<ul style="list-style-type: none"> <li>• Generalization is fuzzy</li> <li>• Interpretation is consensual</li> <li>• Understanding actor’s perspective</li> </ul>	<ul style="list-style-type: none"> <li>• Generalization is scientific</li> <li>• Prediction</li> <li>• Causal explanations are scientific</li> </ul>
<b>Researcher’s Role</b>	<ul style="list-style-type: none"> <li>• Personal involvement and partial</li> <li>• Empathetic understanding</li> </ul>	<ul style="list-style-type: none"> <li>• Detached and impartial</li> <li>• Objectively portrayed</li> </ul>

(Source: Maudsley, 2011)

Qualitative research methods could minimize the power relationships between researchers and participants (Crewell, 2013), being focus on the relationship with the participants rather than acting on the participants, as quantitative methods do (Glesne, 2005). In qualitative research, researchers could get access to real life of the participants. Instead of being controlled in the clinical setting, participants remain in their natural setting and share their experiences with researchers. As such, researchers could interpret data according to their conceptual framework and understanding. Quantitative methods characterize the world as made up of observable and measurable facts and aim to produce generalizable results through objective research designs. Face to the interaction, qualitative investors empower participants to talk about their histories in a natural setting. The degree of interaction between researchers and participants are incomparable in qualitative paradigm.

In the first place, our paper presents the phenomenon of reification in care sector. The voices of participants serve the purpose of understanding our research context and also a series of change processes in medico-social sector. Also, they illustrate the industrialization process in the medico-social sector, especially the delivery of health care to the children with mental disorder is in the change process of industrialization. Secondly, the intent of their stories is the detailed understanding of the issue of our case the association A. Finally, the qualitative research methods used seem to develop a whole picture to inquiry our research question: that is from the question “why and how the association A is increasingly important for children mental health, as well as what inspires the increasing number of mental health professionals to work for the association A” to “what is an alternative strategy to assess “value” of public organization facing of the rise of managerialist form of accountability?”. It is a step by step to investigate research issue. In doing so, quantitative hypothesis testing might not be effective and appropriate way in our study.

## **2.2.2 Research design**

This section has two perspectives. The first is to explain why a case study approach is selected in our study, and whether there is some particular perspective of case study research. The second is to provide a comparative view of two foundational case study texts by Robert K. Yin and Robert E. Stake<sup>10</sup>.

### **2.2.2.1 Why conduct a case study?**

Case study approach to qualitative inquiry of the association A. We could use the term “approach” to indicate case study (Creswell, 2013; Denzin & Lincoln, 2011; Merriam, 1998), as case study “has an overarching research intent and methodological purpose and affects what methods are chosen to gather data” (Simons, 2009). Or case study is a research strategy and helps us to develop a study of a case within a real-life, contemporary context or setting (Yin, 1981, 2009). Or case study is viewed as a methodology, a type of design in qualitative study (Creswell, 2013). Case study is thus not viewed as a method because method is some techniques of research, such as interviewing and observing. Furthermore, it is important to indicate that deciding a case study using qualitative methods in our study is not because case study need only use or is restricted to qualitative methods. It depends on how to make sense of case and how to facilitate an understanding of case, that is to say how to tell “story of the case” (Simons, 2009). Case study could be thus employed in qualitative or quantitative or a contain of qualitative and quantitative methods. Decide to use a case study in the research does not mean the selection of a method, but rather a selection of what will be explored (Flyvbjerg, 2011). Case study may be seen as a design frame that could incorporate some

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10 Sharan B. Merriam’s *Qualitative Research and case study applications in education* (1998) is also frequently cited when taking about case study methodology. However, we do not review her work in our comparative study, because Merriam’s work seems to be much closer to Stake’s viewpoint (being similar to Stake who is an educational psychologist, Merraim employs case study research to explore and evaluate in the field of education) or a combination of Yin and Stake’s approach in some way.

multiple methods (Simons, 2009). Our study is thus the focus on the in-depth study of the single case the association A using qualitative methods.

#### **2.2.2.2 Why conduct a case study with an approach of Stake?**

Despite case study approach is frequently used in qualitative inquiry, most of researchers primarily follow principles of Yin, however the application and citation in their studies ignore taking account of philosophical perspectives. Thus, the following section is to review two case study approaches by Yin and Stake. The intent is not only to provide a synthesis of two authors, but also to describe whether a case study approach is consistent with.

The research conducted by Yin (1981, 2009) and Stake (1995) has been often cited by researchers in talking about case study methodology. However, Yin and Stake have differing philosophical orientations. We firstly begin to talk about Yin (1981, 2009).

1) Yin attempts to develop a comprehensive guide about how to use case study method. His fourth edition *Case Study Research* has more practical value and provides more technical approach of applying case studies. Yin views the role of case studies as understanding complex social phenomenon. The question concerns about when to use case study method, he thinks that a case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its-real life context, especially when the boundaries between phenomenon and context are nor clearly evident (Yin, 2009, P18). In doing so, Yin's work is a focus on the case study design. He attempts to develop a clear case study protocol with careful consideration of validity and potential bias. During the research process, researchers should be clearly aware of the logic behind every move in order to keep consistent with the theoretical propositions. Researchers should have a preparation phase, for example a review of relevant literature and a plan of theoretical propositions before conducting a case study. Yin emphasizes that the preparation phase is so important



that researchers should spend a great quantity of time in the case study design. As long as we begin data collection, only minor changes could make. In other words, researchers are obliged to go back to the first step and redesign their case study when they have to make major change.

Yin does not explicitly describe epistemological orientation in his text. In his guidelines on conducting case study, however, Yin (1994) views case studies as “quasi-experimental”. Case studies could be applied under the logic of experimental design except for the behavior manipulation. Hence, Yin’s approach seems to be testing-oriented and deductive. In other words, Yin is supposed to have positivistic stance in his perspective on case study. Yin’s case study design is composed of five components: the study’s question, its propositions (if any), its unit(s) of analysis, the logic linking the data to the propositions, and the criteria for interpreting the findings. Every component should be cohesive and consistent along with other. Theory is essential at the outset of research and conducting a case study is to test theory, as we mention above. Another point is emphasized that Yin opposes to the simple dichotomy between quantitative and qualitative research in case study design. Researchers could handle with both quantitative and qualitative data resources in order to validate their study. In terms of data collection, Yin carries six tools including documentation, archival records, interviews, direct observations, participant observation and physical artifacts. And then researchers have to analyze the data in line with the theoretical propositions or hypotheses. In other words, those prepositions (preconceived ideas) could help to formulate an analysis plan based on the most relevant data. As Yin mentions many times in this text, a highly structured guideline is of great importance. In the context of case study, “data analysis consists of examining, categorizing, tabulating, testing, or otherwise recombining both quantitative and qualitative evidence to address the initial propositions of a study” (Yin, 2003). Yin emphasizes the power of high-quality case study research that focuses on rigor, validity and reliability. Case study researchers can guarantee

construct validity (through the triangulation of multiple sources of evidence, chains of evidence, and member checking); internal validity (through the use of established analytic techniques such as pattern marching); external validity (through analytic generalization); and reliability (through case study protocols and databases). Yin's book places a high consideration on these four tests. He presents the details about how to employ four tests not only in the designing case study, but also data collection, analysis and compositional stage. His meticulous and rigorous approach to case study gets into the entire book.

2) Stake's case study approach is very different to Yin's. Firstly, Stake explicitly presents his epistemological stance-constructivism. He argues that "how case study researchers should contribute to reader experience depends on their notions of knowledge and reality" (Stake, 1995, p.100). He thus spends a number of time in an explication of epistemological orientations in his book *The Art of Case Study Research*. Stake thinks case study as "naturalistic, holistic, ethnographic, phenomenological and biographic research methods" (Stake, 1995, p.xi). He argues that exclusive qualitative case study seems to be more relevant in reality or knowledge construction, because qualitative case study is holistic, empirical, interpretive and emphatic. That is to say, those characteristics of qualitative research are also valid for qualitative case study. Secondly, Stake's case study design is much more flexible than Yin's. Researchers could make a big change even in the research proceeding, which Yin definitely opposes. In the phase of preparation, the only thing concerns research issues. Stake thinks that investigators "use issues as conceptual structure in order to force attention to complexity and contextuality...because issues draw us toward observing, even teasing out, the problem of the case, the conflictual outpourings, the complex backgrounds of human concern" (Stake, 1995, pp.16-17). Stake holds a notion of "progressive focusing" in terms of flexibility of case study research. Stake thinks the advocate of qualitative case study is to investigate the ambiguity, complexity and uncertainty. The very-detailed guidelines may miss the

research landscape. That is to say, Stake avoids making highly structured guidelines in his case study research. Stake proposes to the use of observation, interview and document review in the data collection. Stake's case study research is exclusively qualitative, which is opposed to Yin's. Furthermore, Stake argues that data collection and data analysis should be simultaneous. He defines analysis as "a matter of giving meaning to first impressions as well as to final compilations (Stake, 1995, p.71). The first impression and intuition in the data collection take precedence over the analysis protocol or guidelines. Stake proposes to use four ways to analyze the data:

- Direct interpretation involves looking for a single instance and drawing meaning from it.
- Categorical aggregation: researchers combine several events and creates categories within the data.
- Pattern identification is similar to categorical aggregation while patterns are established in broad categories as relationships or interactions.
- Naturalistic generalization: researchers learn to form the case and could be able to transfer or apply the finds.

Stake states that different researchers should find his or her own ways in terms of data analysis, impressions and intuitions constitute a high importance in the data analysis. Finally, Stake's validating data is different to Yin's because they have different epistemological orientation. Stake proposes four ways for triangulating data: data source triangulation, investigator triangulation, theory triangulation and methodological triangulation. He holds claim that "most qualitative researchers not only believe that there are multiple perspectives or views of the case that need to be represented, but that there is no way to establish, beyond contention, the best way" (Stake, 1995, P.108). Stake's constructivist stance in case study is to present multiple versions of knowledge since it is a product of a construction between "knower" and "known" (Yazan, 2015), while Yin's case study is to discover an accurate or approximated knowledge under investigation because of Yin's positivistic stance.

The following table 3 makes a summary of difference between two researchers.

**Table 3: Synthesis of Yin and Stake differing philosophical orientations**

	<b>Yin</b>	<b>Stake</b>
<b>Epistemological orientation</b>	Positivism (not explicitly describe epistemological orientation in his text)	Constructivism
<b>Designing case study</b>	<p>Design refers to “the logical sequence that connects the empirical data to a study’s initial research questions and, ultimately, to its conclusion” (p.20).</p> <p>A clear case study protocol is necessary.</p> <p>Case study design has five components: a study’s question, its propositions (if any), its unit(s) of analysis, the logic linking the data to the propositions, and the criteria for interpreting the findings.</p> <p>Qualitative and quantitative evidentiary sources should be combined.</p>	<p>Exclusive qualitative case study because it aides to “study of the particularly and complexity of a single case, coming to understand its activity within important circumstances” (p.xi)</p> <p>Flexible design which allows researchers to make major changes even after they proceed from design to research.</p> <p>Researchers need a set of two or three sharpened issue questions (research questions) that will “help structure the observation, interviews, and document review” (p.20)</p> <p>Progressive focusing: the course of the study cannot be charted in advance.</p>
<b>Gathering data</b>	Data gathering is influenced by case study investigator’s	Exclusive use of qualitative data sources: observation, interview

	<p>skills, training for a specific case study, the development of a protocol for the investigation, the screening of the case study nominations (making the final decision regarding the selection of the case), and the conduct of a pilot study.</p> <p>Six data gathering tools: documentation, archival records, interviews, direct observations, participant observation and physical artifacts.</p>	<p>and document review.</p>
Analyzing data	<p>Examining, categorizing, tabulating, testing or otherwise recombining both qualitative and quantitative evidence to address the initial propositions of a study</p>	<p>Data analysis is “a matter of giving meaning to first impression as well as to final compilations” (p.71)</p> <p>Simultaneity of data collection and analysis.</p> <p>Two strategic ways to analyze data: categorical aggregation and direct interpretation.</p>
Validating data	<p>Case study researchers need to guarantee construct validity (through the triangulation of multiple sources of evidence, chains of</p>	<p>Four strategies for triangulation: data source triangulation, investigator triangulation, theory triangulation, and methodological</p>

	evidence, and member checking), internal validity (through the use of established analytic techniques such as pattern matching), external validity (through analytic generalization), and reliability (through case study protocols and databases).	triangulation.
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(Source: Author’s conceptualization)

### 2.3 Data Collection

Our study includes a multiple of research methods, a variety of data collection, such as audio recording of meeting, interviews, group psychotherapy observation notes as well as other working documents.

#### 2.3.1 Observations

The observation lasts three months in the association A Nantes in order to examine how that association functions. We are particularly interested in its group psychotherapy to which everyone could be accessible. We use non-participant-observation, which could fill the gap between what participants say and what they actually do. Every observation lasts for three hours, from Tuesday to Thursday, almost 15 hours at first stage of research. During observation, we do not take notes and record the interviews between therapist and patients. We attempt to keep it and let the participants talk in a nature setting. They might not be aware of being “observed”.

### 2.3.2 Interviews

The advantage of interviews is that researchers could get a full range of rich data within the context. Our research question is a focus on what the alternative strategy is in the association A to improve the mental health service quality and indeed go beyond the fragmented actual health system. In our opinions, interviews could be employed to understand: i) the interaction between the professionals and the actual mental health system; ii) the interaction between the professionals and the association A. Myers (2009) identifies three types of interviews: structured, unstructured and semi-structured. Structured interviews involve questions that are defined in advance and the interviewee would be limited in those questions. Closed ended questions require only that the interviewer read the question and marks the appropriate answer. It seems to show that interviewer ask the interviewee to fill in the blanks test. Unstructured interviews have fewer predefined questions and are more open-ended questions that empower the interviewee and intend to explore interviews' opinions in depth. However it might bring in some unanticipated information or require the interview to transcribe a lengthy statement (Bailey, 2008). It would thus require the researchers much more skills. A skillful interviewer could bring a talkative respondent back on topic.

The semi-structured interview sites between the structured and unstructured variants. Myers (2009) suggest that semi-structured interviews, predefined questions should be established, however, the answers to the questions are not limited and other questions can be asked during the interview (Myers, 2009). Our study employs semi-structured face to face interviews, which makes us to discover more things we may not consider before. In regard of interview questions, we firstly enter into the context without predefined questions. We chose and interview two different groups: 7 therapists working in the association A and 4 patients treated there. After examining and coding a verbatim transcription of 11 people, we formulate step by step researches objectives and the initial conceptual framework. All the above work

leads us to go beyond the setting of the association A, that is to say we have to analyze the actual mental health system for children. Interview guides are prepared for the different mental healthcare professionals.

The study examines our case the association A at the micro and macro level. Micro level analysis involves mental health professionals who work for the association A (Nantes and other city P). Macro level analysis is to inquire about the context of children mental health in France, that is to say the main-stream children mental health system. Our participants involve psychologists, child and adolescent psychiatrists, special education teachers (teachers with certifications in special education), patient's parents, social workers. They should work for mental health-related services. They are obliged to have at least 10 years<sup>11</sup> of working experience and practices in care sector. Some of them might not know the association A, but they are still recruited in the study. They are willing to talk about their working experience, their passion and enthusiasm despite having deal with a difficult situation, and their opinions of some changes in clinical practices. Patients' parents<sup>12</sup> also take part in the research. Their age, gender, race and work do not influence their eligibility to become participants in the research.

We recruit participants through two channels (a list of participants see Table 4). First and foremost, we express our thinking about data collection (ex: interviews, observation) to the Founder and the Assistant Director of the association A in Nantes. They share their opinions about data collection and a lot of useful resources including contact information, upcoming activities and etc. At the beginning, we frequently have some working meetings in order to talk about participant recruitment.

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11 A minimum of ten years is very important for recruiting interviewees because they have been experiencing a series of reforms introduced in medico-social care, and could present a "full picture" of transformation (before and after).

12 At the beginning we are interested in recruiting some adolescents regarding patient participant, especially some are treated in trajectories of mental health-related service. However, they are in severe mental disorder so that they are not able to share their opinions. That's why we recruit their father or mother as participant.



We write the recruitment notice in French (see in Appendix 1), explaining who we are, what our research goals are and what the participants' criteria are, with our contact information for those who are interested in the research to contact me. For professionals who contact us, we provide them more details about our research and their rights as participants, and answered all their questions by emails and in person. We are careful and clear in explaining who we are, what we want to do research on, why the research is important, and how participants' right would be protected throughout the research. In the association A Nantes, it is a little easier to recruit the participants and conduct a series of interviews with mental health professionals because there are already many occasions where we have face-to-face and casual conversation in the working place. Furthermore, members who work for the association A in other French cities come to Nantes for the meeting and training once a year. During the meeting, the Founder also present our PhD thesis. We make use of this occasion and get more contact. At the present, there are six in France, we finally select one of them in P- a French city near to Nantes. As we mention above, there is a rising attention on the association A from the professionals who work for the national response of the health and welfare service system to the mental health care needs of Frenches. Thus, interviewing with mental health workers in P might not only provide another landscape of the association A, but also outline paths to the French mental health context.

Another recruitment route as through our personal contacts. We begin to think and go beyond the association A after a number of interviews with professionals. In order to address the issue on the health and welfare service system to the mental health care, we attempt to contact more professionals in child mental health-related service. Furthermore, three senior managers and two patients' parents accept to be participants. Step by step, we could develop another group of interviews. This group seem to unfold and uncover the lived world in child and adolescent mental health system of France. During the meeting with them, we introduce ourselves and present the consent from which clearly address the purpose, the procedures, risk and benefits

of the study. We fully explain our research and emphasize their participation would totally depend on their willingness to participate, and they could withdraw at any time during the research. The other is about the confidentiality. Before interviewing and recording, we emphasize on our conversation in confidentiality. In all field notes and accounts, we would refer to the mental health services, participants and patients using pseudonyms to prevent disclosure. The observation notes, interview notes, audio materials, and other reference documents would be used only for our research or potential future publications. The following table 4 indicates all the participants involved in our study.

**Table 4: List of participants involved in interviews**

<b>Interview Code</b>	<b>Sex</b>	<b>Illustration</b>
P1	Female	Educator
P2	Female	Psychologist
P3	Female	Educator
P4	Female	Her daughter, 23 years old, with mental disorder.
P5	Female	Psychologist
P6	Female	Social service assistant
P7	Male	Psychiatry
P8	Male	Educator
P9	Female	Educator
P10	Female	Secretary
P11	Female	Psychologist
P12	Female	Psychologist
P13	Female	Her son is in IME since he is 7 years old
P14	Female	Her daughter is in IME.
P15	Female	Psychologist
P16	Female	Educator
P17	Male	PE teacher
P18	Female	Educator
P19	Female	Psychologist
P20	Female	Secretary
P21	Female	Educator
P22	Female	Educator
V1	Male	Animator
N1	Female	Psychologist

N2	Female	Psychologist
N3	Female	Psychologist
N4	Female	Psychologist
N5	Female	Psychologist
N6	Female	Psychologist
N7	Female	Psychologist
N8	Female	Psychologist
N9	Female	Psychologist, Founder of the association A
N10	Male	Psychologist, co-administrator with Founder

(Source: Author's conceptualization)

## 2.4 Analysis of Empirical Data

This part involves three parts: data transcribing, coding and analyzing.

### 2.4.1 Data transcribing

In the qualitative data analysis, the transcribing is a time-consuming process. The total of interviews is minutes and has been recorded. We make all those interviews in a verbatim transcription. Each interview averagely requires 10-12 hours to transcribe, with a full-length transcript varying from 7 pages to 20 pages. All the interviews are conducted in French. and we do not translate the interviews into English.

### 2.4.2 Data coding

Qualitative study is a focus on the interpretation of the world, that is to say huge amounts of data requires the explanations. Stake (1995) argues that data collection and data analysis should be simultaneous. Cassell and Symon (1994) share the same opinion and think that there is no distinction between data collection and data analysis. In doing so, researchers should have to very clearly understand the data.

Two types for qualitative data analysis are quite often employed: grounded theory, and thematic analysis. Thematic analysis seems to be a little accessible than grounded theory. There seems to be endless versions of grounded theory with

different theoretical frameworks and different procedures (Birks & Mills, 2011). The objective of different approaches to grounded theory is an attempt to develop a systematic method to analyze the qualitative data. At the very beginning of data analysis, we deal with our amounts of data by the use of thematic analysis. It is used to analyze classifications and present themes that relate to the data. It is very appropriate and allows us to develop the relationships between concepts and compare them with the replicated data. But finally, we chose grounded theory rather than thematic analysis.

Grounded theory is very similar to thematic analysis in terms of the procedures for coding themes or coding from data (Braun & Clark, 2006). Grounded theory suggests that data analysis processes should start at the same time as the data collection process. That is to say, the further data collection should be grounded on what has been previously analyzed (Strauss & Corbin, 1990). That is the notable difference to thematic analysis. In our data collection, we have no clue at the very beginning of research. After having a first-around interviews, we attempt to conduct the next series of interviews while grounded on what we have analyzed in the previous interviews. Furthermore, we have to make distinction between a full grounded theory and what we call grounded theory-lite. A full grounded theory is a methodology which requires the implementation of the full range of grounded theory procedures, such as theoretical sampling with the aim of producing a theory grounded in data. A grounded theory-lite, in our opinion, represents some techniques of grounded theory for the development of categories, and involves an understanding of the relationship between the categories (Pidgeon & Henwood, 1997). That is frequently used form of grounded theory while most of researches do not make clear distinction. In this such, we employ the grounded theory-lite to code and interpret our data (make data into categories). Normally there are three basic steps of the coding process:

- 1) Open coding is the process of breaking down, comparing, conceptualizing and categorizing data (Strauss & Corbin, 1998). Such coding is realized here by

comparing each incident, event, quote and instance gathered during the data collection for similarities and differences. To identify the problems encountered in actual mental health system, open coding is employed based on the guideline proposed by Strauss and Corbin (1998, p.101). During the open coding process, data is broken down into discrete parts, closely examined and compared for similarities and difference (McGhee, Marland & Atkinson, 2007). By using open coding, categories along their prosperities and dimensions are extracted from the raw data. This process is iterative where expressive statements in data are detected and the relationship between them evaluated. Some coding categories initially identified are revised during subsequent coding. The following part will present how we code and identify the problems that professionals face in actual mental health system for children.

Step 1: reading the transcripts to get an overview of every professional.

Step 2: analyzing the transcripts sentence by sentence to identify the child mental health system problem and to generate initial codes. The analysis technique in open coding is either word by word, phrase by phrase or sentence by sentence, as suggested by Strauss and Corbin (1998, p. 101). This approach ensures that the important information is left out.

Step 3: identifying first level sub-categories from the unique codes during this step, the identified initial codes are grouped to form sub-categories. There are two “story lines” in our research. At the beginning of empirical analysis, it is quite important to draw two lines from a number of data (See the Table 5 and 6).

- 2) Axial coding aims at defining relationships between the concepts.
- 3) Selective coding is to form a central core category.

**Table 5: Subcategories and categories used an inductive approach to qualitative content analysis**

Category	Physical features	Social features	Organizational features
	Private or semiprivate spaces	Interaction/ relationships with other parents/kids	Service (free, accessibility)
	Public spaces	Interaction/relationships with the staff	Activities (group, individual)
	Non-institutional		Rules/policies (non-formalized treatment overall wellbeing of children health)

The first line aims at objectivizing the physical, social and organizational features of the association A (Source: Author’s conceptualization).

**Table 6: Themes and subthemes using an inductive approach to qualitative content analysis**

Main theme	Managerial techniques for handling accountability	Relationship between professional ethic and attitudes with respect to the accountability measures
Subtheme	files in line with plan-execution Documentation for informing individual work, and means of monitoring staff Inspection methodology	Professional autonomy Clinical practices Relations mediated by outputs, indicators, assessment data, etc.

The second line aims at aims at exploring medical-social staff’s perceptions of accountability measures (Source: Author’s conceptualization).

## 2.5 Conclusion to the Chapter

This chapter is centered on epistemology and methodology. It is composed of two sections. The first section aims at presenting qualitative research over quantitative one, and justifying why use Stake’s perspective of case study. The second section is a focus on data collecting and data analysis. Grounded theory is seen as a method and employed in data coding.

# **3 NPM, MANAGERIALIST NOTION OF ACCOUNTABILITY AND PERFORMANCE MANAGEMENT**

## **3.1 Introduction to the Chapter**

The aim of Chapter three is to present the background of research. It will be centered on NPM reform introduced in public sector, especially its great impact on French healthcare. The emphasize on the logic of details based on neo-liberal economics is in conflict with the logic of self-governance in relation with autonomy, trust and human relations. The rise of managerialist accountability reconstruct the organizational structure and relationships. The decline of trust in professionals in public service has resulted in new forms of control based upon contractual forms of relationships and upon “surveillance” through performance measurement (reward or sanction). In doing so, this section is composed on two parts. The first part is about the origin of NPM, the reason for NPM, NPM reforms translated in French care sector. The second part is centered on accountability, managerialism and performance management.

## **3.2 NPM and NPM-Related Reforms Introduced in French Care Sector**

### **3.2.1 Review of the origin and reason for NPM**

Since the end of 1970s to the beginning of 1980s, in the influence of globalization and information technology, OECD countries have set off the wave of government reform. It originated from the United States, Britain, New Zealand and Australia, and rapidly expanded to other countries. After entering the 1990s, the wave of government reform has also appeared in some emerging industrialized countries and developing countries. The reform ideas are basically through the introduction of market competition mechanism and the business management concept, in order to improve the quality of public service and the level of public management, which is the NPM movement. The essence of NPM is the marketization of government functions and public service output, and the reconstruction of government responsibility mechanism, under the guidance of customer first and public responsibility. At the same time, public management practice has also introduced effective management methods such as performance management and evaluation, competition mechanism and so on.

The diversity of public values and demands, the enhancement of public democracy and participation, etc. put forward new requirements for the government. The government needs to be more flexible and efficient, improves its resilience and creativity, and allows more public participation in management. The traditional public administration system is rigid and obtuse, with the tendency of maximizing the scale of administrative agencies and the amount of public budgeting. The problem such as government expenditure, increasingly serious financial crisis, difficult welfare system, economic stagnation and low efficiency, make the public more and more dissatisfied with the government. Meanwhile traditional public organizations are portrayed as inefficient and ineffective, focused on maximizing inputs<sup>13</sup> and rendering compliance. They put more consideration on the amounts

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13 Inputs are the resources that an organization uses to produce service. Inputs include human, finance, facilities and materials. A complete definition of input includes information, requests, problems and even conflicts (Linden, 1994) as inputs



spent for certain government tasks and the means with which these are achieved. That pushes the government to change its traditional system and move to the reform in order to pursue the goal of “3E” (economy, efficiency and effectiveness). Economy is the minimization of resource consumption (Hilliard, 1995) or the cost of inputs that are used to produce outputs<sup>14</sup>. Economy refers to the acquisition of resources in the right quantity, of the right quality, at the right time and place at the lowest possible cost. It cannot be useful that a service is cheap but it does not satisfy the intended objective or quality. Effectiveness is an extension or consequences (Coombs & Jenkins, 1994) that results from efficiency and determines the relationship of an organization’s output to what it intends to accomplish (Dalton & Dalton, 1988). It also means that match between the results achieved and those needed or desired. Etzioni (1964) defines it as the degree to which an organization realizes its goals. It can also refer to the extent to which set policy objectives and other intended affects are achieved (Erridge, Fee & McIlroy, 1998). Efficiency is a dimension of performance that is based on a direct relationship between input and output (Epstein, 1992). It is measured by the ratio output: input or what is referred to as productivity<sup>15</sup>. The central question of efficiency is normally posed as follows: are we doing things right? The phrase "doing things right" means without necessary expenditure of time, money or effort (Rothwell & Kazanas, 1992). Individuals have more control over how that input is economized for maximum output. Broadly defined, this is the ability to bring the limited resources of an organization into a proper relationship to the desired goals.

NPM may be viewed as an instrumental approach to management. To be specific NPM embraces a hybrid of management accounting concepts and

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to be processed to attain complete products, deliver services or goods.

14 Outputs are goods and services produced. Some scholars see output as an indicator of activity (Coombs & Jenkins, 1994; Brudney & Morgan, 1988) like the number of houses built. Outputs are activity oriented, measurable, and usually under managerial control This refers to how well services are delivered without regard as to whether they contribute to effectiveness.

15 Productivity in the public sector is often complicated to define. It refers not only the output that is important, but more the outcome. It thus results in performance management itself being divided into two: output and outcome.

techniques with public health strategies and initiatives. The main elements of NPM are decentralization, accountability, transparency and efficiency. NPM has become a well-known world-wide phenomenon. It became international trend in the public sector within the OECD countries during the 1980s and 1990s with some late adopters after 2000 (World Health Organization, 2000). Many scholars view management accounting aspects of NPM, especially that of performance measures. Jacobs (2012) calls for the development of theoretical frameworks to enhance our understanding of the role of accounting in the public sector. In fact, NPM is a series of management philosophy and organizational control systems. The private sector has developed those system devices to measure their performance. The principal concept of NPM is thus constituted by management accounting ideas, which is a focus on efficiency and productive.

NPM components, as articulated by Hood (1991, 1995) in two of the most widely cited articles in the public sector literature, identify seven key elements:

1. Unbundling public sector into corporatized units organized by product.
2. More contract-based competitive provision, with internal markets and term contracts.
3. Stress on private sector management styles.
4. More stress on discipline and frugality in resource use.
5. Visible hands-on top management.
6. Explicit formal measurable standards and measurement of performance and success.
7. Greater emphasis on output controls.

### **3.2.2 NPM introduced in healthcare sector**

Health care is one of the major governmental sectors that have faced many changes due to implementation of NPM. The public health care sectors differ in structure, availability and governmental influences across nations. However the overall aim of public health care is to ensure good medical treatment to the public;

the implementation of NPM in public health care has revealed several differences in perception, application, usage and knowledge, which has resulted in various dilemmas and paradoxes of NPM, particularly the conflicts between opposing core values such as care and management. The consequences and effects of introduction NPM vary depending on the context and setting in which the health care system operates. One of the main arguments against the introduction of NPM in the health care sector is a focus on economic discursive ways of thinking and the neglecting of social relations (Glennerster, 1994). Nevertheless worldwide increases in health care costs along with the increasing demand forecasts caused by aging populations force health care managers to constantly review procedures and organizations. The set-up of public health care systems is often very complex since political aspects play a major role in it. Furthermore the line of authority and command is distinctively long, with various layers of decision-making and with a great distance between top political decision-making and actual daily working experience. Therefore the initial intentions of the politicians often change as they are translated through the hierarchy and this can result in different outcomes than those initially anticipated by policy makers.

### **3.2.3 NPM translated in French healthcare**

The reforms are in the name of NPM and numerous authors note the relative failure of these reforms. France has also taken part in NPM reforms, and this more particularly from the beginning of the 2000s. It is possible to read the principles of the NPM in France through three successive reforms after 2000: the LOLF, voted in 2001 and implemented in 2006, the RGPP in 2007 and the MAP, announced in 2012 and whose first works have started in 2013.

In the 1970s, some attempt is made in French public management. It introduces the broader ideology of managerialism, for example accountability for performance, performance auditing, rationalization or streaming of administrative structures, more use of information technology.....It is at full stretch to develop scientific

management in the public sector. At the same time, it progressively leads the development of administrative thought in the public sector. The important measure is to train students for executive positions in the public sector (Bezes, 2012; Gruening, 2001).

The first attempt to introduce formal evaluation mechanisms is the Rationalization of Budgetary Choices (RCB)<sup>16</sup> introduced in 1968 and inspired by the American Planning Programing Budgeting System (Perret, 2006). RCB reorganize organizations and standardize administrative procedures. In the logic of RCB, the new budgeting is based on “program”. Drawing up the budget is always prepared by nature of expenditure (Perret, 2006).

The second attempt is to train official and civil servant for skills in management. The policy is important, but the application of policy is much more important. Two organizations, Centre for Higher Education in Public Management<sup>17</sup> and Higher Council for Management Training<sup>18</sup>, play a very important role in public management training. Students, officials or future civil servants receive the content of public-management courses which draw on “*the findings of generic management research from the heydays of the neoclassics*” (Gruening, 2001). The field of public management is to be a discipline with the same courses of schools for business administration. The neoclassic approach is highly influential in the private sector, and then translates to the public sector via public management. The objective of those course is to develop more rational management styles. That is to say, that rational thinking tends to gather and analyze more information in order to find optimal answers to management problems.

RCB receives many criticisms and is abandoned in 1983. Since then several evaluation initiatives take place, chiefs among them are the creation of the Scientific Council for Evaluation<sup>19</sup> in 1990, changed into the National Council for

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16 Rationalisation des Choix Budgétaires (RCB)

17 Centre d’Étude Supérieur du Management Public (CESMA)

18 Centre Supérieur de Formation en Management (CSFM)

19 Conseil scientifique de l’évaluation (CSE)

Evaluation<sup>20</sup> in 1998 and the passing of French Budget Act (LOLF)” in 2001, an organic law reframing policy funding. Following this law, the reforms launched by the General Review of Public Policies (RGPP, 2007-2012) accelerated the need for program evaluation.

#### (1) LOLF

In 2006, a performance measurement system is set up in France based on a series of performance indicators. We called it LOLF. It is actually promulgated on 1<sup>st</sup> August 2001 and aims at measuring the performance of public organizations in order to ensure more democratic and efficient management of public expenditure. Totally influenced by NPM, France’s French Budget Act importantly undertakes in public reform. The LOLF has been remarkably innovative on the following two levels:

On the political level, Parliament gets back a power in matters dealing with public financing. That is to say, the LOLF significantly increases the role of the Parliament in holding the Government to account for the stewardship of public money and improving the transparency of expenditure allocation (Rabrenović, 2009). The government has to be more rigorous in management since the Parliament enhance its supervisory function. The members of Parliament have the right to amended des budget framework, and allocate appropriations between the various programs which constitute a particular mission. Regularly, the members of Parliament are provided with a detailed report on the overall economic, social and financial information. The report should be “readable” and “comprehensible”, regarding to the complex issues of Government financing. The report is composed of the list of missions, programs and performance indicators. In this sense, Parliament executes the power in budget allocation, execution and supervision. In consideration of the social interest, it may raise a question about whether the Parliament has enough strength and capacity to effectively ensure the modernized expenditure framework, or ensures efficiency and effectiveness of public spending in accordance

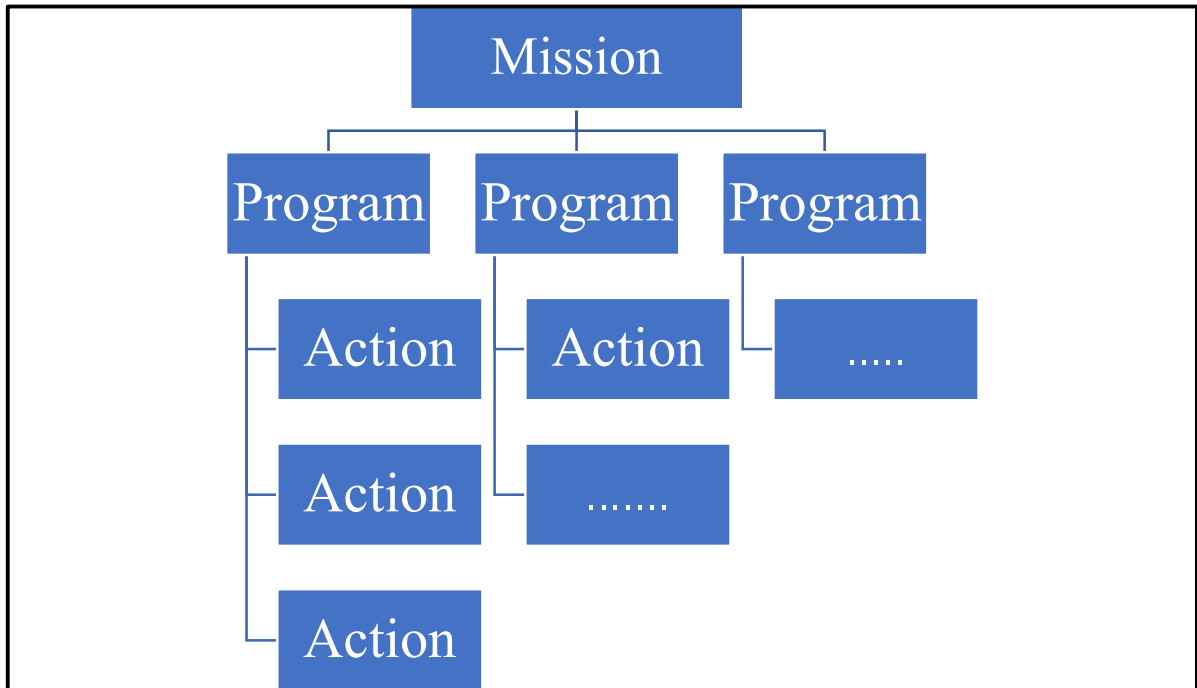
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20 Conseil national de l’évaluation

with a battery of indicators.

On the economic level, the LOLF decides to create a result-oriented performance budgeting system and build a new budget frame based on the three levels of “mission”- “program”- “action” (see the figure 2). That draws more attention in its layered aspect, its complexity and the introduction of the results of state action by means of indicators. In the first place, the LOLF consists in a new architecture of the General Budget, no longer defined by ministry but by mission, program and action. A mission may concern one or more ministries. A program is a grouping of means in a public policy: it is run by a ministry in accordance with a defined strategy. An action identifies the means and modes of action of the protagonists of a program. Drawn up according to this architecture, the budget reflects the key choices in public policy relating to employment, education, security, housing, and others. The complexity of state policies is simplified in order to be comprehensible, legible and readable. Secondly, every mission, program and action are evaluated by a series of indicators. The budgeting system is much more result-oriented. It seems to be more transparent. In the third place, all the allocation of public money is discussed and decided by the Parliament. Provide accountability to the public and higher levels of authority. It is a communicative way between government and citizens.

**Figure 2: Structure of state budgeting**



(Source: Author's conceptualization)

It is well concluded that the core of France Budgeting Act is the evaluation of state policy based on a battery of indicators. In doing so, we have to raise the following questions: whether state policies, social actions, etc. could be quantified by a means of indicators? whether the performance indicators could be simply defined as a digital? whether the indicators are well relevant for the performance? After having sampled the indicators and discussed their relevance, Brunetière (2006) points that some indicators fail to pinpoint the principal action of the state in a precise area, as a result, only measure assessor elements of this action. The example of Foreign Affairs is well presented. Its objective is to defend and represent abroad the interests of France, while the only indicator is the number of visits to departmental websites and posts. It is clearly shown that the indicators don't well measure the performance of state policy. Moreover, some indicators are not relevant for the evaluation of a given action and can even lead to results that hardly reflect

that action. See the example in the Department of Justice. Its objective is to deal with the criminal cases with a high quality, in the reasonable time. Its indicator is the number of criminal cases handled by investigating magistrate (TGI<sup>21</sup>).

It seems, in their opinion, that “productivity” means the level of quality of “product”. If last year the Justice deal with 100 cases per year, and this year 300 cases per year, whether we could make a conclusion that the performance of Justice is in a high level? Or that they present a very good work? It exits the ambiguous definition of quality in its objective. Furthermore there appears the irrelevant relation between the quality of work and the evaluation indicator. In this condition, it seems to lead a “cheat in making numbers” in order to get more funding from the government. There are still some indicators which are only able to measure internal activities, without taking consideration into the impact of its activities on users or the general public. For example, the objective of General and Territorial Administration is to improve prevention in the field of civil security. Yet its indicator is to investigate the open ratio of institution to the public subject to the obligation of inspection by the Safety Commission. In effect, the open ratio is determined by the actual needs of the public, not by the government. It measures the capability of setting up the modest programs (internal activities), and doesn’t measure the performance of civil field.

## (2) RGPP and MAP

On the eighteenth of December of 2012, Modernization of public action (MAP) take over the General review of public policies (RGPP)<sup>22</sup>. MAP has two key features.

(a) It builds un additional step in the reforms on some organization with private status. (b) It provides a much more clearly framed (than RGPP) methodology for the way evaluations should be carried out. MAP establishes a Secretariat (SGMAP)<sup>23</sup> under the direct supervision of the Prime Minister, in order to provide

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21 TGI : tribunal de grande instance (future tribunal judiciaire)

22 Révision générale des politiques publiques (RGPP)

23 Secrétariat général pour la modernisation de l’action publique (SGMAP)



guidance and a streamlined process for evaluation. According to a series of policy documents, Lux (2013) summarize in the following three points:

- a simplification of administrative action. This simplification involves in removing the old doctrine in order to create the new doctrine. The measures are composed of simplifying daily routines, setting up an independent “barometer” to supervise the quality of public service.
- an acceleration of the digital transition in order to improve the accessibility of public service.
- an evaluation of public policy. The objective of MAP is still the same as that of RGPP: maintain a high-quality public service while spending less. Compared with LOLF (focus on the public administration, but totally influence the following reforms), MAP and RGPP expand the evaluation scope in all the regional and local authorities. The significance influence, we need to point, is that MAP’s focus on policy evaluation in medical-social facilities<sup>24</sup>. It attempts to make medical-social facilities adapt to the performance-driven MAP. That brings them to be more efficient, transparent and economic.

### **3.2.4 Challenges of the French medical-social care**

The French medical-social sector is faced with new challenges, one of which is to deliver quality public services to a larger population (most of them are the disadvantaged communities), with limited resources. The challenges and pressure on service delivery have led to a search for better mechanisms to deliver service economically, effectively and efficiently as is required by the government. Furthermore it is quite important to manage risk and assess where risk could come from.

The struggle for policy implementation (since NPM a series of law and regulations have been implemented) still continues today despite the many efforts directed at implementation. The major struggles are those of introducing a

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<sup>24</sup> In France the existence of medical-social facilities is somewhat complicated. They are in private status, but they are funded by the government.

performance culture (OECD, 1994), increasing performance and accountability of public organizations. Performance management tools for improving performance amount to sending to signals in medical-social establishments.

### **3.3 Accountability and performance management**

#### **3.3.1 Accountability**

One sense of “accountability” is considered as a “process, account to some authority for one’s action” (Jones, 1992). Or its meaning is understood by the exchange of reasons for conduct (Garfinkel & Bittner, 1967). One is accountable, so he or she is bound to give an explanation for actions taken to another one. Gray and Jenkins (1986) think that the accountability means “an obligation to present an account of and answer for the execution of responsibilities to those who entrusted those responsibilities”. Accountability presents an ability, an ability to explain how resources are assigned and used (Sinclair, 1995). Romzek and Dubnick (1987) think that accountability refers to answerability<sup>25</sup> for one’s action or behavior. Administrators and agencies are answerable for their actions. In doing so, we can’t think accountability only as a literal accounting or reporting although the term “accountability” often appears in a financial report. As such, the concept of accountability should involve two components:

- account to or give an explanation for one’s action or behavior,
- answerability for one’s action or behavior.

Romzek and Dubnick (1987) attempt to review four types of accountability systems in order to analyze the basis for accountability (see the figure 3).

a) Bureaucratic accountability systems (cell1). This mechanism is widely used. It implies focusing attention on the priorities of those in power (at the top of the bureaucratic hierarchy). The bureaucratic accountability systems functions at two points: (1) a legitimate relationship between a superior and a subordinate in order to

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25 In our paper, the term “answerability” means “responsibility”, and “answerable” means “responsible”.

follow “orders”; (2) a standardized and operating procedure, a clearly stated rule and regulation.

b) Legal accountability (cell 2). Comparing to bureaucratic accountability, legal accountability system is based on relationship between a controlling party outside the agency and members of the organization. At the same time, the legal accountability involves the autonomous parties and a formal or implied fiduciary (principal/ agent) agreement. It does not imply the ability of supervisors to reward or punish subordinates that is involved by the bureaucratic accountability system.

c) Professional accountability (cell 3). It often occurs in the complex and technical condition. Authorities need rely on skilled experts to solve a complex problem. In doing so, those employees hold fully accountable for their actions in order to meet job performance expectations. There might occurs a potential problem. How those employees account for or justify their actions, in consideration of the government having different scopes of expertise with those experts.

d) Political accountability (cell 4). It implies the relationship between the representative (the public administrator) and their constituents. The potential constituencies include the general public, elected officials, special interest groups, etc. The question involving in political accountability is that “*whom does the public administrator represent?*”.

Figure 3

		Source of Agency Control	
		Internal	External
Degree of Control Over Agency Actions	High	1. Bureaucratic	2. Legal
	Low	3. Professional	4. Political

(Source: Romzek and Dubnick, 1987)

There would induce a conflict if these above models operate at the same time and in the same organization. In this situation it is a complicated problem about how to develop the mechanism for accountability.

Greatly influenced by NPM, the accountability is possible favorite to make public managers realize their objectives. Because they need have to “*give an account of what they have done in the past, what they are responsible for in the present and what they are going to do in the future*” (Farneti & Bestebreuer, 2004). The term of accountability is often linked to the contemporary political discourse. Koppell (2005) distinguishes five dimensions of accountability, including transparency, liability, controllability, responsibility and responsiveness. From Koppell’s point of view, we find that it is a little difficult to say whether an organization is accountable in the broad sense of accountability. Because those elements cannot be measured with the same scale. For example, the element “transparency” could be helpful to

accountability, but not constitutive of accountability. Other element “responsiveness” tends to be viewed in an evaluative dimension (Bovens, 2007). Accountability in this very broad sense is basically related to the evaluate, not the analytical dimension. It is often used to qualify the performance of an actor and a state of affairs. That is to say, it attempts to develop an standard for proactive responsible behavior of actors. In that sense it would lead some problem, because it is difficult to develop the consensus of standards for accountable behavior, and they differ in the role, place and time.

In a narrower sense, according to Bovens (2007), accountability refers to a specific set of social relations. In this paper, we will define accountability in a narrow concept-sociological sense. Because accountability involves in a concrete practice of account giving. It needs to be analyzed empirically. In the following of our paper, we will study why many medical-social staff have a great burden of burnout. Accountability as a social relation is pertinent to develop an analytical building block for addressing our research question.

### **3.3.1.1 Public accountability**

Accountability is an important element of governance. As such, the public accountability also involves being accountable and answerable for behavior. In our paper we will concentrate on *public* accountability. “Public” firstly refers to the accessibility, i.e. be open to the general public. Public accountability requires openness of account giving, whereby those in power should be accountable in public for their behavior. “Public” secondly refers to the object of the account to be rendered. It is a focus on how public funds are utilized by public managers and officials, how to exercise public authorities, and how to conduct public institutions. Here it’s important to point that public accountability mainly implies matters in the public domain, but it could extend to private bodies that receive public money or public privileges<sup>26</sup> (Scott *et al.*, 2000). Public accountability involves in rendering

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26 We point it in particular because some French medical-social institutions (the

an account for matters of public interest. That's why we could say public accountability is in and about the public domain. Patton (1992) reviews the following concept of public accountability:

1) Both report and explanation. Public accountability puts a focus not only on governmental reports (financial reporting), but also on an explanation for actions. That is to say, those in power should have to present reporting materials, and at the same time to explain or justify their judgments or decisions.

2) Sanctions or rewards implied. Some believe that if the real accountability occurs, the receiver of information need have to reward or punish the accountant for whatever the accountant is being held accountable. If such sanction or rewarding is related to accountability reporting, the incentive effects of information system may have an influence on the reporting practices. If that is misused, it would lead some "cheating in numbers", i.e. to break the objective feature of reporting. We could find that public accountability executes a democratic control.

3) Relationship between accountant and accountee. The nature of the relationship could affect the information that might be demanded and transmitted.

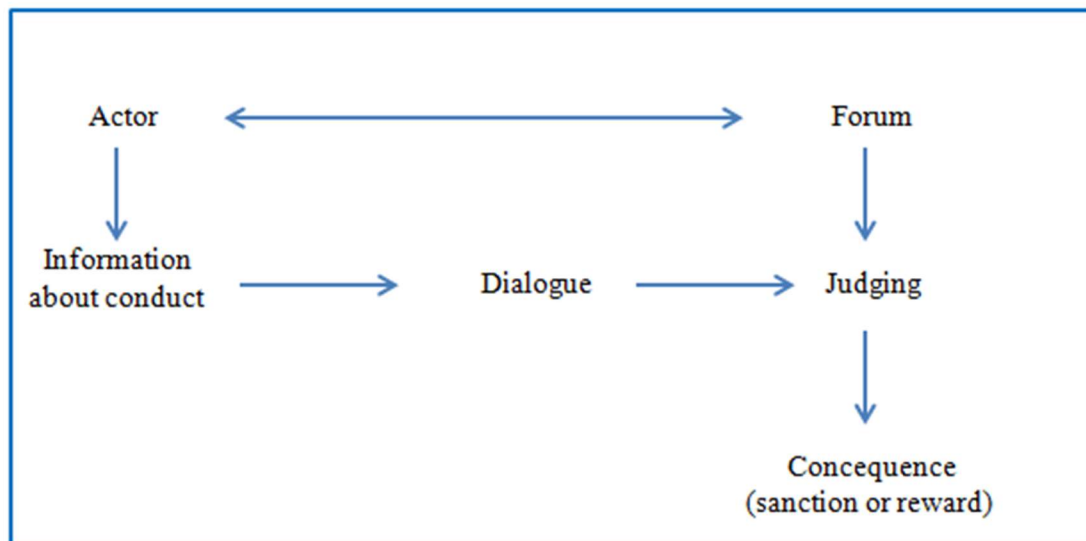
In short, public accountability has two major definable characteristics: (1) it involves a social relationship between at least two parties (2) in which one party feels accountable for his behavior to the other. Accountability used in this paper refers to a specific set of social relations that can be studied empirically. Thus we firstly need to know who is accountable to whom? Those social relations imply an actor, the accountant, and a forum, the account-holder, or accountee (Pollitt, 2003). Secondly, what is a social relation qualified as accountability? Accountability is defined as a relationship between an actor and a forum in which the actor has an obligation to explain and justify his or her conduct, the forum could ask questions and pass judgement, and the actor may face consequences. With public accountability, the actor would be a government or a public institution. The accountability forum would be an agency, such as parliament, a court or the audit

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object of our research) are private but they receive public funding and need have to be accountable for their actions.

office, even the general public. The actor is obliged to explain to the forum for his conduct by providing some sorts of information (procedures, results and etc.). And then the forum could question the adequacy of the information or the legitimacy of the actions. Finally the forum would qualify whether the actor is answerable or not (pass judgement on his conduct). The consequence would be sanctions if negative judgement is passed (see the figure 4). From here, we could find it is crucial to develop a “dialogue” in that relationship (Sanderson, 1998), i.e. in the process of public accountability. Because there is no general consensus about the standards for accountable behavior. Every actor should have to explain his concrete practice of account giving. The forum would pose questions and debate with the actor.

**Figure 4: The process of public accountability**



(Source: Pollitt, 2003; Sanderson, 1998)

### 3.3.2 Performance management

While performance management generally would be referring to a system used to evaluate performance of people, here it refers to a combination of both the people and systems and processes but very specific to the latter. Performance management is the means through which performance against objectives is reviewed, using

appropriate performance measurement<sup>27</sup> information and decisions made regarding direction, required action and resource allocation. In defining performance management, it is important to begin with the concept performance before dealing with management and combining them.

It's widely agreed that the definition of performance is in a multidimensional construct. Having referred to some literature, we have reviewed different definitions of performance (see the figure 5). At the same time, we classify them under six sorts. (1) a result; (2) the ability; (3) the manner; (4) the process or the state; (5) linguistic behavior; (6) performing a role before audience. The object of our paper is centered on the public sector. In doing so, we will be a focus on the definition of (1)---(4). Performance is generally defined as regular measurement of outcomes and results, as the definition (1) says. It's important to note that it could lead to some negative effects if the result or output is excessively related with performance. As such, the term "performance" should be a multi-dimension and dynamic concept. It comprises both a behavioral (i.e., an action) and an outcome aspect. At the same time, performance is in change.

**Figure 5**

**Different definitions of performance<sup>28</sup>**

- 
- |    |   |
|----|---|
| 1  | Something accomplished: deed, feat  |
| 2  | The ability to perform: efficiency  |
| 3A | The manner in which a mechanism performs                                    |
| 3B | The way in which someone or something functions                             |
| 3C | The manner of reacting to stimuli   |
| 3D | Behavior in which an organism engages in response to task or activity which |
- 

27 Performance measurement is the process of quantifying the efficiency and effectiveness of past actions through acquisition, sorting, analysis, interpretation and dissemination of appropriate data (Neely, 1998). In our study, we argue its definition into this perspective: performance measurement refers to it as evaluating how well organizations are managed and the value they deliver (Moullin, 2004). In doing so, performance measurement is the essential element on which performance management could be built.

28 The American Heritage Dictionary of the English Language by William Moris; Dictionary of Behavior Science and Webster's New Collegiate Dictionary by Benjamin B. Wolman; Dictionary by Merriam-Webster.



lead to results, especially to a result which modifies the environment in some way

- 4A The act of performing or the state of being performed
  - 4B The fulfillment and implementation of a claim, promise or request
  - 4C The execution of an action
  - 4D Activity
  - 5 Linguistic behavior, contrasted with competence
  - 6A The action of representing a character in a play
  - 6B A public presentation or exhibition
  - 6C The act or style of performing a work or role before an audience
- 

(Source: Author's conceptualization)

The above descriptions are made from the very general approach. In the next step, we will put the concept of performance into individual and organizational perspective.

### **3.3.2.1 Individual performance**

Individual performance is one of the key variables in an organization, because highly performing individuals help achieve organizational goals and improve competitive advantage. Individual performance, like performance, firstly encompasses both an action ((i.e., behavioral) aspect and an outcome aspect of performance. But it is important to note that only behavior which is relevant for the organizational goals is included under the performance concept. The outcome aspect refers to the consequence of the individual behavior. It actually might be difficult to describe the action aspect of performance without any reference to the outcome aspect. In doing so, the behavioral and outcome aspects are related empirical. Secondly, performance changes overtime, and is not invariable. That is to say, individual performance is not stable over time. In doing so, we need have to focus on the process and long-term changes.

### **3.3.2.2 Organizational performance**

The increasing number of research is interested in how to improve

organizational performance. Organizational performance is not the sum of the individual performance. From a micro perspective to analyze, organizational performance includes task and contextual performance (Borman & Motowidlo, 1993). Task performance contributes to the organization's "technical core". It refers to the staff's proficiency in his work. Contextual performance refers to those activities which support the organizational, social and psychological environment in which organizational goals are sought. For example, one staff consciously take on some work that doesn't belong to him, or co-work with another colleague to complete a case. It's evident that contextual performance reflects those behaviors which aim primarily at the smooth functioning of the organization at the present moment, and proactive behaviors which aim at improving work procedures in the future. Moreover, individual performance changes over time. As a consequence, helping the individual's continuous leaning and competence development become increasingly important. The development is implicated in conceptualizing organization performance. Pulakos *et al.* (2000) recently advice 'adaptive performance' as a new performance concept in which 'learning' constitutes a major performance dimension. In doing so, organization needs to pay attention the ongoing changes and develop an adaptive performance regulation.

In a macro perspective, organizational performance is equated with effectiveness measured as goal attainment. Effective organizations are those that organize around a set of objectives, determine the activities necessary to achieve those objectives, and allocate resources to those activities. Organization theory provides different tools for dealing issues about organizational efficiency. It has different perspectives to it including the rational, natural, institutional and open systems. The first is the rational perspective, which includes scientific management (Taylor, 1911), the administrative (Fayol, 1949), the administrative man (Simon, 1945), bureaucracy (Weber, 1946), coordination and specialization (Gulick & Urwick, 1937). The second is the natural perspective, for example the "Hawthorne Effect" (Mayo, 1945). The third is the open system approach to which March and

Olsen (1976) see organizations as loosely coupled systems. Weick's (1976) cognitive theory can be also attributed to this perspective. The fourth is new institutionalism, which is found within economic organization theory, political science, public choice and sociology. Institutional economists and public choice theory assume that actors construct institutions that achieve the outcomes they desire. Institutional arrangements are viewed as adaptive solutions to problems of imperfect or asymmetric information. In short, these perspectives to organization theory represent not only what an organization is about, but also give consideration to develop organizational performance.

Above all, performance management is the formal information based on managerial techniques managers apply to maintain or alter patterns in organizational activities (Simons, 2000). The dominant concern of performance management in the public sector is productivity improvement, i.e. the production of more and / or better services. In doing so, it is the application of standards and indicators, application of a performance measurement system, supervision and motivation of staff, training, performance budgeting and accounting and community involvement (Balogun *et al.*, 2003). Performance depends on measurement and before measurement can take place, it needs to be decided what it is that will be measured. In view of scientific management by Taylor, basic elements of organizations have remained relatively constant. Purposes, structures, ways of doing things and approach to coordinate activities are only varied. Thus the scientific management conducts a scientific analysis in order to develop "one best way" to care out each operation.

### **3.3.3 Accountability requirements**

The application of accountability brings the modern society the greater democracy and justice. With democracy comes accountability for actions, they may be political or those taken by and on behalf of public organizations. Government agencies need to be held accountable for resources they use and the outcome they achieve. The most important, many claim, that the modern application of accountability improve organizational performance. Especially in the NPM ideology,

the government thinks the public accountability is a “good instrument” to enhance the effectiveness and efficiency of public governance.

For government, the core requirement of accountability is to make a full use of resources allocated to programs in order to meet public expectations. The officials are entrusted with fiduciary responsibility of using public money budgeted by legislators. They are obliged to be accountable for the efficient and effective operation of programs. They are not only to account for the use of financial resources, but also to fully accountable for the result of missions. That is to say, the full accountability reporting involves both program and financial performance evaluation. Accountability is an ethics requirement of good government.

For the public, the taxpayers have the right to know the utilize of public money. The public accountability process is usually determined by legislation and the parliamentary system. The legislature collects taxes and appropriate them to executive government by the budgetary process. So that executive government should be accountable to parliament for the use of public money. Parliament chose its representative members. They are responsible to the public and they judge whether the government fulfil its responsibilities. It is evident to conclude that every process should be transparent and be measured how well it achieve its mission.

In short, the traditional reliance on hierarchical control is changed by the quasi-market and contractual relationships. The new forms of accountability in which the notion of performance (evaluation and measurement of performance) figures prominently. Performance management is driven by the accountability and responsibility revolution, which propels the new culture towards efficiency and effectiveness in public organizations. To be able to measure particular processes, there is a need to identify, isolate and facilitate accurate measurement of both process efficiency and the effectiveness of the results or their outcomes. Accountability requires that the roles and responsibilities be clarified (Norman, 2002). However, many governments may not have sufficient accountability mechanisms, especially at organizational level. In doing so, many public policy and

regulations (we have above reviewed) attempt to provide an approach to accountability mechanisms.

### **3.4 Rise of Managerialist Accountability in the Public Sector**

Managerialism occupies an important place in Western management history, and it has a profound influence on the development of management theory and practices. In terms of theory, managerialism emphasizes management paramountcy, techno-scientific reasoning of instrument application. In terms of methodology, managerialism emphasizes standardized methods, quantitative analysis methods and performance management methods with distinctive technical orientation. In doing so, managerialism presents the scientific and rational management, as well as specialization and division of labor in order to normalize behavior and develop efficiency.

Managerialism is seen as a “technical” solution to the political problem of increasing the productivity and efficiency of public service (Pollitt, 1993), which provides a significant implication for forms of accountability. The rise of managerialist accountability reconstruct the organizational structure and relationships. First, there is a shift from public service professionals (who provide and promote social service) to manager and administrative staff (or superior and inferior). Second, it results in more managerial performance than professional trust. The decline of trust in professionals in public service has resulted in new forms of control based upon contractual forms of relationships and upon “surveillance” through performance measurement (reward or sanction).

In conclusion, managerialist accountability attempts to make public service more accountable for the efficient and effective use of resources through technical solutions to performance management.

### **3.5 Conclusion to the Chapter**

This chapter is centered on the background of research. It is composed of two sections. From the historical perspective (the first section), we have reviewed the origin and reason for NPM reforms, the translations of NPM reforms in French healthcare sector. Those reforms are growing at a time of tightening governance and control system. The second section is a focus on the accountability requirements in the public sector. Greatly influenced by “New Managerialism” (Seymour Wilson, 1996), the managerialist accountability attempts to make public service more accountable for the efficient and effective use of resources through technical solutions to performance evaluation. There is no way this could be done without accountability mechanisms (measuring and managing performance).

## **4 FOUCAULT'S PERSPECTIVE ON POWER**

### **4.1 Introduction to this Chapter**

This section presents Michel Foucault's views on power as a theoretical framework for this research. In the first place, the relevant concepts of power relation, power/knowledge and regime of truth, resistance, disciplinary control, etc., are investigated. The relevance of Foucault's perspective on power to managerial devices and accounting is also discussed. In the second place, Foucauldian applications within accounting are reviewed and critiqued. Thirdly, the adoption of Foucault's theoretical foundation on power is indicated. Finally, research questions are formulated based on the literature review and the objectives of research.

### **4.2 Foucault's Perspective on Power**

Michel Foucault is a French philosopher, historian and political activist. His thinking and ideas refer to many academic disciplines, including psychology, history and sociology. He has also published a wide range of books with the issues on power, knowledge, the nature of punishment, the surveillance state and others. Foucault has written and theorized intensively about society and human condition. Some of his key concepts and contributions to sociological theory are discourses, power/knowledge, disciplinary power and the panopticon. In doing so, our study will make a review of Foucault's work that could be generally divided into three stages and marked by the shift in research methodology and focus (Burrell, 1988).

The first stage is named as the "Archaeological Period". In view of Foucault, archaeology is used as a method of historical inquiry to examine the statements of discourse. Archeology uncovers the discursive practices that constitute fields of knowledge (Foucault, 2013). The second stage is called the "Genealogical Period", Foucault introduces genealogy to examine on power relations and power/knowledge as a complementary approach to the archaeological method. The genealogical analysis is presented that a given system of thought is not the outcome of rationally inevitable trends, but rather the result of contingent turns of history (Gutting, 2008).

Foucault argues that our knowledge of reality is immersed in a power field and knowledge itself increasingly constitutes of the play of domination (Burrell, 1988). In the third stage, Foucault transfer his focus on individuals and “care of the self” as self-constitution. In tracking the history of sexuality, Foucault shows the relation of oneself to oneself, and meanwhile argues that individuals are motivated to pursue desired lives and to make a conduct according to certain ethical rules through self-constitution by applying certain forms of knowledge and strategies (Hartmann, 2003). Three stages refer to the three aspects of Foucault’s work: madness, delinquency and sexuality. There is always a focus on each stage of his study: “... the establishment of a certain objectivity, the development of a politics and a government of the self, and the elaboration of an ethics and a practice in regard to oneself” (Foucault, 2000). The experience of madness is mainly organized as a field of knowledge; the experience of crime is regarded as an area of political intervention; the experience of sexuality is described as an ethical position. In conclusion, Foucault seeks to develop the interaction between knowledge, power and ethics. In the next part, our study will talk more about Foucault’s work on power.

#### **4.2.1 Power and resistance**

Foucault views power as being relational. In other words, power is not a capability which is just held by someone. Power is thus associated with practices, techniques and procedure. Foucault thinks the nature and the exercise of power as follows:

*Power is the implementation and deployment of a relationship of force. Power and must be analyzed as something that circulates... that functions only when it's part of a chain. It is never localized here or there, it is never in the hands of the some, and it is never appropriated in the way that wealth or a commodity can be appropriated...Power is exercised through networks, and individuals do not simply circulate in those networks: they are in a position to both submit to and exercise this power. They are never the inert or consenting targets of power; they are always its relays. In other words, power passes through individual. (Foucault, 2003, cited in the work of Willcocks, 2004, p.254)*

Foucault (1980) argues that every relationship is power relation. He describes this



thinking as follows:

*Between every point of a social body, between a man and a woman, between the members of a family, between a master and his pupil, between everyone who knows and everyone who does not, there exist relations of power which are not purely and simply a projection of the sovereign's great power over the individual; they are rather the concrete, changing soil in which the sovereign's power is grounded, the conditions which make it possible for it to function (Foucault, 1980, p. 187-188).*

Power is thus utilized dependent on some context and conditions. From the perspective of relationship, power is employed on the basis of a win-win situation. Power is thus utilized in quite positive approach. If power passes some boundaries, it may go to the other side and resistance occurs.

Resistance is the concept which is always linked with or the opposite of power (Knights and Vurdubakis, 1994). In view of Foucault, resistance and power interweave and constitute “a kind of permanent limit” (Foucault, 1982). Resistance is only possible as power is exercised. Resistance is not possible without discipline. The exercise of resistance does not mean that discipline is threatened, rather it means that discipline may grow stronger and know in which direction its efforts have to reach (Burrell, 1988). For those who are subject to power and control, they tend to change or divert the systems and rules that are imposed them (Knights & Vurdubakis, 1994). It means that power may play a role of empowerment. Knights and Vurdubakis (1994) further argue the relationship between power and resistance:

*...the identification of sites of resistance to change being used as a crucial vehicle through which the space of intervention carved out in the organization. Resistance consequently plays the role of continuously provoking extensions, revisions and refinements of those same practices which it confronts.*

The above mention makes an emphasis on the individual's self-construction in the later study of Foucault. Resistance is not conflicting with power, but is the reversal of force relations. The new way of understanding of power and resistance presents a positive perspective: resistance could inspire to explore self-reflection and self-construction. In his following work, Foucault (1982) names the technologies of the self (or practices of the self) as “care of the self”. Human beings constitute

themselves through these methods.

“Care of the self” could be understood as a way of resisting. Foucault argues that individuals are rarely obliged to conform by coercion. Individuals perform intentionally and voluntarily within organizational systems which organize their ways of doing things. However, they sometimes do not directly apply these systems. Rather, they may critically detach themselves to these systems, and modify them within limits. In other words, individuals can make creative or productive use of the space for self-construction (McCarthy, 1990). This process of self-reflection and self-construction is what Foucault defines as problematization, which is the engagement of thought that is triggered by questioning the meanings, conditions, and goals of domain of action in the face of uncertainty and difficulties.

#### **4.2.2 Power/knowledge and regime of truth**

Foucault (1984) describes power and knowledge:

*directly imply each other... there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose, and constitute power relations... These “power-knowledge relations” are to be analyzed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system; but, on the contrary, the subject who knows, the objects to be known, and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations (p. 175).*

The above description shows that power and knowledge are closely intertwined. In the first place, Foucault argues that power and knowledge are not an independent existence. Knowledge may lead to power, and power may be enhanced by the acquisition of knowledge. He also explains how mechanisms of disciplinary power are simultaneous instruments for the formation and accumulation of knowledge. In the second place, Foucault (1984) argues power could be productive. It means that power is not negative, but is creative (Townley, 1993).

In organization studies, recent focus is transferred on issues of both power and discourse in organizations (Mumby & Stohl, 1991). Power is regarded as instantiated in the routine discursive practices of day-to-day organizational life. In this sense,

power is vehicle through which discourse and knowledge unfold through the actions of human actors upon others. Foucault (1977) argues that discourse holds certain things to be “truths”. Power produces knowledge and discourse, meanwhile discourse and knowledge have power and truth effects. When knowledge, discourse entangle with the practice of the power, a new “regime of the truth” emerged (Foucault, 1977). In summary, the formation of regime of truth is a dynamic process, during which certain knowledge can be disqualified or becomes the “subjugated knowledge”. Continued disruption of existing discourses by emerging ones can establish a new regime of truth. Alternatively, emerging discourses can be undermined and subjugated.

#### **4.2.3 Disciplinary power**

Power is conceived as a technique that achieves its strategic effects through its disciplinary character (Foucault, 1977). When exploring the mechanisms of surveillance and assessment, Foucault transfers his attention on prisons (Clegg, 1994). In the book of *Discipline and Punish* (1977), Foucault is inspired by the prison structure designed by Jeremy Bentham (1791). The design is named as a panopticon. The panopticon is both a specific type of institutional building and an architectural instrument of surveillance. In the prisons, the morphology consists of a circular array of cells with a watchtower in the center of the structure. The guards could thus observe every inmate at any time, unseen by the prisoners. The prisoners could be aware of the constant presence of authority, not knowing when they are being observed. As such, the prisoners would be self-disciplining. The prison typology’s core principle is monitoring the maximum number of prisoners with the minimum of guards. Through the constant surveillance, it would coerce inmates into adjusting behavior. Panopticon perspective is received particular attention by Foucault and used as an analogy for the emergence of the modern disciplinary society (Foucault, 1977).

The focus of the disciplinary power is on disciplining and correcting abnormal

behaviors, making them trained, obedient and docile (Foucault, 1977). Disciplinary power begins with the gaze of individual human body. When individuals are continuously seen by guards and they become accustomed to the gaze, individuals learn to exercise self-discipline. In other words, no matter they are under the gaze or not, they will exercise self-control. The panopticon is the ideal metaphor for Foucault to explain how the complexity of social activities and public organization are under surveillance to ensure conformity and a normalized approach.

The core of the formation of disciplinary power is the “correct training” which is derived from the use of simple instruments: “hierarchical observation, normalizing judgment and the examination” (Foucault, 1984). We will make a quick review of three instruments as follows ((Foucault, 1984, p.188-205):

*Hierarchical observation: the disciplinary institutions formed around people an apparatus of observation, recording and training by means of hierarchical and continuous surveillance...This makes possible for a single gaze to see everything constantly and functions like a piece of machinery. It leaves no zone of shade and constantly supervise the individuals who are subject to control.*

*Normalizing judgment: at the heart of all disciplinary systems functions a small penal mechanism...The workshop, the school, the army were subject to a whole micropenality of time (lateness, absences, interruptions of tasks), of activity (inattention, negligence, lack of zeal), of behavior (impoliteness, disobedience), of speech (idle chatter, insolence), of the body (“incorrect” attitudes, irregular gestures, lack of cleanliness), of sexuality (impurity, indecency) ...It brought into play the binary opposition of the permitted and the forbidden. The micropenality operates in a non-observable way. The power of normalization imposes homogeneity.*

*Examination: the examination combines the techniques of an observing hierarchy and those of a normalizing judgement. It is a normalizing gaze, a surveillance that makes it possible to qualify, to classify, and to punish...It deploys the force and establishes the truth at the same time...The examination also introduces individual into the field of documentation, such as a whole series of codes of conduct or performance. These codes mark first stage in the “formalization” of the individual within power relations...The documents can also make it possible to classify, to inform categories, to determine averages, to fix norms which turn individuals differentiable, measurable, and finally manageable.*

The form of power applies to everyday life: it categorizes the individual, it marks the individual by his or her own individuality, and it imposes a law of truth on him or her. It is a form of power that makes individuals subjects (Foucault, 1982). Doolin (2004) argues that there are two means of the word “subject”. The first meaning refers to being subject to someone because of control and dependence. In this context, power is exercised through making individuals as the object of some mechanically derived power. The second meaning refers to being self-knowledge. The subject develops a nexus with his or her own identity by conscience. In this situation, power is operated through normalization of the individual’s judgements about what is legitimate and non-legitimate behavior.

#### **4.3 Linking Foucault to Technical-Managerial Accountability Mechanisms**

The extensive works of Foucault make a focus on social science. Foucault has analyzed a number of techniques of space (e.g. prisons, railroads), and demonstrated the close relationship between power embodied in these techniques and material arrangements. The first example is about prison and panopticon (as above mention). The disciplinary control is incorporated in the design of space. The technique of power embedded within the prison is perceived and prisoners develop internalized self-discipline. The second refers to a work of railroads (Foucault, 1984). The design of railroads indicates the relationship between power and space could make rise of a number of social phenomena, such as transformation of population and changes in people’s behavior. In short, power is embedded in materiality which is enacted in practices through the use of techniques.

The techniques are the material organizing of space. Technical-managerial accountability mechanisms can be understood as the techniques and material organizing in order to account for one’s action. The accountability mechanisms could be thus regarded as making visible in material forms the mode of control, organizational reality and social discourses incorporated in the information, data and various documents or reports. Moreover, it should explore how contextual

managerial techniques are implemented, applied, examined and interpreted. The disciplinary power results in being subject to someone else by control or self-construction. Above all, Foucault's perspective on power is of high relevance to accountability mechanisms.

#### **4.4 Foucauldian Application in Accounting**

Michele Foucault introduces a number of ideas, such as power, knowledge, governmentality and etc., which has received attention in accounting research. This part will make a review of the influence of Foucault in accounting: major trends and findings of the studies in accounting research. A number of selected papers<sup>29</sup> have been analyzed to understand his contributions to accounting studies.

Hoskin and Macve (1986) seem the first one to use the concept of Foucault in accounting. The paper is published in AOS. Their study explores how accounting education learn advanced experience from elite educational institution, particularly normalization of control in accounting education. However, Neimark (1990) adopts the critical perspective to question the Foucault's concept. He argues that Foucault's concept (the postmodern theory) is questionable to apply in the modern accounting practices (Neimark, 1990). Armstrong (1994) also holds opinions against the use of concepts introduced by Foucault. He argues that disciplinary power may constrain details in accounting, including changes in accounting, relationship between accounting and management control devices and context of accounting (Armstrong, 1994). Following with the same conceptual method, Rodrigues and Craig (2007) argue that the extent of harmonization of accounting standards depends on whether knowledge of IFRS discourse becomes power. They use the concept of knowledge-power to assess the harmonization effort of international accounting standards. Rather than coercion, the harmonization dependences on common global acceptance. Kosmala and McKernan (2011) transfer attention on ethical dimensions

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<sup>29</sup> The selection is made from the key journal of accounting: Critical Perspectives in Accounting (CPA), Accounting, Organization and Society (AOS), Accounting, Auditing & Accountability Journal (AAAJ).

that is overlooked in accounting research. They argue that Foucault's concept of openness, responsibility to others in the process of self-construction is neglected in the work of management and accounting (Kosmala & McKernan, 2011).

The Foucauldian approach of accounting is meanwhile explored from empirical perspective. Mckinlay and Pezet (2010) explore the new mechanisms (e.g. lean production) of Caterpillar to boost performance under panopticon control. Dyball and Rooney (2019) develop research on a role of accounting as a disciplinary power on the migrant works of Philippine at Hawaii. Their study indicates that role of accounting in the spaces is quite important and vital. They explore how accounting with discipline (statistics and medical expertise) work together on migrates workers' health and family to create governmentality. In other words, accounting is utilized to improve workers' productivity by creating discipline and governmentality (Dyball & Rooney, 2019).

It should be mentioned that an increasing number of papers have been exploring the concept of Foucault. Variations in theme and in findings are seen in accounting research. The approach of Foucault enriches and highlights the accounting research. Many studies attempt to identify accounting as a mechanism of power and domination. Consequently, it may spread its influence (repressive power or normalizing power) across organization. However, there is still considerable room for developing a deeper study and understanding managerial techniques related power phenomena. Our work can go further and deeper application of Foucault's idea of power/knowledge nexus, regime of truth, ethics and "care of the self". The study firstly explores the resistance to accountability measures. The materiality of accountability measures is argued. The focus is on the technical rationality, model of organizational reality and medical expertise. How materiality of accountability regime embodies technique of power and how this power is enacted by particular groups of actors (care staff in our case). Secondly, Foucault's notion about resistance through self-construction may be an alternative explanation to the phenomenon of medical staff resistance to technical-managerial accountability

mechanisms application. In other words, our study presents the twin interaction between technologies of domination and care of the self.

#### **4.5 Implication of Foucault for the Dissertation**

The discussion of the Foucault's perspective on power indicates that there are various means that theorization can be applied to examine how power and techniques are intertwined in practice. First of all, Foucault's perspective on power as a relation which addresses both the social and material aspects. Foucault argues that power is not separated from materiality; rather power is incorporated into the materiality of technology, which is then enacted by the human actors who implement techniques. Thus, the relational view of power and techniques develops a way to analyze the implementation of managerial techniques, addressing both the social and the material.

Second, the study on contextual managerial techniques, particularly on the drivers behind them, provides a window to examine the impact brought by these devices. Public managers and care staff are subject to the reforms and the direct targets of power in the name of economy, efficiency and effectiveness. Their experiences, clinical practices and knowledge are concerned with power and resistance.

Third, Foucault's concept of disciplinary power indicate that power is derived from the deep social system, such as discipline and social discourse; the exercise of power is the process of mutual constitution between social structures and human actors through various embodiments of techniques of power, such as, panopticon. It can clearly explain the broader societal and political consequences of the introduction of accountability mechanisms.

Later but not the least, Foucault's notions of resistance and care of self can see a different and more subtle approach to explore the dynamics of disempowering and empowering, care profession resistance, in turn, the changes of the regime of truth. The empirical studies examine a substantial change and the new



accountability-mediate practices within the organization. Subtleties and dynamic of disempowerment and empowerment remain explored.

#### **4.6 Research Questions**

The broad research problem in this dissertation is how power relations affect the introduction of accountability techniques, and what the role of technical-managerial accountability mechanisms is in the reconfiguration, distribution and exercise of power in the clinical practices, social and organizational context. The primary objectives of this research are 1) to explore the underlying mechanisms by which the contextual managerial techniques are implemented and used within the medical-social establishments, and 2) to provide deeper understanding of the role of the technical-managerial accountability mechanisms in reconfiguration reconstruction and exercise of power in the medical-social sector.

The broad research problem will be examined from a perspective informed by Foucault's work. More specifically, the study aims at exploring the following research questions:

1. How are various forms of exercise of power and control enacted through the managerial techniques implementation and use in clinical practices and medical-social establishments?
2. How do these enactments reconfigure power relations and reconstitute the regime of truth?
3. What is the role of the technical-managerial accountability mechanisms in such a process of power reconstruction?

The above questions have been formulated in direct response to the need to explain the implementation of contextual managerial techniques and outcomes from a relational and social-material perspective. Foucault's notion on regime of truth implies that our research should take a critical approach. The managerial use of idea of accountability is emphasized in the analysis of the study.

# **5 MANAGERIAL STRATEGIES FOR HANDLING ACCOUNTABILITY**

## **5.1 Introduction to the Chapter**

According to Foucault (2002), external event may result in discontinuities in the context of a society or organization, and change the problems faced, the risks, as well as opportunities, thus the regime of truth. For the medical-social sector, the “law of renovation of social and medical action” (often named as Law 2002-2) is one of the most important to challenge the legitimacy of the traditional role and practices. NPM and NPM-related reforms clearly trigger a perceived need for a modern governance model compatible with neoliberal policy-making in social care sector. The contextual managerial devices, as an important component of accountability measures and governance, play a vital role.

In this chapter, the implementation of contextual managerial techniques in the medical-social sector, is analyzed through the theoretical lens of Foucault’s perspective on power/knowledge. Medical-social sector as a specialized field, grounded in scientific knowledge and skills, deals with the bio-psychosocial-spiritual elements of an individual with a problem. It assesses pliability and strength of the patients, social support system and their families, in order to assist the patients to resolve their problems independently. Thus, it is necessary to provide a review of contextual background before the implementation of managerial techniques. The rest of the chapter presents the techniques and their implications, and analysis of the new social-material discourse, seen from Foucault’s perspective.

## **5.2 Regime of Truth before Technical-Managerial Accountability Mechanisms Implementation in the Sector**

To a large extent, medical-social sector is dominated by professionals and is fully laden with both formal regulations and informal rules (values, norms, ethics, etc.). Its main missions are to offer humanitarian aid and medical treatment. Due to

the high level of expertise and task complexity, social and medical establishments are thus described as professional bureaucracies by Mintzberg (1983), who are thought to be key actors in the modern welfare system (Kuhlmann, 2006). In the professional bureaucracy, professional workers have great autonomy and freedom to implement their work based on their knowledge and skills (Mintzberg, 1983). They make comprehensive control over their work and are given professional self-regulation. Thus, the work of professionals not only is embedded in the norms and values of organizational structures and institutions, but also originates from their expertise training. Professional logics are rooted in the normative framework of a given profession (Scott *et al.*, 2000). The logics in healthcare thus imply a strong focus on preserving the interests of colleagues or peers with the same professional background: daily and strategic planning in accordance with the internal dynamics, priorities, values and identities of a professional group (psychologist, social worker, nurse, educator, etc.). The central issue is on quality of the services provision and professional development. Decision-making is consensus oriented and bottom-up. The managers often have a hidden role in implementing the organizational goals. In the case of care sector, professionals work autonomously from their colleagues but close to their patients. They have well-defined skills and have learned how to undertake their tasks in a specific manner (Glouberman & Mintzberg, 2001). In this way, professional accountability is an internally driven mindset. It is a commitment that health professionals enable themselves to advance, grow, improve and adapt to their work. Within their professional roles, care staff are expected to implement accountability safeguards. These include evaluating patient care through peer review, quality improvement, and research, which promotes the mindset that the actions have consequences that directly impact the patients they care for. As a clinical psychologist illustrates her working environment as follows, she describes the team members engage in their clinical work with passion, enthusiasm and creativity.

*En 2003, je suis très vite rentrée à l'IME de M. J'ai découvert une institution formidable : les professionnels sont très engagés, très investis dans la culture institutionnelle, puisque ce qui était très prégnant, c'est que c'était des gens qui avaient construit cette culture intentionnelle, qui tournait justement autour du*

*collectif, de l'entraide, de la solidarité, de l'écoute et du lien...* (Interviewee: P12)

A positive relationship between care profession, patients and organization is to share faith in the validity of the represented system, decision-making and professional judgements, as well as in the value of “togetherness” in organizations backed by efficient management (Bezes *et al.*, 2012).

A part of professional logic, social and medical sector are characterized by a political logic-- providing an equal access to public service (Scott *et al.*, 2000) and the fair distribution of common goods (Thornton, Ocasio & Lounsbury, 2012). Hence, the political logic in medical-social sector managers could place emphasis on aspects equality (access to services) and equality (equal treatment amongst patients). Indicators of this logic could be investigated in internal and external rules and legal systems, documentation and a hierarchical orientation in decision-making. In conclusion, healthcare sector has been traditionally mixed with two logics-professional logic and political logic. The main aim is to provide adequate and equal treatment, these two logics are well combined and indicators of them are also quite relevant.

### **5.3 Linking a Modernization Discourse with Technology**

Dahl (2009) argues the translation of NPM to care giving has contradictory logics: the logic of details is based on neo-liberal economics; the logic of self-governance has its origin in management studies. The two logics discipline medical-social care in different ways. The logic of details discipline care by the control of time, standardization of practices, governance of details characterized as Taylorization or assembly line production. Its overall objective is “do more with less”. The other logic of governance is centered on good leadership and co-operation, self-governance and autonomy. The two logics coexist of NPM, while the first logic is increasingly more dominant than the second. Given the rise of the market logic, the focus is put on efficiency, economic control and management. Moreover the

clinical work in most cases does not conform to the normative moral yardstick imposed by ideas of accountability. Thus it is necessary to implement formal accountability framework. The framework is centered on observing normative prescriptions and recognizing the importance of the accountability behavior. That is why many techniques are employed in the realization of an accountable management. For example, research on balanced scorecard (BSC) is one of the best tools recognized as useful in operating following the accountability principle (Farneti & Bestebreur, 2004). The drivers of these managerial tools are that a greater awareness of integrating strategic orientation with objectives might improve the work of public sector organizations. They are expected to contribute to a higher level of accountability.

According to Foucault (2002), external events might result in discontinuities in the context of a society or an organization, and change the problems faced, the risks, as well as opportunities, thus the regime of truth. In France, the NPM-related reforms are the major discontinuity to challenge the legitimacy of the traditional role and practices of the medical-social establishments. These events clearly trigger a perceived need for a modern and fully new governance model compatible with the neo-liberal economics. In doing so, it is quite important to develop the systemic approach of combing standards, assessment and accountability into a unified set of laws and regulations. The following part is to review a series of laws and regulations that contribute to accountability measures in the social and medical establishment

#### **5.4 Technical-Managerial Accountability Mechanisms Implementation Efforts in the Sector**

The users are placed at the heart of the service system since the Law 2002-2. The Law seeks to develop control devices in order to ensure the rights of the person in the medical-social establishments and those of their families. It introduces an entire section devoted to users' rights and aims to enhance a greater trust by the public. A series of evaluation guide are published to supply the needs and cover the rights of the targeted populations. Moreover there is no any compulsory internal and external control based on an evaluation approach before Law 2002-2. In other words, overseeing authorities may have difficulties in making decisions about which one operates more efficiently and how to allocate resources. There are no "effective" standards to assess various forms of establishments. It is the Law 2002-2 that defines the operational mode of establishments for handicapped children and adults. The evaluation is the main control tool, which is strictly required by the overseeing authorities. The evaluation is composed by the internal and external evaluation. The internal evaluation is carried out by the site direction in order to measure the effectiveness of practices and the quality of services. This evaluation could be seen the preparatory phase for external evaluation. External auditors (from recognized independent bodies) carry out their diagnostics according to some references. The internal and external evaluation are complementary in order to get an evaluation report for overseeing authorities. In doing so, overseeing authorities such as Regional Health Agencies <sup>30</sup> can use the evaluative reporting and exert their control on different establishments with a common system of reference and standard since the reform 2002-2.

By extension of government machinery, external and internal evaluation seek to ensure the practical application of the mission of medical-social improvement, and

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30 France' Reginal Health Agencies: (Agence régionale de santé, ARS) coordinate prevention and health and supportive care. They ensure that resources care managed in a consistent manner to ensure that all patients have equal access to safe, continuous, high-quality care.

ensure compliance through accountability. Central to this process is periodic inspection<sup>31</sup> in which care staff would be observed, whilst documentation would be scrutinized and interviews held to ensure that the medical work is offering both a “quality” service and delivering “value for money”. In addition to setting regular assessment, reform 2002-2 does not mention specific criteria. It is General Directorate of Social Action<sup>32</sup> that is the first one (in February<sup>33</sup> and Mars 2004<sup>34</sup>) to provide decision-support tools in practices.

Reform 2002-2 refers to the recommendations for good practice validated by National Social and Medical-Social Assessment Committee<sup>35</sup> prior to the reform. On 10 November 2005, CNESMS firstly publishes some paper to guide how to build metrics around internal and external evaluations. Its aims at developing the same mechanism for all the social and medical-social establishments when making evaluation<sup>36</sup>. Meanwhile, it emphasizes on the obvious link between institutional project and performance assessment. Secondly, on 24 January 2006 CNESMS further make emphasis on the missions of National Committee: “it must validate good professional practices, whatever the form they take (procedures, references or recommendations) and it does not have to validate devices that are used to carry out the assessment<sup>37</sup>”. Thirdly, in September 2006 CNESMS lays basis for forthcoming internal evaluations in its working paper<sup>38</sup>. It mentions to keep knowledge and

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31 Internal evaluation: every one year. External evaluation: every five years.

32 Direction Générale de l’Action Sociale (DGAS)

33 Note d’information DGAS/5B n°2004/96 du 03/03/04 refers to actions promoting the evaluation and constant improvement of quality for medical-social establishments.

34 Guide méthodologique DGAS février 2004 démarche qualité-évaluation interne dans un établissement ou service médico-social ou social et recours à prestataire

35 Conseil national de l’ évaluation sociale et médico-social (CNESMS)

36 CNESMS, note d’orientation, 10 novembre 2005 : “Toute évaluation portant sur un service ou un établissement social ou medico-social instaure un processus global et coherent de conduite du changement, dans l’optique d’amélioration conduite de la qualité des prestations. ”

37 The original quotation in French is as follows: “le Conseil doit valider les bonnes pratiques professionnelles, quelle que soit la forme qu’elles adoptent (procédures, références ou recommandations) et il n’a pas à valider les outils mobilisables pour procéder à l’évaluation”.

38 The name of working paper is L’ évaluation interne: Guide pour les establishments et services sociaux et medico-sociaux, version n°1, 36 papers.

practice evolving, anticipate the needs of users and make contribution to the medical-social sector. Fourthly, CNESMS<sup>39</sup> makes a series of good practice recommendations in order to implement quality approach in April 2008 and April 2009. The recommendation of April 2009 particularly makes a focus on the needs and expectations of users. The evaluation should be centered on the core work to satisfy the user. In conclusion, the soaring demand for assessment and accountability is combined into a set of laws and regulations. External benchmarks for quality control pushes to engage internal self-discipline.

## **5.5 Contextual Managerial Techniques Introduced by the Reform 2002-2**

Law 2002-2 intends to put the “user” at the heart of care delivery in order to guarantee service quality. The quality is the policy carried out on behalf of the user. It opens up the logic of the profession and allows people to see things from different perspectives. It is a way of respecting the law through strict quality management. The medical-social establishments make efforts at instilling a new public ethos that involves intensifying mechanisms of self-assessment in the workplace. Many written documents as approach to self-knowledge are extensively required. A number of toolkits are regarded as the contextual managerial devices for accountability purpose.

### **5.5.1 Residence contract<sup>40</sup>**

According to Law 2002-2, the contract needs to clearly define the objectives and the services provided to the targeted person. Each establishment should have to consider the performance of practices and have a user-friendly method of evaluating their practices. The aim of residence contract is:

- to define the objective of care, to mention the social or medico-social action, care and therapy, to support and accompany services when the contract is signed;

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39 CNESMS later becomes a National Agency for Social and Medical-social Evaluation Agence Nationale d’Evaluation Sociale et Medical-sociale (ANESM) in the year of 2007. ANESM succeeds the work of CNESMS.

40 Le contrat de séjour



- to describe the conditions of stay and reception;
- to indicate the terms of the beneficiary's financial participation or invoicing, including in case of absence or hospitalization.

### **5.5.2 Information booklet<sup>41</sup>**

Information booklet provides the child and their parents with information, knowledge, conditions and institutional objectives. It delimits a framework of the professionals' actions and seeks to build public confidence. Producing the information booklet requires a combination of individual and collective work, which then gives a formal structured process. The brochure needs to contain the following:

- specificity and multiplicity of professionals;
- team history, team members, multidisciplinary teamwork, professional culture of the institution;
- the location and organizational structure;
- organizational missions, clinical practices;
- be aware of what is imposed in the legal text.

### **5.5.3 Charter of rights<sup>42</sup>**

The regulation states that the establishment must display the charter of rights as an annex to the information booklet. It must also be accompanied by the basic principles of social actions, regarding the rights of users and the protection of care staff in the case of mistreatment. The charter sets out the fundamental rights of users treated in the medical-social establishments. The charter aims at serving users. They are source of information about their rights. The charter are also for the professionals. They should use it as a guidance in their dealings with users of service.

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41 Le livret d'accueil

42 La charte des droits

#### **5.5.4 Service regulations<sup>43</sup>**

The service regulations aim at preventing arbitrariness for all users of services. Moreover, the service regulations should be consistent with the rights set forth in the charter of rights.

#### **5.5.5 Institutional project<sup>44</sup>**

Each socio-medical site must have the institutional project. The project defines its objectives, particularly in terms of coordination, cooperation and evaluation of activities and quality of services as well as its operational procedures. The project is considered as a device to guarantee the rights of users, since it defines the values and translate into operational services.

The above presentation aims at summarizing the managerial devices compulsorily introduced by Law 2002-2. These devices seek to guarantee the quality of provision and users' rights. Furthermore, the techniques attempt to contextualize the managerial use of the idea of accountability into medical practices. We will argue that in the next section.

### **5.6 Managerial Strategies for Handling Accountability**

Public policy (as we have above reviewed), which implies a theory of causal relationship is useless if no implementation strategy exists to ensure delivery. Morah (1996) citing Sabatier and Mazmanian argues this idea into two following points: *“the first relating to achievement of the desired end-state(s) back to changes in target group behavior; the second specifying the means by which target group compliance can be obtained. Both the technical and the compliance components must be valid for the policy objective(s) to be obtained”* (Morah, 1996). Technical-managerial accountability mechanisms mean to put into effect according to some definite plan or procedure. They can be regarded as a deliberate and

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43 Le règlement de fonctionnement

44 Le projet d'établissement

sequential set of activities directed towards putting a policy into effect of making it occur. This accountability regime should consist of organized activities by the establishments directed towards the achievement of goals and objectives. Gunn (1978) suggests a need for a complete understanding of an agreement on the objectives to be achieved. According to this view, accountability mechanisms should be designed to help staff track whether they are moving in the direction they want. They also help public managers establish whether they are going to reach the destination they set to reach. Strategy, however, is not about destination, but it is about the route chosen by and directing the organization to its desired destination.

Following this thinking, this part is to explore strategical implementation of managerial techniques and the drivers behind these strategies. Accountability mechanisms have appropriate tools to see and assist with the policy implementation. In doing so, the following empirical study will be centered on techniques for accountability mechanisms implementation.

### **5.6.1 Patient files: “visible clinical treatment process”**

First, the user’s paperwork seeks to strongly build the relationship between planning and execution. When patients and their representatives enter into the socio-medical institution, they have to read and sign many documents, such as information booklet, service regulations, individual care-treating document, etc. In the market discourse, care service is seen as a commodity and service users are regarded as customers. When the document is signed, it forms the relationship between client-provider (see the figure 6). Care profession are required to relate differently to patients as “clients” of their services.

**Figure 6: Relationship between client-provider**

Le Project Personnalisé de _____ à l'association d'Action Educative de P	
Nom du Reference _____	

**Ton projet avec nous**

Quel projet personnel voudrais-tu formuler maintenant avec notre accompagnement éducatif et psychologique ?

Quelles sont les difficultés posées par ta situation actuelle ?

Quels sont à ton avis les moyens efficaces pour réaliser avec notre aide les objectifs que tu viens de te fixer ?

Quels moyens allons-nous mettre en œuvre avec toi ?

Qu'est-ce que l'aide éducative et psychologique de notre service pourrait t'apporter pour préparer ton avenir ?

Quels objectifs raisonnables et précis voudrais-tu atteindre afin de réaliser ton projet personnalisé ?

La date de ce jour : .....	Quelle durée crois-tu nécessaire ? .....
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(Source: Association for Educational Action of city P)

Second, day-to-day practices should be recorded into the file and be all result-oriented (see the figure 7). It means that clinical practices are documented as data. With the rise of the evidence based practice movement (evidenced-based medicine, EBM), medicine's desire is transferred to a positivist and rational inquiry in the consulting room. EBM includes a focus on behaviorist theory, quantitative research, randomized controlled trials, meta-analyses and "hard" numerical data (Feinstein & Horwitz,1997). In doing so, the ongoing interrogations of visible data

has become increased interest in the development of practices. In our view, data is more than numbers. Since the NPM-related reforms in medical-social sector, there has been emphasis on calculability by numbers and evaluation by indicators. Making activities and practices more transparent are quite common trend in the sector. Datafication has become an area of concern for clinical staff. Datafication seeks to render a diverse dimension of social life into machine-readable, quantifiable data for the purpose of aggregation and analysis (Southerton, 2020).

Data have a very influential position and inform the decisions of a wide range of stakeholders (e.g. patients and their parents, care profession, public managers, medical governance authorities, medical policy makers). Moreover, patients and care staff as subjects are actively constituted through tracking data and keeping data on track, and through these mechanisms subjects could be manipulated and disciplined. The whole process is: documenting clinical practices into patient files, setting a number of metrics to evaluate the procedures of treatment, and finally comparing patient outputs with expected medical achievement levels. Data are deployed to map and track the progress and outcomes of both patients and clinical staff subjects. They promote the visibility of two subjects and identify effective and less effective clinical practices. The whole process also constitutes a data-driven monitoring of professional' self-assessment. Data reduce the complexity of human experience to numerical form and indicators. But it should be quite mentioned that a rising focus on these forms of data could only tell part of the story. Datafication as medical-social inspection methodology may narrow the complexity of social activities and clinical practices.

**Figure 7**

**Project Personnalisé association d'Action éducative de P**

**Nom du jeune :**

**Date du projet :**

**Date de naissance du jeune :**

**Date du début de l'accueil :**

**Nom du référent éducatif :**

**Décision à l'origine du placement :**

**Professionnel référent :**

*Quel est le problème à l'origine du projet ?*

*Quels sont les engagements et quelles sont les attentes du jeune ?*

Signature

*Quels sont les engagements et quelles sont les attentes du service ?*

Signature

*Durée du projet ?*

(Source: Association for Educational Action of city P)

Third, the table 7 refers to the assess treatment outcomes. It implies a goal achievement which means the combination of goal setting and performance, contrary

to the progressive exploration of child’s mental health. It seeks to build clearly causal relationships between input (“sick patient”: children with mental disorder) and output (“well patient”: children without mental disorder). Implementation tools need to ensure the validity of cause and effect and that implementing personnel have the necessary skills and competencies (Sabatier & Mazmanian, 1979). During the process of treatment, professionals are able to organize and screen clinical skills in search for performance.

**Table 7: Self-policing performance during the process of treatment**

<b>CRITÈRE N° 1 : CHANGEMENT DANS LA SITUATION DE L'ENFANT</b>				
N1 : progression				
N2 : stagnation				
N3 : régression				
n°	Information recueillie (avec date et source)	Niv.	Instrument de recueil	Appréciation diagnostique
1/1				
1/2				
1/3				
<b>CRITÈRE N° 2 : ATTEINTE DES OBJECTIFS DU PROJET</b>				
N1 : atteinte des objectifs				
N2 : atteinte partielle des objectifs				
N3 : absence ou échec des objectifs				
n°	Information recueillie (avec date et source)	Niv.	Instrument de recueil	Appréciation diagnostique
2/1				
2/2				
2/3				

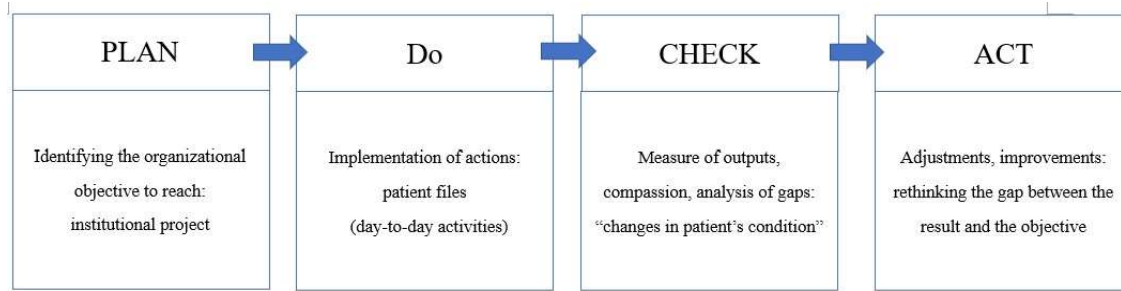
(Source: Association for Educational Action of city P)

Forth, the treatment process implies a strategic management in the public service. The difference in strategic management between the private and public sector is in the content rather than process (Anderson & Lawrie, 2002). Public organizations consider various activities as planning. The accountability system is based on the premise that children with mental disorder can reach clearly defined,

integrated standards by planning-based system, children could complete a personalized plan designed by their parents and care profession, and then they could achieve at the highest level possible. Many empirical studies conclude that public managers have confirmed a need for strengthening strategic management to improve performance (Anderson & Lawrie, 2002). Defining planning as applied rationality give rise to the external qualities of the decisions (Wildavsky, 1973). Strategic planning leads to a development of clear criteria about what the organization is trying to achieve. The process calls for the examination of the complete system and the generation of alternatives. Moreover, planning-based system complies with PDCA (plan, do, check and act, see the figure 8). The whole process seems to be a systemic one: starting from the planning stage (a project) to control (self-surveillance e.g. change of the child's status) and finishing with the evaluation (self-assessment e.g. achievement of specify objectives). The American statistician and physicist Walter Shewhart is the father of PDCA, and he designed it for continuous improvement of quality. Years later, quality experts J.M Juran and Deming implemented this method in several Japanese companies. PDCA can be applied to different business environment and are used to quality management. The PDCA model is the accountable management linked to the result-oriented way. It follows strategic objective to results: what is the core problem we need to solve? What resources do we need? What resources do we have? What is the best solution for fixing the problem with the available and limited resources? In what conditions will the plan be considered successful? The application of the idea PDCA seeks to develop strategic management in order to track performance versus objectives in the care sector. It attempts to identify specify objectives, process and results monitoring.



**Figure 8: PDCA cycle applied in medical-social sector**



(Source: author’s conceptualization)

Above all, the frontline workers have observed strictly normative prescriptions, performing a formal accountability. Medical knowledge and practices are increasingly subject to be visible, transparent, and standardized.

### **5.6.2 Production of documentation as technique of accountability**

All sorts of written documents (patient files, policy documents, etc.) constitute an important role of information exchange and dominant hallmark of the institutional bureaucracy. The use of written documents firstly develops a system for informing management of individual work. Secondly, it constitutes an additional means of monitoring and assessing staff.

#### **1) System for informing management of individual work**

The writing plays a vital role as a mode of communication in an organization. In the first place, the written texts distinguish from speech in their physical perdurance. Comparing with the oral information that is too dependent on both the sender and the receiver, the choice of written medium also contributes to the homogenization and transmission of information. Care profession could write down in which time they treat which patient. Patient-centered concerning for transparency could be traced in paperwork. The written information (such as individual care-treating document) not only provides proof of information ex post, but also traces the process of treatment.

*(...) c'était leur système de comptabilité. Ça leur permettait de compter le nombre de prises en charge et d'avoir une lisibilité financière. Compte tenu du nombre de salariés qu'ils avaient, combien de temps on travaillait, combien de patients on pouvait avoir à la journée ou à la semaine. Donc ça leur donnait une lecture, une maîtrise de ce travail là, et de voir finalement, d'un rééducateur à un autre, est-ce qu'il y avait autant de patients ou moins ou plus. Voilà, c'était la possibilité de lier notre travail autrement que d'avoir des échanges oraux parce que c'était des choses qu'on rentrait dans l'ordinateur. (Interviewee: P5)*

Secondly, documents are treated as a facilitator of rational bureaucratic order. In scholarship on bureaucracy, the written document remains an image of formal organizational practices. Documents are viewed as instruments for materializing reference and predication in order to establish a stable relation between discourse and individuals, actions, objects and environments (Weber, 1978). Patient files are employed as a major means to materialize day-to-day treatment. A series of documents develop a system for informing management of care profession's work.

From above analysis, research on bureaucracy thinks “bureaucracy develops more perfectly, the more it is ‘dehumanized’, the more completely it succeeds in eliminating from official business love, hatred and all purely personal, irrational, and emotion elements” (Weber, 1978). From this point of view, minimizing the “emotion element” of bureaucracy in medical-social sector should make a focus on the “project”, because it could be materialized in a system of files rather than an individual life story. The extensive bureaucratic requirements of written documents may distort their references. We argue that from the following points:

**a) The completion of paperwork is given priority over and above clinical itself.**

*...c'est-à-dire que des activités éducatives, travailler avec les enfants sur leur compréhension...) voilà tous c'est travail éducatif pour moi, c'est mon cœur de métier, je propose beaucoup de choses. (...) Quand on a dû faire des projets d'établissement, cela nous avait fait beaucoup de temps. (...) c'est-à-dire que j'étais obligée d'enlever du temps d'accompagnement de faire mon métier pour réfléchir à ce projet, c'était bien en soi, mais un moment donné il fallait qu'on écrive le projet personnalisé d'accompagnement, ça c'est un document qu'on doit donner tous les ans aux familles, on doit l'élaborer avec les enfants et leurs familles. Moi je veux bien remplir des papiers et des projets, mais il y a un moment où je dois voir les enfants et les familles pour pouvoir remplir ce projet,*

*sauf que tout le temps j'ai moins de temps pour les enfants, comment je fais ?*  
(Interviewee: P1)

*Je trouve qu'on nous en demande plus. Dans les ULIS, on doit fournir des écrits sur les enfants, mais dans notre emploi du temps, c'est pas repéré ce temps d'écrit. Donc moi, j'en fais beaucoup à la maison. Maintenant, je les mets en heures supplémentaires parce que j'en ai marre de donner du temps.*  
(Interviewee: P15)

The comment expresses the feeling of intense pressure frequently experienced by the care staff as a result of the additional and time-consuming burden of administrative duties. The written documents (ex. patients files, institutional project) constitute the main means of documenting and accessing information about the work, and therefore they determine the productivity and success of healthcare delivery in the field.

*En fait il y a une importance qui est donnée de telle façon à ces outils dans la démarche de la qualité, on perd le sens, ça devient une finalité en soi, les projets deviennent une finalité en soi, mais pas ce qu'on met dedans, mais pas ce qu'on fait avec des enfants. Vous voyez la distorsion!* (Interviewee: P1)

Production of documentation is treated as an end in itself. Documents may do not reflect their referential value. From the analysis of above interviews, completing patient file may no longer rely upon a patient's condition. The concern for the care staff is about submitting the document in time for the deadline. The extensive managerial requirements take occupied clinical work. The clinical work is increasingly mediated by considerable paperwork, not via face-to-face interactions between patients and care staff. In so doing, the written documents are employed as an end in itself and are for mediating social relationships.

**b) Documents are not simply instruments of bureaucratic organizations, but rather are instruments for an accountable management.**

*On (manager) dit que « moi je travaille et j'arrive à ça avec cet enfant », c'est quantifiable. Nous défendons une idée que tout n'est pas quantifiable et il y a*

*des choses qui se passent avec une relation et etc. Il m'a demandé de changer mes grilles d'évaluation : sur mes grilles d'évaluation, il faut que ça apparaisse là où sont les enfants, ce que je mets en place pour les faire progresser, par exemple tel enfant qui a telle difficulté de motricité, il peut monter sur une petite marche et ensuite accéder à une marche ordinaire. (Interviewee: P17)*

This statement implies the frustration felt by many professionals that their work in the field is unappreciated by management. The written documents are not limited to reporting to the superior. The disagreement concentrates on what outcomes they have to give accounts to in the written document. Documenting or recording in an accountable way facilitate the realization of planned objectives, thus result-oriented focus is required. The above interview (P 17) implies the preoccupations are different between manager and clinical staff. Managers seek to employ a series of files for identifying individual responsibility behavior for an accountable management, while care staff use paperwork as recording patient's condition. In this form of managerialism, channels of accountability exist less between care profession themselves than between two separate spheres of clinical and managerial practices, dealing with distinct and often contradictory priorities.

## **2) Additional means of monitoring and assessing staff**

Paperwork has been central to the care profession's work for decades. The written document is carried out in the framework of evaluation, which intensifies the rationalization of practices. It is intended to enable, therefore, a more systematic method for auditing professionals' work. Everyday therapeutic practices are translated into written document. The great use of graphic elements, tables and numbers in files are also for the purpose of "transparent meaning". We argue that these forms of bureaucratic documents seek to explore visualization and transparency imposed by ideas of accountability.

### **a) Files as mediators between normative orders and practices on the ground**

The above empirical study (P17) describes that files are for minimizing the gap

between policy (recommendations of validated professional best practices) and implementation. Paperwork is a means of documenting care staff competency and containing it within material format, giving it permanency and objectivity. Documenting medical tasks should be in compliance with the practice criteria. In the interview, the sport teacher would like to propose a new activity based on the psycho-affective development. But outcome indicators are being difficultly developed across a broad range of this approach. In the view of manager, staff should be more accountable. The clinical work with indicators has many purposes: informing patients of the quality of service, and allowing purchasers of health care (overseeing authorities such as ARS) to see that they are getting value for money. Public managers seem to have the same discretion as their counterparts in the private sector, because the managers have the choice of which service will be used in order to achieve the greatest efficiency possible. In so doing, the written document could be as a evidence of past events, which constitutes an ongoing audit mechanism for assessing staff. Writing establishes the stable relation between words and things to implement regimes of control and compliance through accountability.

**b) Governance by self-assessment techniques**

A rational gaze of indicators and metrics is supposed to increase productivity and efficiency and facilitate transparency and accountability. There is a keen sense of medical accountability through self-evaluation document: pre-set objectives, examination in the process, post-evaluation. It is quite important to develop the inspection methodology in public organization, where clinical staff self-regulation becomes the norm. There are three central themes which could draw from the evaluation framework. Firstly, it is primarily driven by quantitative data analysis. Care staff are required to support their clinical work with data profile. The quantitative approach is most apparent where staff are asked to grade many aspects of their provision (admission, service quality, appropriate clinical procedures, etc.). In the context of such prominence to a reductionist model, clinical staff have to

adopt a simplistic and quantitative approach to self-assessment. As the table 8 presents, the professionals make certain indicators and grades (T1/2, N1/2) to evaluate patient's condition. The professionals should have a sense of causation by the inspection process. This emphasis on quantitative evidence makes it difficult for staff to engage in any complexity of the activity under inspection and with the contextual meaning of data. Secondly, it is about normalizing provision of healthcare. As mentioned above, clinical staff have to alter their provision to meet the needs of these evaluation indicators, particularly the way the treatment is delivered. The self-evaluation techniques therefore could be seen an effective tool for standardizing treatment. The third theme is of managerialism. A series of indicators have a purpose for "improvement", and self-assessment of improvement should concentrate on measurable outcomes. The self-assessment system leads to a clear evaluation of the quality of service delivery: performing well (success) and underperforming (failure). This mechanism ignores the complexity of treatment to children with mental disorder, and encourage short term and target-driven management rather than strategic development of child wellbeing.

**Table 8: Always self-policing performance**

Concept central	Dimensions	Critères d'évaluation	Niveaux des critères	Instruments de recueil
Évaluation du projet personnalisé	Efficacité du projet <i>Évaluation de résultats</i>	Changement dans la situation de l'enfant → Situation de l'enfant à T1 → Situation de l'enfant à T2	N1 = écart T1/T2 = progression N2 = écart T1/T2 = stagnation N3 = écart T1/T2 = régression	Dossier de l'enfant Projet personnalisé Évaluation en équipe
		Atteinte des objectifs du projet → Objectifs du service T1/T2 → Attentes et objectifs de la famille T1/T2 → Objectifs partagés T1/T2	N1 = atteinte des objectifs des objectifs N2 = atteinte partielle des objectifs N3 = absence ou échec des objectifs	Projet personnalisé Évaluation en équipe
	Efficience du projet <i>Évaluation de moyens</i>	Pertinence des objectifs du projet	N1 = pertinence satisfaisante N2 = pertinence partielle N3 = défaut de pertinence	Projet personnalisé Évaluation en équipe
		Adéquation des moyens éducatifs → Avis de l'enfant → Avis de la famille → Avis des professionnels	N1 = adéquation satisfaisante N2 = adéquation partielle N3 = défaut d'adéquation	Projet personnalisé Évaluation en équipe
	Procédure du projet <i>Évaluation de conformité</i>	Respect de la procédure projet	N1 = procédure conforme N2 = procédure partiellement conforme N3 = procédure non conforme	Projet personnalisé
Teneur de l'intervention <i>Évaluation de l'implication</i>	Ressenti professionnel	N1 = bien-être professionnel N2 = risque professionnel N3 = préjudice professionnel	Évaluation en équipe	

(Source: Association for Educational Action of city P)

### 5.7 Regime of truth transformed through the disciplinary power

Our study highlights accountability devices and medical surveillance. As we above review, the drivers of managerial techniques implementation are for the purpose of being accountable. The data-driven monitoring of professionals' performance is frequently portrayed incontestable in medical-social sector. It creates a new governance mechanism. The field of surveillance studies performs a vital role in organization research over recent years (Collinson, 1999). Scholars explore organizational surveillance from the following perspectives: surveillance-based organization (Collinson, 2003), self-surveillance (Deetz, 1998), peer surveillance (Barker, 1993), electronic multi-directional surveillance (Sewell, 1998)<sup>45</sup> and biometric surveillance (Ball, 2005). All these studies seek to explore employees' perceptions and performance when they are located within the context of such monitoring. Employees would enact the behaviors desired by someone watching

<sup>45</sup> The significantly increasing research is exploring video surveillance in the workplace (Diard, 2018).

them as well as coming to identify with the organizational values embedded in that gaze (Iedema & Rhodes, 2010). In other words, the central idea is about how to develop internalized self-disciplining culture in an organization. Our study argues that documentation plays a vital role in disciplinary control. Documentation produces corresponding knowledge and establish truth for managerial devices informed practices. The standardization of treatment (documenting clinical process and self-examination with indicators) seeks to establish norms of behavior which make individuals differentiable, comparable and manageable. It brings into play the “binary opposition of the permitted and the forbidden” (Foucault, 1984), which becomes the basis for normalizing judgement and examination possible by overseeing authorities. It aims to turn multi-ways of doing things into a unique one, which imposes homogeneity of behaviors in different medical-social establishments.

The accountability devices are introduced into the sector, the human actors (care profession) go through a process of adjusting their views towards the devices and making a judgement on their existing power/knowledge nexus, based on the experience gained in the leaning and experimentation activities and their individual rationalities of working and life. The professionals’ critical reflections on the value of the accountability devices for the existing power/knowledge nexus result in a negotiation between the two regimes of the devices and the medical-social establishments. It will be examined in the following chapter 6.



## **6 JUSTIFYING THE MARKET AND INDUSTRIAL INTEREST IN CHILD MENTAL HEALTH: INDUSTRIALIZATION PROCESS IN CARE SECTOR**

### **6.1 Introduction to the Chapter**

This chapter will continue to examine the impact on accountability devices implementation, through the voices of medical-social professionals. Healthcare sector is previously dominated by professional and political logic in management, and the professionals are as a center in managerial positions. However the rise is with great tensions in social-care sector: a dominant logic of details based on neo-liberal economics and a minor logic of self-governance (Hood, 1991). The logic of details is becoming more powerful than that of self-governance, which results in many forms of resistance. We are particularly exploring how and why frontline professionals encounter, negotiate and resist to two conflicting logics in the light of economies of worth (Boltanski & Thévenot, 2006).

There are several parts and a conclusion in Chapter six. The first part (6.2) is to review radical Transformation in medical-social Establishments. The second part (6.3) is to review six worlds of justification by Boltanski and Thévenot (2006). The third part (6.4) is to investigate justifications based on “domestic” worth in conflict with a combined mix “industrial and market worth”. The fourth part (6.5) is to characterize the industrialization process in care sector. We finish this chapter with a conclusion.

## **6.2 Radical Transformation in medical-social Establishments**

The new social context dominated by new managerialism and economic rationalism, challenges the social care work profession, based on human friendly value system. The content of social work practice has to be significantly changed in order to be compatible with new social environment. In our view, the practice environment is not comfortable to care profession. Ife (1997) reviews four characteristics of radically changed environment in which care workers have to practice. First, social and welfare policy seem to be secondary in economic rationalism. The idea of economic rationalism believes that the market could represent individual choice, ensure the minimum price with efficient service. Thus, the government should take minimal intervention, particularly some welfare expenditure delivered to social work practice. Second, managerialism as an ideology thinks that good management is the solution to problems in human service organizations, because it could make them more efficient and effective. Follow this line of thought, the so-called managers could manage any care service only they have managerial skills. They are barely from clinical field, they know nothing about healthcare knowledge, they only need to implement and apply managerial techniques. This trend of managerialism enables care staff to be executors of skills and techniques. The emphasis on technical aspects and specified skills isolates the professionals in a broader exploration. Then the rationality is the third important aspect of the environment social care workers feel uncomfortable. The healthcare sector characterized as modern rationality mechanism seems to eliminate irrational human relations and subjectivity. It seeks to combine economic, social and political dimensions in order to reach rational choice as a principle of legitimacy. Thus the social and care service should be determined by logical analysis on the basis of evidence based practice. There is no space for the values and ethics.

The implementation of contextual managerial techniques reveals that how techniques function as a technology of the self” (Foucault, 1988), and facilitate the

process of transforming individuals into accountable and subjugated ones. In doing so,

social-medical professionals yield to two combined but different logics: an increasingly dominant logic of details and a minor logic of self-governance (Hood, 1991; Dahl, 2009). The two logics present a major contradiction for staff in medical-social sector, both reshaping their sense of professionalism and proving their resistance. The study will mobilize the economies of worth by Boltanski and Thévenot (2006) to analyze the deeper reason of resistance. Furthermore, exploring the reactions of professionals to the new methods of working is provided a small window to see the phenomenon of an industrialization process in care sector.

### **6.3 Six Worlds of Justification**

In this section, we will mainly review Boltanski and Thévenot's theory of the six "orders of worth" (civic, market, inspired, fame, industrial and domestic). The work of Boltanski and Thévenot (2006) is a focus on disputes and justifications in social life. They propose a defense of a pluralist conception of the economy, social value and the conceptions of justice in society. From the standpoint of theory, we investigate social actors within disputes and how people justify their actions within different contexts of society. The modern societies consist of multiple orders of worth and justifications that follow different values and norms. When social actors advance their positions, they may draw upon multiple justifications (or orders of worth).

#### **6.3.1 The inspired world**

It is also called the world of creativity which focuses on individual creativity and originality. The worth is related the creative accomplishment of the individual person, like a famous writer. This world is embedded with creativity and originality of the individual in contrast to mass society. Boltanski and Thévenot (2006) argue the inspired world is relatively fragile and unstable, because it is driven by "the

outpouring of inspiration” and some emotions (such as love, passion, excitement etc.) from spontaneously transformative experience. Thus, the inspired world invests inspiration centered on evading routines and accepting risks in pursuit of creative success.

### **6.3.2 The domestic world**

“Domestic” is not limited in family circles. It is actually a general logic of the family that could be applied in all spheres of society. In the domestic world, generation, tradition and hierarchy are particularly important. Because the domestic world is founded upon stable tradition and hierarchy. The domestic world resembles households, which is predicated on customs and conventions. The image of father in family (patriarchal household) is almost as same logics as that of superior in an organization. Superiors bear responsibility for “good upbringing” towards subordinates. The idea “well-raised” is to instill rules of etiquette, good manners, and principles of respect etc. Superiors and inferiors are closely interdependent and keep harmonious social relations: superiors make judgment and inferiors trust superiors. Thus, decline in the domestic world occurs when social actors loose inhibitions, become indiscreet and betray the group’s trust.

### **6.3.3 The world of fame**

This world needs to be high exposure to public. Boltanski and Thévenot (2006) argue the world of fame is embedded with stars with distinctive personalities, their fans, and various professional journalist, public relations officers. The regime of fame is based on being recognized and gaining celebrity status. Decline in the world of fame occurs when its public image is lost and fame is faded out.

### **6.3.4 The market world**

This world cannot be reduced to the economic world. It is based on the logic of competition and of commercial relations between individuals. The market

worthiness is measured through saleable goods that have price. The market world is with aim to do business and make transactions (selling and buying). Thus, judgement is from the reasonable value and measurable price. It is the order of profit as opposed to human dignity.

### **6.3.5 The industrial world**

It is determined by industrial technical and scientific conception. The regime is marked by the function of the enterprise according to an industrial logic. The industrial world encompasses the efficiency, productivity, reliability and performance of social actors. The logic of technical performance and functionality is dominant. In order to reach high performance, workers should be well qualified and hierarchically organized. They have to know how to be productive with instruments or tools. The paradigm of this world is the regime of technical productivity and of standardization in relation to the factory. In doing so, the regime of the industrial treats people as things or objects that could be measurable. Indicators in industrial world is centered on the question of effective functioning, with evidence involving in performance measurement.

### **6.3.6 The civic world**

The regime of the civic world refers to persons that are not human being in the same sense as individuals in the family. Civic social actors have “natural” commitment to political bonds and collective identities. Thus, civic world may lead into a social movement, make actors unify and take collective action. Civic relations require to abandon self-interests in favor of the collective. The sphere of justification refers to the logic of solidarity and respect in the welfare state. Table 9 is a summary of all six orders of worth.

**Table 9: Six orders of worth in Boltanski and Thévenot (2006)**

	<b>Inspired World</b>	<b>Domestic World</b>	<b>World of Fame</b>	<b>Market World</b>	<b>Industrial World</b>	<b>Civic World</b>
<b>Higher common principle</b>	Inspiration	Tradition	Public opinion	Competition	Efficiency	Collective will
<b>State of worthiness</b>	Spontaneity, emotion	Hierarchical superiority	Fame	Value winning	Efficient, reliable	Representation
<b>Human dignity</b>	Creativity	Habit	Desire recognition	Interest, selfishness	Work	Civic rights
<b>Worthy subjects</b>	Visionaries	Superiors, inferiors	Stars, fans	Competitors	Professionals, experts	Collectives
<b>Worthy objects</b>	Waking dreams	Etiquette	Named in media	Wealth, luxury	Means, tools	Law, rights
<b>Investment formulas</b>	Escape habits	Reject selfishness	Reveal secrets	Opportunism	Progress	Renounce sectionalism
<b>Relations of worth</b>	Uniqueness, genius	Respect, responsibility	Recognition	Possession	Control	Membership
<b>Natural relations</b>	Unexpected encounters	Well-raised people	Influence	Business	Function	Democratic assembly
<b>Test, peak moment</b>	Adventures, voyages	Family ceremonies	Presentation to audience	Deals	Trial	Demonstration for just cause
<b>Modes of judgement</b>	Stroke of genius	Trust	Public opinion	Price	Effectiveness	Vote
<b>Forms of evidence</b>	Intuition	Anecdotes	Being known	Money	Measurement	Laws, rules
<b>Deficiencies, falls</b>	Come back to earth	Impolite, treasonous	Lose image, obscurity	Enslavement to money	Instrumentality, "treat people as things"	Divisions, individualism

(Source: Boltanski & Thévenot, 2006: 159-211)

## **6.4 Justifications Based On “Domestic” Worth In Conflict With A Combined Mix Of “Market and Industrial” Worth**

This section mainly investigates and understands disputes and resistance within medical-social sector. We provide a critical elaboration of six “orders of worth” or worlds of justification (Boltanski & Thévenot, 2006) that are drawn upon by social actors within these disputes. We particularly examine how social actors (managers<sup>46</sup> and care professionals) may draw upon multiple justifications in order to advance their interests; how power difference arise between these worlds (justifications); how weak worlds of justification may not be passive actors, they may extend their influence within policy issues.

### **6.4.1 From hierarchical relations to professional bureaucracy**

The distinct features of “domestic world” involves the following two points. The first one is about stable tradition and hierarchy. Superiors and inferiors are closely interdependent (harmonious relations). The second refers to the importance of superiors resemblant households led by patriarchal figures. They assume responsibility for ensuring future generations (their inferiors) “well-raised”. The neo-managerial reforms and the rise of managerialism transform the interactions between superiors and inferiors to that between managers and professionals. Superiors and inferiors are simply hierarchical relationships, while managers and professionals are more than hierarchical divisions. Certain managerial functions (leadership, control) in public organizations are boosted by the ever-greater numbers of audits (Power, 1999) by the new technologies for “governing at a distance” or by performance and an increasing number of control bureaucracies (Hood *et al.*, 1999).

*(..) En tout cas, il y a une perte de repères. Pour rencontrer le directeur, c'est très difficile et puis je pense qu'ils sentent que nous, on est dans cette même insécurité : mais qui dirige le bateau ? Parce que à des moment, on ne sait pas*

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<sup>46</sup> Managers in our context represent those who radically apply conception of neoliberal policy in care sector.

*dans quelle direction on avance et on a l'impression que le capitaine a quitté le navire. C'est compliqué, il y a énormément de changements qui se passent en ce moment et nous, on ne nous parle pas de l'objectif à atteindre. Donc, on nous demande de changer des pratiques sans savoir vers quoi on se dirige. Donc pour nous, c'est très insécurisant. (Interviewee : P3)*

*Il y a un grand fossé (entre les managers et les professionnels) qui s'est mis en place avec tout ça. Du coup, après ces sept ans de « chouette » travail, il a fallu qu'on rentre dans une dynamique de résistance, c'est-à-dire qu'il a fallu qu'on se batte pour faire exister l'écoute, la réflexion et le lien à l'autre en disant « arrêtez cette grosse machine destructrice ». On (les managers) n'arrêtait pas de nous dire « c'est la loi, vous n'avez pas de choix, il faut se mettre en conformité par rapport la loi ». Et nous n'arrêtons pas de dire « on dit pas le contraire mais il faut aussi se préoccuper de combien ça coûte sur le terrain aux enfants, combien ça coûte sur le terrain aux équipes etc. ». Ça, ce n'était pas entendu en fait, il y avait un mur en disant « c'est pas nos problèmes, notre mission est de vous mettre en conformité par rapport la loi, au clair débrouillez-vous comme vous pouvez. On nous a rajouté du travail, d'écriture, de réunions, d'administratif. On nous a réorganisé le travail en disant « vous faites ça, vous ne faites plus pas ça. (Interviewee :N8)*

*C'est souvent une personne qui va trancher parce qu'elle est chef d'établissement et alors qu'elle n'a pas forcément la connaissance de l'enfant ou pas forcément la connaissance du développement psycho-affectif de l'enfant etc. Des fois, on a envie d'avancer dans un sens, mais la hiérarchie fait qu'on n'avance pas forcément dans ce sens-là parce qu'il n'y pas forcément de confiance et d'égalité dans l'écoute, en tous cas c'est ce que j'ai pu rencontrer. Des fois, des professionnels dans les responsables hiérarchiques ne sont pas forcément formés à ce qu'on fait au quotidien dans la structure. Ils sont formés plus sur le budget, plus sur le management, des choses comme ça. Mais par contre quand il s'agit de prendre des décisions pour les enfants et pour les parents, il n'a pas forcément les connaissances du handicap de la personne. (Interviewee: N7)*

Social-medical sector draws on justifications from the “domestic world” to take care child with mental health problems. These justifications appear to take two main forms. First, the role of superiors is not only to guide the boat (as the psychologist P3 says “dirige le bateau”), but also to give inferiors emotional and professional practice support. From the standpoint of “domestic worth”, the latter seems to be quite more important. Superiors resemble patriarchal figures in a family and they assume responsibility to “well raise” the next generations. In this context, it means to instill



etiquettes, organize the training programs, transfer clinical practice, empowerment and autonomy etc. Superiors and inferiors are in a close and independent relations. This form of relations is not as the same as that of managers and professionals. Because the latter implies a strong focus on hierarchical control (rewards and sanctions). Second, the relationship is a core concept in “domestic world”. This concept is also implied in treatment to children with mental health problems. The clinical psychologists make practices centered on psycho-affective development rather than behavioristic approach. Every child’s uniqueness recognized, care and appreciation of children’s sociocultural experience as they engage in treatment are usually value highly by the professionals but seen as obliterated by bureaucracy. There is a pressure to “technicise” their practices. Neo-managerial policies impose on professionals to accountable to medical outcome, but affective relation is very subtitle and difficult to quantify. This rise of managerialist conception of accountability is based on justifications of the “industrial worth”.

#### **6.4.2 Productivity, technical efficiency and performance of social actors (“industrial” worth)**

The category of justifications includes arguments where evaluations depend on technical efficiency, professional planning and expertise, economic outcomes, and productivity. As NPM principles and instruments are injected into the public, such managerial questions become more frequent and more pressing. Reforms are described as aiming to undermine professionals’ power and reinforce to control of their activities by introducing and promoting rationality, standardization and accountability. NPM-related reforms seem like strategies aiming to reinforce control in general and managerial control in particular (via managerial tools) over powerful profession groups delivering services in the public sector.

*Il faut qu’il soit performant, un psychologue, ça doit aujourd’hui donner la recette à l’éducateur pour que le jeune s’invertisse plus dans les ateliers techniques. Par exemple il y a longtemps, en réunion de synthèse on voulait accompagner l’enfant dans sa découverte du travail ou de l’atelier technique.*

*S'il faisait les choses de travers, pas forcément comme il fallait, c'est pas forcément qu'il était en échec mais il fallait pouvoir mettre en transformation, utiliser l'objet qu'il avait fait travers pour pouvoir le mettre en valeur en fait. Aujourd'hui l'objet qu'il fait travers, on le met à la poubelle, on lui dit c'est pas comme ça qu'il faut faire, qu'il faut faire droit. Donc ça raconte encore quelque chose de la norme c'est-à-dire qu'on ne prend plus en compte, on n'accueille plus la difficulté du handicap, on n'essaie pas de tenter d'en faire quelque chose, (...) Donc, il y a quelque chose de la dévalorisation, on fait des tableaux maintenant avec compétences, incompétences, forces, faiblesse<sup>47</sup>. On n'a jamais pensé les choses comme ça ! C'est impossible de classer les enfants ou les personnes en situation du handicap en terme de force ou de faiblesse ! Il n'y a pas de force et de faiblesse, il y a un symptôme, il y a une difficulté, comment on fait avec et comment on essaie d'entrer en relation avec ce symptôme et cette difficulté. On vient pas dire à l'autre « ce symptôme il faut qu'il disparaisse, cette difficulté il faut qu'elle disparaisse, si ça ne disparaît pas, tu es en échec ! » c'est impossible de penser les choses comme ça ! pour autant c'est comme ça qui sont formés nos managers et nos cadres. (Interviewee: P12)*

For decades, strategy and strategic management has been important management field in the private sector (Grandy & Mills, 2004). SWOT (strengths, weaknesses, opportunities, threats)-analysis is a tool developed for strategic analysis, which is seen to be popular and take a key role in successful entrepreneurship. Only recently has strategic management caught the attention of manager in the public sector, because the introduction of regulated market competition and self-regulated. This development is strongly influenced by NPM and its rise of managerialist conception of accountability. It is thus demanded for introduce principles and methods from the private sector in the public sector, as they are supposed to boost performance (Boaden *et al.*, 2008). This point of view is supported by some scholars who assume a generic management relevant for all organizations (Weber, 1947; Fayol, 1949). The standpoint is also supported by other scholars who think there is almost no difference between the public and the private sector (Nutt & Backoff, 1993). Following this line of thought, management principles and methods from the private sector are increasingly used by public managers. Arguments involve

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<sup>47</sup> Here the psychologist P12 actually mentions the adjusted SWOT-analysis strategic tool (competence, incompetence, strengths, weaknesses). Even this managerial tool is modified in this context, it is still rooted from and strongly influenced by management principles in private sector.

industrial justifications evaluate worth based on technical efficiency and performance, while arguments involve domestic justifications based on tradition and relations. It's evident that people would have conflicts and disputes when they draw on two justifications of worth before advancing their actions. As that psychologist P12 feel incredible when she finds SWOT as a managerial tool to analyze children with mental disorder. The application of such managerial technique implies the strong demand on performance and outcome. In our paper, we do not inquiry whether managerial methods form private sector are suitable to public sector, particularly in healthcare<sup>48</sup>. We will have to explore what the impact is on health sector after have been introduced management principles and methods from private sector. And we will investigate the consequences though argument over SWOT applied in mental health.

SWOT-analysis is a tool developed for the strategic analysis. It consists of confrontation between external developments and internal capabilities. External developments are identified as either opportunities or threats for the organization; internal capabilities are described as strong or weak points of the organization. Based on the analysis of strengths, weaknesses, opportunities, threats, the organization could develop a matrix in order to make relevant decisions and strategies (see the table 10). It is widely applied in the private sector. From the table 10, we could find such managerial instruments seek to develop a rational decision-making in health care. Suppose that the organization is machine bureaucracy, managers could control the strategy process and ensure its rationality by using tools and procedures. Public managers seek to in care sector develop the model of problems-solutions (see the table 10). This model resembles a toolbox that could quickly address the diagnosis and management the patient with rapid mobilization of treatment. Thus, these normative techniques imply a strong focus on outcome and removes irrational elements, social relationships, subjectivity and etc. It is in disputes with justification

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<sup>48</sup> Through the number of interviews with care professionals, we find some managers would restructure management principles in order to be suitable for the context (healthcare sector).

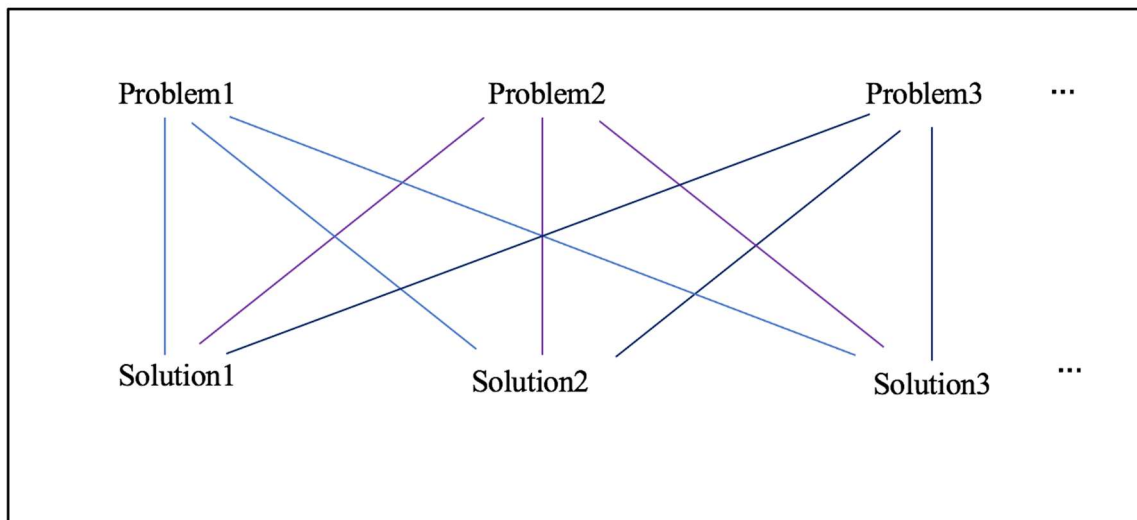
with “domestic worth”.

**Table 10: Matrix of SWOT-analysis**

	Internal Strengths	Internal Weaknesses
Internal Opportunities	(SO) Supports an aggressive strategy	(WO) Supports a turnaround-oriented strategy
External Threats	(ST) Supports a diversification strategy	(WT) Supports a defensive strategy

(Source: Porter, 1985)

**Figure 9: Model of problems-solutions**



(Source: author’s conceptualization)

From the interview of psychologist P12, such the conception of rationality and

normative not only seeks to identify weak and strong points of the public organization in order to better regulate activities, but also is applied to diagnosis children with mental disorder. With the influence of neo-managerial reforms (accountable to individual performance and rationing in healthcare), there comes an increasing conflict in treatment and work practices. As the following psychologist N2 and N8 mention the treatment to infantile autism seeks to obliterate subjectivity, difference and other affective or irrational elements.

*Sur le lieu où je travaille, on a été confrontés beaucoup à des problématiques autistiques, on a été invités très fortement à pouvoir évaluer très précocement l'autisme au détour d'évaluations qui sont standardisées. Il y a comme des passages obligatoires en fait qu'on nous demande de prendre avec la menace sinon de ne pas avoir les financements ARS par exemple, ça c'est venu vraiment perturber et contrarier notre clinique, parce qu'on pense que accueillir et accompagner des enfants qui sont dans des troubles majeurs du développement, ça ne passe pas que par des évaluations formalisées, il y a toute la question affective qui doit être prise en compte, qui va être très vite possiblement évacuée, tellement c'est standardisé justement. On doit rentrer dans une espèce de protocole en fait, des applications de méthodes, du coup on entache vraiment la rencontre avec le sujet humain et sa famille.(...) ( Interviewee: N8)*

*L'humain ce n'est pas un robot, il fait telle chose qui n'est pas adaptée, on nous va faire tel acte et ça va rentrer dans l'ordre, non, malheureusement, c'est beaucoup plus complexe que ça. Or, tout ce qui est protocolisé du côté des méthodologies, nous amènerait à nier la différenciation en fait. Donc ça nous demande encore tout un ajustement qui impacte notre condition de travail du coup, parce qu'on est contrarié dans la façon dont on aimerait exercer, parce qu'il y a des obligations qui nous arrivent d'en haut avec cette menace aussi que si on ne les applique pas, il n'aura pas de financements par exemple. (Interviewee: N2)*

One of the main components of managerialism is to develop “neo-Taylorian” practices such as setting standards and standardized practices in order to get productivity and efficiency (Pollitt, 1993). The actual treatment to child mental disorder is composed to two genres of theory<sup>49</sup>: the psychodynamic perspective

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<sup>49</sup> From our interviews with the professionals, we find the main disputes in practices are centered on these two genres of theory.

(originated with Sigmund Freud) and behaviorist orientation. The latter is increasingly dominant and popular in child mental sector. Because it is particularly useful for the development of competencies and for demonstrating technical or psychomotor skills. This theory is most advantageous when a change in behavior is the desired outcome of a medical intervention. But a great number of professionals resist against the behaviorist orientation, as its method is quite formalized and standardized. A behaviorist approach is to make patients know the conditions under which it will be performed and the criteria with which it will be evaluated. The psychodynamic approach has the following distinct features (Shedler, 2010). It focuses on affect and expression of emotion; It is an exploration of attempts to avoid distressing thoughts and feelings; Psychodynamic psychotherapists work to identify recurring themes and patterns in patients' thoughts, feelings, self-concept, relationships and life experiences; Furthermore psychodynamic psychotherapy places heavy emphasis on patients' relationships and interpersonal experience. The goal is greater flexibility in interpersonal relationships and an enhanced capacity to meet interpersonal need.

From the above analysis, the psychodynamic perspective relies on the discovery of cause-effect mechanisms by the observation of the way in which patients (children) interact with people in a natural environment. It seeks to an overall development. While the behaviorist approach aims to "remove not good behavior" in order to get desired behavior. The paper is not to talk about which method is better or suitable for treatment to children mental disorder. Our argument is a focus on the great transformation in work practices, in clinical therapy (the high demanding for outcome, control through performance evaluation implied sanction or rewards). We also compare primarily the claims and arguments made by the conflicting entities of two environmental disputes (relation based on "domestic" worth in conflict with technical efficiency and outcome "industrial" worth).

#### **6.4.3 Competition based on the "market worth"**

Market justification evaluate worth based on the economic value of goods and

services in a competitive market. “Market worth” requires opportunism and emotional distance from others. NPM-related reforms seek to establish a quasi-market regulation orienting the organizations’ offers of service according to their users’ demands, transformed into quasi-clients of standardized goods. Relationships between professional and patients are converted into customer relations, namely through the establishing of quasi-markets, the use of customer satisfaction surveys and evaluations, and quality measures and payment by results. That impersonal and comparative measurement of performance could motivate “producers” (medical-social professionals in our context) to compete for access to resources. Following this line of thought, the care institution could compare the performance of every care professional in order to identify a “best” one. And the state also allocates financial resources based on the “performance” (outcomes) of every care organization. As the above psychologist N2 says “if her institution is not ‘well evaluated’ based on a series of standardized indicators, it may not be funded by ARS” (actually implying a sanction). The professional is instructed to practice in certain ways by government appointed agencies in order to produce outcomes to meet the aims of protocols. Neo-managerial reforms are described as aiming to undermine professionals’ power (they are obliged to follow some therapy method, such as imposed on behaviorist therapy in place of cognitive-affective therapy) and reinforce the control of their activities by introducing and promoting rationality, standardization and accountability. As such, competition based on “market worth” implying strong worlds of justification seeks to extend a wide influence on “domestic worlds” of justification. When power differences arise between these two worlds, it leads social disputes among actors.

### **6.5 Industrialization of Children Mental Health**

The delivery of child mental health care is in the process of “industrialization”. This process is characterized by an increasing division of labor, standardization of tasks, the rise of managerial method, and the degradation of work. These changes hold the promise of more efficient and effective health care, but professionals have

to be concerned about the resultant loss of autonomy, disruption of overall wellbeing, and the potential erosion of professional values. The aim of this section is to present the characteristics of children mental health in process of industrialization.

### **6.5.1 Industrialization**

Being an American mechanical engineer, Frederick Taylor is the founder of scientific management theory. Prior to industrial working, complex work is performed by skilled workers. They generally carry out all the of the steps in the process of production and could mostly determine their own working methods and pace. Skills is handed down from one generation to the next, and developed by experience. After Taylor seek to develop efficiency improvements in productivity. He does many research in workshop and spearheaded a revolution in the organization of work. In our view, his innovation could be concluded the following two points. The first is about breaking down a complicated job into relatively simple tasks. The second is about analyzing each task and tool, and finding the one best way to perform. His idea is then in the 20<sup>th</sup> century transferred into the automotive industry by Henry Ford, which achieves a great success in the efficiency of working practices. The industry has all benefited from this efficient work method. We have to argue what the consequences are, when this conception (looking at work being broken down and standardized to improve efficiency, quality and productivity) are totally, thoroughly applied into the mental health care.

### **6.5.2 Dividing work into component tasks**

Mental health professions always treat patients as a broad spectrum of medical problems. For example, they usually apply cognitive-affective approach rather than behaviorist orientation, as the latter relatively makes into narrower disciplines. Around treatment to a child with mental disorder, psychologist, social educator, other therapist and specialists focus on particular organ system. A complex work is broken into several simple components. This working style is centered to a particular stage of care and fulfill one procedure of assembly line in Taylorization. Every



professional has to follow the protocol and focus on his/her specialization. This division of labor offers some advantage (such as efficiency and productivity), while it does not take specific context into consideration. The increased fragmentation of care, particularly the development of process-oriented specialization, would have crisis--simplifying complexity of cognitive disorder.

### **6.5.3 Evaluating and standardizing tasks**

Traditionally, each care professional is autonomous and largely free to practice in his or her manner based on professional ethic. In response to the managerialist accountability, the process of evaluating and standardizing the work has received a great deal of attention. Guidelines have been developed to establish and disseminate a standard of care (Woolf, 1993). Computer-aid information system facilitate the monitoring and analysis of professionals' practices, a quite important function is to make their practices more "transparent" (easier to be evaluated by non-care profession). As such, professionals' decisions are increasingly scrutinized, questioned and limited by outside forces (Farneti & Bestebreur, 2004). The aim of standardization of work is an increased surveillance and control over professional's time (i.e. their efficiency) and productivity. Administrative burdens have intensified pressures on care profession and corroded their passion for career. It finally results in be lack of time with patients and de-quality of social medical care.

### **6.5.4 Degradation of work (care profession transformed be a technician)**

According to Taylor, the ideal worker is someone who just follows instructions, receives a minimal training and use adaptive instrument. Traditional medicines are always independent and creativity. Care institutions are structuralized by professional bureaucracy. Care profession is more like skilled craftsman. Nowadays, health care is increasingly adopting the industrial model in an effort to improve efficiency and productivity. Care profession is instructed to practice in certain ways in order to produce outcomes to meet the aims of protocols. They become to be executor or technician. In our views, care professions focus on providing

standardized services at a particular stage seem to be more efficient and productivity (in terms of outcomes), while it would feel less connected with their patients' overall wellbeing and long-term outcomes.

### **6.5.5 Industrialization of child mental health**

In conclusion, child mental health care is in the process of “industrialization”. This process is characterized by an increasing division of labor, standardization of tasks, the rise of managerial method, and the degradation of work (see the table 13). The industrialized process brings the promise of better quality and more efficient health care, while to some extent it results in more pressure to control over professionals' behavior and working practice, and finally sacrifice their autonomy. Be like in assembly line, care staff are reduced to technician and they feel less valued over time. In our standpoint, the empirical study also provides a window to explore industrialization process in healthcare sector.

### **6.6 Conclusion to the Chapter**

The aim of chapter 6 is to explore why and how medical-social professionals encounter and resist to two conflicting logics (logic of details and self-governance), since the increasing demand of managerialist accountability. We particularly investigate when managers and care profession may draw upon justifications (“domestic” worth and a combined mix of “industrial and market worth”) in order to advance their actions. These multiple orders coexist together and such power difference arise between them, which result in social conflicts. We also find the increasingly dominating “industrial and market” orders of worth result in the phenomenon of industrialization in care sector. It is composed of three features: dividing work into component tasks, evaluating and standardizing tasks and degradation of work (see the table 11). The standardization process in the care sector cuts down subjectivity and identity. It transforms individuals into subjects who do not secure their sense of what it is to be worthy. That will be argued in the following chapter 7.

**Table 11: Industrialization of child mental health**

<b>Characteristics</b>	<b>Illustrations</b>
1. Dividing work into component tasks	<p>Pour travailler mon temps de sport, j'ai travaillé aussi avec des groupes, j'ai travaillé en relation professionnelle, j'ai demandé que ça soit partagé avec des collègues, en fait mais non tout est pris individuellement, c'est-à-dire que mon temps de sport, c'est ma mission, c'est ma fonction, ça correspond aux autres. Moi ce qui s'est passé, c'est que j'ai eu une manière de parler des enfants en réunion etc., le lendemain j'étais convoqué dans le bureau des cadres, c'était incroyable ! ils me disaient « votre intervention sur la réunion, vous n'êtes pas dans votre mission, vous avez pas de fonction, si ça vous parlait comme ça, ça ne vous relève pas de votre responsabilité ». (P17)<sup>50</sup></p>
2. Evaluating and standardizing tasks	<p>Sur le lieu où je travaille, on a été confrontés beaucoup à des problématiques autistiques, on a été invités très fortement à pouvoir évaluer très précocement l'autisme au détour d'évaluations qui sont standardisées. Il y a comme des passages obligatoires en fait qu'on nous demande de prendre avec la menace sinon de ne pas avoir les financements ARS par exemple , ça c'est venu vraiment perturber et contrarier notre clinique(...) (N2)</p>
3. Degradation of work	<p>Petit à petit, on se rend compte qu'on va être de moins en moins associés à de la réflexion pour les décisions. On n'a plus du tout notre mot à dire. On nous demande plus du tout si sur le terrain, c'est pertinent de faire ci ou ça, avec telle ou telle personne qui a telle ou telle pathologie. Mais c'est décidé là-haut et on n'a plus qu'à appliquer. Donc petit à petit, on devient des exécutants. (P11)</p>

(Source: author's conceptualization)

# **7 REIFICATION IN CARE SECTOR: STRUGGLE FOR RECOGNITION**

## **7.1 Introduction to the Chapter**

The aim of chapter seven is to review the phenomenon of reification in care sector. The study traces the ways in which medical-social professionals' work is increasingly being mediated by standards-based accountability to show how these professionals grapple with the tensions between policy and a sense of their professional responsibility for their patients.

This chapter is composed of two sections and conclusion. The first part (7.2) is to review literature about identity and dilemma of identity, struggle for recognition and the mobilized theory of reification by Honneth. The second part (7.3) is to provide an empirical study from the standpoint of recognition, reified care sector and professional responsibility and ethics. The chapter seven finishes with a conclusion.

## **7.2 Dilemma of Identity, Struggle for Recognition and Reification**

### **7.2.1 Dilemma of identity**

According to the dictionary of Merriam-Webster, “identity” means “who someone is” (the name of a person) and “the qualities, beliefs etc.” (that makes a particular person or group different from others). From the definition, we could find that the focus of “identity” is on the “sameness”. If some individuals have the sameness of essential, they belong to the same community (a sense of affiliation). Identity construction is the process through which individuals, collectives and states construct narrative accounts of who they are. Identity is also to construct a relationship and interaction. To some extent, identity implies the distinct traits or qualities of a person or a group that different from others. Thus, identity is to reduce uncertainty and construct sameness in the people’s interaction. For example, professional identity means the attitudes, the value, knowledge and skills shared with others “within” a professional group (the group in which members have the same occupation). In doing so, too much emphasis on the concept of identity could not solve many ethical problems in work caused by the diversity or the difference.

### **7.2.2 Struggle for recognition**

Recognition is composed of two types. The first means that recognition is about being recognized as a member of a group. Fraser (1997, 1999) defines recognition as equality in social status. In this sense, it is about identity with other actors. The second means that acknowledges difference or uniqueness. Honneth (1995) has argued that recognition of a person’s abilities and achievements enhances that person’s social esteem in that he or she is recognized as a contributor towards achieving community goals. Thus, recognition is a focus on an intersubjective nature of human and acknowledging others’ diversity (including difference or uniqueness) as a contributor, being acknowledged as a competent and legitimate social actor (Noble, 2009). In doing so, recognition-theoretic view of social life could get over dilemma of identity and acknowledge positive difference in interpersonal recognition, as well as imply an attention to agency in the process of exploring social struggles

(Siim, 2000).

### 7.2.3 Reification

Brugiatelli (2020) has reviewed the concept of reification from the studies of Marx, Lukacs, Honneth and other scholars of Frankfurt School. From his viewpoint, the studies on reification are centered around the following three points.

The first group put a focus on what is the root of phenomenon of reification. In 1844 Marx analyzes that the “fetishism of commodities” is a form of reification in which the social relations of labor appear as relationships between things rather than social relations of people. Man and social relations in a capitalist society are “reified”, i.e. reducing man to an object. This phenomenon is named as “reification and described as “alienation” in the book of Marx. In the fluence of Marxist concept of reification, Lukacs (1971) points that the reification occurs when “a relationship between people takes on the character of a thing” and reification is closely connected with forms of economic exchange. Because in the exchange of goods, subjects perceive objects as things that could bring profit. Man and his abilities are regarded as a source of profit. In the People’s interaction, one count the other who is evaluated to generate and maximize profit. For Lukacs, in capitalist society the reification has penetrated the conscience of people. This conscience becomes the habit of considering self, feelings, others and all living beings as a simple object. For this reason, Lukacs states that reification has become “man’s second nature”.

*The second nature, the nature of man-made structures, has not lyrical substantiality...(It) is not dumb, sensuous and yet senseless, like the first; it is a complex of senses-meanings-which has become rigid and strange, and which no longer awakens interiority; it is a charnel-house of long-dead interiorities. (Lukacs, 1971, p. 64)*

Second nature, according to Lukacs, is with characteristics of a cold rationality and manipulation. His concept also implies the instrumental rationality is the reason of reification. Above all, both Marx and Lukacs argue that the market

(merchandising exchange) is the cause of reification.

If the first group (Marx and Lukacs) explore the cause of reification, the second group of philosophers are to investigate the way in which the modern society is in the process of reifying. Other philosophers of Frankfurt School, such as Horkheimer and Marcuse, continue the work of Lukacs. At the same time, they are well influenced by Max Weber. They state that our contemporary world is dominated by a technical-scientific rationality that pursues a reifying approach. The technical rationality considered as an instrument could reduce man to an object in order to control, manipulate and impulse profit. The reification based on technical-scientific tools leads people to a passive recipient and being obedient to the status quo. The technical-scientific rationality treats everything (living beings, social interaction, feelings, emotion etc.) in an indifferent and neutral manner. As such, technical-scientific rationality is seen as an instrument to implement reification.

In the third group investigating reification, we will explore reification as forgetfulness of recognition by Honneth (2008). Honneth provides a critique of Lukacs' concept of reification, because attributing the main cause of reification to the capitalistic context (economic exchange) is relatively narrow. According to Honneth, that conception excludes the diverse forms of brutal dehumanization, for example racism and human trafficking. Our paper is not to explore racism issue, but we will mobilize the concept of reification of Honneth because of his particular relevance to our argument. Firstly, the phenomena of reification can be traced back to human behaviors orienting from cancelling forms of relations characterized by the recognition of a person's qualities and dignity. That cancellation are presented that physicians should follow instrumental-rational guidelines and codes regardless of flesh and blood individuals in working place. This enables us to touch the ethical in the institutional context of medical accountability as a matter of social justice. Secondly, Honneth develops a concept of "recognition" as a core to the de-reification of social interaction. He thinks "act of recognition is oriented not towards one's own aims but rather towards the evaluate qualities of other" (Honneth, 2002). In other words, act of recognition means to recognize difference and diversity, a person as

autonomous and agentic.

### **7.3 Recognition, Reification in Care Sector and Ethics of Work**

#### **7.3.1 Recognition-view of work**

The recognition-theoretical perspective is constituted intersubjectively through participation in forms of social life. The participation generally implies a standpoint of interpersonal recognition. For Honneth (2008), the recognition involves positive affirmation of the other person. Here “positive” does not mean positive emotions to the other, while it means to acknowledge people’s agency as participant. NPM and the rise of managerialist accountability are usually perceived to homogenize discourse, i.e. that means to repress people’s agency and develop the same gesture in organization. Thus, recognition is seen as a basis of social organization, personal autonomy and self-realization.

##### **7.3.1.1 Rationalization, reinforcing control over output and accountability**

A series of NPM-based reforms and the rise of managerialist accountability have the aim to put a control from a logic of means to a logic of results. The emphasis is on “output” and “performance”.

*Ils (les enfant qui ont de troubles psychiques) ont des troubles très intriqués. Et on mesure vraiment à quel point on est loin de maîtriser les tenants et les aboutissants du développement de l'être humain. (...) Le diagnostic n'est pas forcément posable en amont. Le temps va jouer dans le diagnostic. (...) Le handicap, il est rapport avec ce que la société attend de quelqu'un. (...) C'est l'interaction que ça se joue. Et notre travail au CAMS, ça va être de construire cette filiation là. Mais c'est extrêmement compliqué puisque, en parallèle, il y a un travail d'annonce. C'est-à-dire que le parent, quand il arrive, très souvent, il vient avec cet enfant là qui présente un handicap, un retard et il nous demande de réparer ce retard. Or, nous, on sait très bien que non seulement ça va pas se rattraper mais que ça va se creuser la différence. (...) Du coup, c'est vraiment un travail de dentelle, de tricoter ce maillage entre le parent et l'enfant. (...) Du coup, c'est vraiment un travail de dentelle, de tricoter ce maillage entre le parent et l'enfant. (...) (Interviewee: N4)*

It’s known that the medical professionals, patients and patients’ family are not



isolated entities, they need to interact with their environment and with each other. They need have time to constitute intersubjective interaction to make a treatment.

*Maintenant, on a plus de cadres, plus de protocoles. Avant, on faisait en fonction de la personne. Maintenant, il y a des protocoles pour tout. (...) On n'a plus le droit de parole. On n'a plus le droit de rencontrer les parents. C'est les cadres qui rencontrent les parents. Il n'y a plus de communication dans notre travail. (Interviewee : P20)*

*c'est qu'on l'appelle « une prise en charge », c'est-à-dire que possiblement on voit l'enfant toute la semaine ou l'enfant et son parent,(....) On a une pression là-bas qui est liée à l'acte, je dois faire certain de nombre de rendez-vous, je n'ai pas de choix. on est soumis à des actes. Voilà ! c'est surtout ça qui me fais la pression là-bas, on a beaucoup de dossiers, ce qui me fais la pression, c'est qu'on accueille beaucoup de familles, on n'a pas de possibilité de leur proposer un soin dernier parce que très vite les plannings sont pleins, ça sur un plan humain et professionnel, c'est très compliqué parce que on accueille des familles, elles nous racontent leurs souffrances et puis derrière nous ne leur proposons rien, professionnellement, c'est très dur! (Interviewee: N2)*

From the description of three psychologists, it is concluded that the treatment to child mental health is complicated. With the process of intersubjective truth-finding, it dissociates professional ethics from rational-instrumental conception of action. Recognition is a key to medical professionals, because it is radically opposite to a focus on accountability (neoliberal accountability) that asserts an abstract notion of *being* a doctor (or a good care-provider) and his obligation to ensure “outcomes” (as in the interview of psychologist N2, she says “soumettre à rendre des actes”). Recognitive caring evokes a notion of *being there* as a doctor and one’s ability to respond to the demand of every particular child, their families, namely the flesh and blood individuals are there.

### **7.3.1.2 Division of labor: enforcing individual expertise and isolating intersubjective diversity**

Professions are not homogenous entities, they are constituted by internal divisions. Professions are not unchangeable, they appear, disappear, or are

reorganized. The aim of NPM reforms is to reinforce the division of labor, eliminate the concept of professional responsibility and replace it with individual accountability. It is particularly mentioned that the “poles” are created to assemble several services and define a line of command more directly controlled by the supervisory authorities. From the standpoint of the organization, its services or activities are divided and assembly reorganized into a “pole”. The supervisor of pole is in a line of command with his professionals. Every professional should be accountable to his “outcomes” and the supervisor should be accountable to his “outcomes of pole”. The emphasis on individualism in a community could not solve many ethical problems in work caused by the diversity, while recognition aims at acknowledging positive difference (or uniqueness) in interpersonal nature of human as a contributor.

*Il y a eu déjà l'arrivée des pôles, c'est-à-dire que plutôt d'avoir chaque institution les unes à côté des autres, avec leurs spécificités, leurs identités, on s'est dit, maintenant, on va parler des pôles. On réunissait plusieurs institutions en pôle, il fallait uniformiser ces institutions pour qu'elles répondent aux mêmes exigences qu'un directeur de pôle avec une normativité de pôle etc. Là, ça a commencé à être un peu bancal parce qu'on a perdu un peu en identité et en spécificité, mais on est quand même venu continuer à raconter que, attention ! Chaque institution était différente puisque chaque enfant était différent donc on ne pouvait pas avoir le même type de soin etc. (Interviewee : N8)*

*Je pense que l'administration connaît très mal ce travail-là. Par exemple, elle (l'administration) nous a jamais demandé comment on travaillait. Moi j'invite régulièrement des gens de l'administration à venir sur des séances, mais personne ne vient. (Interviewee :N4)*

*On a eu un changement de direction et de manière de manager les équipes. Suite à ça, on a vu une présence moindre des cadres sur le terrain. Même nous, pour être en lien avec notre chef de service, c'est compliqué. Ils sont plutôt en retrait du terrain et quand après, on veut partager notre travail avec eux, on sent qu'ils sont en décalage par rapport à la réalité de terrain, entre nous ce qu'on vit et eux, ce qu'ils peuvent nous demander. Je trouve qu'avant c'était beaucoup moins le cas parce que les chefs de service pouvaient manger avec nous et avec les jeunes etc. Donc là, on parlait de la même chose. Et là, c'est plus difficile de se retrouver et de défendre des choses pour les enfants. (Interviewee :P3)*

*C'est arrivé plusieurs fois, je suis un petit convaincue que mes écrits n'ont jamais été lu. Au niveau de la MPDH<sup>50</sup>, il va regarder le bilan du psychologue, le bilan scolaire et après les autre c'est pas intéressant, donc il y a des fois des choses et leurs décisions à prendre justement un peu surprenantes. (...)Au niveau de la direction, il y a vraiment un intérêt pour quelles personnes qu'on travail, c'est-à-dire qu'il y a vraiment une idée qu'est-ce que c'est le travail de médico-social ? qu'est-ce que c'est prendre du soin de quelqu'un ? Mais il y a vraiment des gestionnaires qui brassent des chiffres qui répondent des appel d'offre, qui parlent que ça...ça vient complétement envahir tout. (Interviewee: P1)*

From the interview of four medical professionals, we could find that reforms are described as aiming to undermine public sector frontline professionals' power and reinforce the control of their respective activities by the specialized labor division. The today's medical world is organized by three parts: scientific elites charged in evaluating good practices founded on evidence-based medicine; a new managerial elite positioned on the interface between clinical activities and management: frontline practitioners carrying out exclusively clinical activities. Every profession is accountable and responsible to his or her practices. It leads to self-identity in the same categorization and a neglect of culture diversity. As the interviewee P1 says "the decision made by managers are sometimes "supersized" by rank and file practitioners. In doing so, a positive relationship between profession and organization springs from recognizing each person's expertise in his/her special field and sharing value in decision-making. As the following interviewee (P5) illustrates, the recognition-view of work constitutes intersubjectively inclusion of culture diversity and more integrated medical system.

*Travailler en interdisciplinarité, ça faisait une espèce d'entente et d'écoute entre la direction et le médecin psychiatre et du coup, ça permettait de faire du lien entre le service administratif, le service éducatif et pédagogique et le service de soins, avec des personnes référentes à la tête, mais plus dans la coordination, Et ce que j'ai trouvé assez chouette, c'est qu'on m'a vraiment laissée faire ce travail-là, on m'a laissée prendre ce temps-là. On m'a fait confiance en fait. Évidemment, j'avais de quoi m'appuyer avec le médecin*

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<sup>50</sup> MPDH (Maison départements des personnes handicapées): a French social care institution for disabled person

*psychiatre pour pouvoir discuter des indications de soins. Et ça s'est mis en place et moi j'ai pu dérouler mon travail en disant que bien sûr je pouvais intervenir auprès des enfants sur des séances types mais qu'il y avait aussi tout un travail de réflexion pour tisser une interdisciplinarité. (Interviewee: P21)*

In our view, the value of teamwork is not easily equal with the summation of value of the individual. The division of labor in a team is not totally seen as a multicultural workforce. Traditional human resource management (HRM) views the division of labor as costs to be minimized and as resources to be deployed efficiently, which highlights the idea of “using” people. As such, HRM practices make a human capital view of work by providing the managerial tools by which to categorize work in terms of discrete, individualized worker properties. The division of labor highlights the individual difference perspective, while it isolates intersubjective diversity from the recognition standpoint of community. As the following psychologist P7 and P19 illustrates, the actual meaning of interdisciplinary team is to recognize uniqueness (e.g. expertise, specialty or technique) in relating with others and evoke a notion of *in situ* as a care staff to respond to the demand of a particular child.

*(...) il y a quelque chose qui fait qu'on se rencontrait autour de valeurs avant de penser expertise. Enfin il y avait quelque chose d'une éthique et puis d'une possibilité de travail transdisciplinaire. C'est-à-dire qu'on partage des valeurs, chacun avec sa spécificité. Ce qui fait qu'on fait équipe, c'est les valeurs partagées quelle que soit notre discipline. (Interviewee : P7)*

*On peut parfois même être en peine de se rejoindre parce que l'un va dire qu'en fonction de sa spécificité, c'est son approche ou le trouble qui prévaut sur le travail des autres alors qu'on devrait pouvoir construire les choses de façon beaucoup plus globale. Avant de traiter une maladie ou un symptôme, on a affaire à un individu qu'on doit aider dans sa construction globale et pas de façon parcellaire. Moi c'est ça qui m'a particulièrement intéressée quand je suis arrivée à l'institut d'éducation motrice, parce qu'il était question d'approcher le corps, le corps cassé et ce qui était intéressant, c'était la place que le direction, les équipes, enfin l'ensemble de l'institution allait à essayer de se dire que les gens n'étaient pas que des corps à réparer, qu'ils avaient aussi une relation à leur propre corps. (Interviewee: P19)*

### **7.3.2 Reification in care sector**

The phenomenon of reification appears, when the social relations of people is replaced by relationships between things. Our paper is to reveal how managerialist notion of accountability is regarded as a form of reification, threatening to replace the notion of community and human relations in medico-social sector by relations between things (e.g. relations mediated by outputs, performance indicators, assessment data, work standardization, etc.). For Honneth (2008), reification is a process of forgetting antecedent recognition that are based on an emphatic and engaged relationship with oneself, others and the world. After reviewing and characterizing the phenomenon of reification in care sector, our study is also to reveal a possibility of de-reification that a sense of human relations is based on recognition. This recognition is acted through intersubjective relations with others. In the first place, the professionals working in care sector need to remember their role as collective subject of medical practices. Secondly, in the daily interaction the professionals and patients (even including patients' parents or families) should be intersubjectively recognized people's agency as a contributor.

Human beings are constitutively dependent on non-instrumental social relations for many aspects of their lives, particularly those sectors which touch upon their ethical integrity in relation to the other. In doing so, Honneth (2008) critiques the instrumental-rational core of reified relations and regards recognition as central to the de-reification of social relationships today. In the following part, we are to trace the ways in which social-care work is increasingly reified.

#### **7.3.2.1 Responsibility for medical outcomes (express them as a number)**

(...) De ne pas accueillir d'enfant avec son symptôme, c'est d'accueillir l'enfant avec toute sa subjectivité, avec sa globalité, avec le parent, le grand frère qu'il a, et avec nos différentes lorgnettes.

Parce qu'on s'adresse à la globalité d'un sujet et ça, ce n'est pas mesurable. Quand on nous demande constamment d'être du côté des mesures, c'est un exercice, pour nous, d'attention qui est impossible à faire. Et combien de fois je suis surprise : « je sais pas pourquoi j'ai fait ça, mais après j'ai compris pourquoi j'ai fait ça ». Comme s'il y avait d'inconscient à inconscient quelque chose qui a

fonctionné. Et ça ce n'est pas mesurable. (Interviewee : N4)

### 7.3.2.2 Result-oriented performance evaluation and benchmarking

*On devait mettre des points rouges, oranges ou verts en fonction des objectifs. Alors il fallait dire qu'est-ce qu'on fait. On nous donnait l'objectif, donc ça, ça ne m'allait pas du tout qu'on nous donne un objectif qui n'était pas pensé par l'équipe mais qui tombait comme ça. Et puis, pour tel enfant, il fallait l'emmener à l'objectif mais ça n'allait pas du tout parce qu'on ne prenait pas en compte sa capacité à y aller. Et ce qui nous intéressait nous, c'était pas qu'il atteigne l'objectif, (...)Et là, ça commence à pas aller pour moi qu'on ait des objectifs précis et du coup, on s'éloigne du parcours individuel de chacun et des capacités individuelles de chacun. Là, ça commence à pas aller avec le sens de mon travail. J'ai du mal à m'adapter à ça mais je m'adapte, je tiens, je tiens. (Interviewee : N6)*

*Pour les psychologues, il y avait aussi du changement. Les psychologues doivent faire des bilans, ça doit remplir des grilles pour dire quel âge de développement, quel quoi, et on doit avoir des chiffres. Les psychologues, il faut qu'ils arrêtent d'aller sur des groupes, prendre du temps avec les équipes pour savoir comment vont les équipes, parce que ça, c'est du temps perdu. Un psychologue, il faut qu'il arrête de nous parler tout le temps du monde émotionnel (Interviewee : P4)*

*Il faut qu'il soit performant, un psychologue ça doit aujourd'hui donner la recette à l'éducateur pour que le jeune s'invertisse plus dans les ateliers techniques. Par exemple il y a longtemps, en réunion de synthèse on voulait accompagner l'enfant dans sa découverte du travail ou de l'atelier technique. S'il faisait les choses de travers, pas forcément comme il fallait, c'est pas forcément qu'il était en échec mais il fallait pouvoir mettre en transformation, utiliser l'objet qu'il avait fait travers pour pouvoir le mettre en valeur en fait. (Interviewee: N8)*

### 7.3.2.3 Reinforcing control over frontline practitioners: demanding working transparency and lose autonomy

*(...) Depuis 2014, on doit rentrer des actes Médiatteam<sup>51</sup>. En tout cas, ça m'est apparu plus fort, parce que ça nous amène à écrire toutes les séances, le plus important ça à l'air d'être celles qui sont en direct, les séances en présence du jeune, du coup moi je reste avec cette question, petit à petit les temps qui sont pas en direct avec les jeunes comment ils vont être pris en compte, c'est-à-dire que tout les temps de réunion, de réflexion et d'élaboration qui font l'intérêt du*

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<sup>51</sup> It is a software applicated in medical-social sector with the aim at recording professionals' practices (make their practices "transparent") and importantly using to code patients' disease with tariff.

*travail en SESSAD, en fait on est en train de voir les SESSAD vont être petit à petit démantelés, ils vont petit à petit se transformer, on commence à voir ça parce que là on vient de répondre à un appel d'offre autour des maladies rares, (...)* (Interviewee : P15)

#### **7.3.2.4 Standards, managerial protocols and other rational instruments**

*il fallait que ça soit quelque chose plus utile pour les parents et les enfants, ça ne me posait aucun problème d'écrire mais un moment donné il fallait savoir à quoi cette écriture va réellement servir ? Est-ce qu'elle tient réellement compte du niveau de compréhension de l'enfant et des capacités des parents ? l'amont veut avoir un joli dossier, bien rangé et avec des choses qui sont remplies dedans, mais finalement au niveau de la direction c'était pas très important ce qu'on mettait dans ce projet. Ce qui est important, c'est le papier soit rempli. Comment redonner du sens à cette chose-là qu'on prenait beaucoup de temps et qu'on prenait du temps sur l'accompagnement auprès des enfants. C'était assez compliqué par rapport en plus à des discours avec la direction qui n'étaient jamais claires, en gros on nous a dit « faites votre projet de service, allez-y, mettez ce que vous voulez, pour que final ça soit eux (les gestionnaires) qui décident » pour un an et demi pour construire quelques choses et finalement on s'en lave les mains !* (Interviewee: P1)

#### **7.3.3 Managerialism and accountability: reification, professional responsibility and ethics**

From the above study, it is well concluded that medical-social professionals in France have witnessed multiple incarnations of the idea of “medical accountability” and its enactment. Today, accountability constitutes a core concept of neoliberal policy-making in medical-social sector, and managerialism is seen to provide a “technical” solution (Pollitt, 1993), both reorganizing and normalizing what counts as practices, professionalism and relationships between care staff, patients, patients’ parents and the public in the “audit society”. Audited technologies of accountability and a series of performativity measures reduce both professional autonomy and the value of care professionalism. A key to this process is the idea of a “new professional”- the one who is sensitive to the demands of the market (i.e., customers) and is motivated to produce quality and accept public accountability. The paradox of neoliberal discourses in social medicine is that, in putting emphasis on professionals’ performance (output), the idea of a socially responsible professional has been

replaced by a “managed and surveilled” one. The frontline professionals are deprived of their autonomy, creativity and agency. They are then reduced to be executors. As such, the managerialist conception of accountability reifies professionals through the increased regulation of their work, performance appraisals, reporting of medical results to the public and other surveillance and disciplining mechanisms (see the table 12). The neoliberal conditions of reification, in which care professionals, their practices and patients are treated as measurable, instrumentalized objects of scrutiny (to be rewarded or punished), conflict with the larger purpose of social-medicine (real meaning of work: care, love, compassion, empathy etc.) and affect the professional identity, their relationships with patients and their capacity to implement rich forms of social care activities.

Our study is also to touch the ethics topic in medical-social sector. In our opinion, ethics is understood as a recognition of others and professional responsibility for the patients. Turning to ethics does not mean fighting against the policy. Rather, it is to put the ethical as a foundation for political action. If act of recognition or recognitive ethics is core of de-reification of social relations between care professionals, patients, patients’ family and society, if this enables our care professionals to be agentic, creative and keep doing what they think best regardless of rational-instrumental circumstances, then this is a true medical-social ethics.



**Table 12: The ways of reification, threatening to replace the notion of community and human relations in medical-social sector by relations between things**

<p>1. Relations mediated by a pressure about output</p>	<p>En même temps, il a fallu en passer par là pour que aussi sur notre secteur on soit aussi dans cette dynamique de se dire : « je dois rendre des comptes sur ce que je fais ».</p> <p>Sinon on oublie le cœur de notre métier : c'est l'accompagnement de l'adulte ou de l'enfant handicapé. Donc qu'un moment donné on rende des comptes sur ce qu'on fait, oui, mais il ne faut pas que ça nous fasse oublier ce pour quoi on est là, qui est bien d'accompagner un adulte en difficultés. Après il faut trouver le juste équilibre. Le secteur médico-social n'a pas été créé pour être rentable. (Interviewee :P18)</p>
<p>2. Relations mediated by a pressure to “technicise” practices</p>	<p>Donc, il y a quelque chose de la dévalorisation, on fait des tableaux maintenant avec compétences, incompétences, forces, faiblesse. On n’a jamais pensé les choses comme ça ! C’est impossible de classer les enfants ou les personnes en situation du handicap en terme de force ou de faiblesse ! Il n’y a pas de force et de faiblesse, il y a un symptôme, il y a une difficulté, comment on fait avec et comment on essaie d’entrer en relation avec ce symptôme et cette difficulté. On vient pas dire à l’autre « ce symptôme il faut qu’il disparaisse, cette difficulté il faut qu’elle disparaisse, si ça ne disparaît pas, tu es en échec !» c’est impossible de penser les choses comme ça ! pour autant c’est comme ça qui sont formés nos managers et nos cadres.</p> <p>(...) avec les nouvelles techniques de management et avec la nouvelle réglementation qui sont arrivées, on vient transformer ce projet associatif global en une dictature, c’est-à-dire qu’on vient rendre le salarié exécutant. (Interviewee : P12)</p>
<p>3. Relations mediated by performance indicators, statistics, assessment data, etc.</p>	<p>Donc après on a eu des évaluations internes et externes. Ça, ça a été nouveau aussi. Et les évaluations viennent nous obliger à nous réunir régulièrement avec des chefs de pilotage. Au tout début, on devait mettre des points rouges, oranges ou verts en fonction des objectifs. Alors il fallait dire qu'est-ce qu'on fait. On nous donnait l'objectif, donc ça, ça ne m'allait pas du tout qu'on nous donne un objectif qui n'était pas pensé par l'équipe mais qui tombait comme ça. Et puis, pour tel enfant, il fallait l'emmener à l'objectif mais ça n'allait pas du tout parce qu'on ne prenait pas en compte sa capacité à y aller. Et ce qui nous</p>

	<p>intéressait nous, c'était pas qu'il atteigne l'objectif,(...) (Interviewee : N6)</p> <p>Dans cette recommandation, les approches comportementales sont beaucoup basées sur dans le principe de fonctionnement psychologique qui a une stimulation et une réponse, ça fonctionne par l'apprentissage et il est exclusive comme ça sauf il réduit énormément à ça, on pense qu'il a plein d'autre manière d'apprendre. Avec approche-là, tout est évalué et mesuré, on parle d'un point avec un enfant et on fait des mesures pour arriver un autre point et pour justifier de notre intervention, on dit que « moi je travaille et j'arrive à ça avec cet enfant », c'est quantifiable. Nous défendons une idée que tout n'est pas quantifiable et il y a des choses qui se passent avec une relation et etc. (Interviewee :P17)</p>
<p>3. Relations mediated by some protocols</p>	<p>Avant on pouvait travailler ensemble, le cadre permettait de prendre un peu de recul, de se faire aider. Avant, si une personne faisait une crise, on pouvait avoir une écoute. Même entre collègues, on ne se parle plus parce qu'on a l'impression que tout va être répété à la hiérarchie. (...)</p> <p>Le travail social devient hyper-individualiste comme la société d'ailleurs. Même dans notre travail où il y avait une vraie cohésion de groupe, maintenant, ils sont en train de faire disparaître les valeurs du social. Tout le côté humain, entre-aide, écoute, partage. Même dans le social, il n'y a plus ça. C'est diviser pour mieux régner, mettre en concurrence les salariés. Ils (les cadres) font des petites phrases insidieuses pour mettre l'autre à mal. Donc les gens finissent par plus s'entendre. On devient même parano dans ce travail. (Interviewee: P20)</p>

(Source: author's conceptualizatio)

## 7.4 Conclusion to the Chapter

In recent decades, neoliberal reforms introduced in French medical-social sector have significantly affected public health system. This impact is multidimensional and profound, involving a series of transformations in medical-social governmentality, medical professionalism, assessment in care sector and social relationships between the profession and the public. In conclusion, we have to mention the following three points:

In the first place, we review the theory about identity, recognition and reification. Because of the dilemma of identity, it is asked for intersubjective recognition in relations with others. And then we justify the relevance of reification by Honneth (2008) in our paper.

Secondly, our empirical study provides a small window on how some medical-social professionals encounter, negotiate and resist demands of regional or national accountability measures. Their social relationships with patients, patients' family and colleagues are arguably mediated by managerialist conception of accountability (outputs, performance indicators, data and statistics etc.). Our medical-social care sector is in a form of reification where the social relations do not appear as the immediate social relations of people but as relationships between things.

Finally, according to Honneth (2008, 2009) de-reification is a process of "remembering" a role in making the social world. Recognition is therefore a core to care staff remembering of their role *in situ*. It is radically opposite to neoliberal accountability that asserts an abstract notion of *being* a medical professional and his duty to ensure outcomes or just provide service. From this point of view, professional ethics is understood as a recognition of others and professional responsibility for the patients. It is a true ethics because it is called professionals to commit to responsibility for others, to be agentic and creative in practices.

## **8 DEVELOPING A “DIALOGICAL” BETWEEN RELEVANT STAKEHOLDERS IN THE EVALUATION OF VALUE OF MEDICAL-SOCIAL SECTOR**

### **8.1 Introduction to the Chapter**

For decades, NPM-related reforms introduced have applied in care sector with market relationships and managerial practices from private sector. The managerialist accountability is rising and impulse a series of performance indicators in order to evaluate public organizations. But this rational technique seems to afford inadequate basis for realizing a role of evaluation mechanism in public sector. We have shown that a series of managerial techniques appear to be sharp instruments for change. Formal techniques (such as strategic planning, quality management and etc.as we above mentioned) appear strong in their capacity to redistribute power and alter patterns of interests. As argued by Foucault (2000), as soon as power manifests itself, it should expect resistance. Individuals do not directly accept and apply new systems. Rather they can critically and reflectively detach themselves to these systems and modify them. In other words, they will make creative use of the space for self-construction. In light of this point, the chapter 8 will characterize our case study the association A, investigate its relational governance and coproduction process of public values. We argue a language-based nature of accountability (i.e. a dialogical approach) may be an alternative strategy in face of evaluate society. In our view, this approach could cope with the complexity of the social world and of the effects of public services. The language-based nature of accountability proposed could provide a much richer scope of accountability relationship between government, medical-social establishments and care service users.

## 8.2 Review of Child Mental Health

The purpose of this part is to review scientific literatures that explain child mental health. Medical complexity, uncertainty and variation are highlighted in child mental care.

Mental health and mental illness are often increasingly regarded as the same thing, but they do not. Mental health is an integral and essential component of health. When talking about the mental health, we talk about our mental wellbeing, that is our emotions, our thoughts, our feelings. It's about how we connect with the society, how we solve and overcome the problems. However a mental illness is an illness that effect people think, feel, behave to other people. There are different mental illnesses and they have different symptoms, such as a mental disorder. In the 19th century, William Sweetzer seems to be the first person to use the term "mental hygiene" and develop an approach to work on promoting positive mental health. Jahoda (1958) separates mental health into three domains. First it's the process of self-realization through which we look for our potential ability. Second it's the belief that we could manage our life. The third one is a little similar to the second. People with positive mental health could identify, confront problems and master the situation. World Health Organization stresses that metal health is not merely the absence of disease, it defines it as "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (WHO, 2014). That definition puts forth the core notion of mental health and remains irrespective of diverse interpretations across cultures.

According to WHO, metal disorders by 2020 will account for nearly 15% of disability. The increasing number of people are seeking help from mental health professionals while they cannot be classified under the Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications. Their questions often involve difficult social or peer interactions, relationship issues, career decision, academic problems...They might suffer from frustrations and depression if they are not treated. Such people are around us. Thus prevention and early intervention play a quite

important role for mental health, especially for those at risk population. WHO (2004) makes distinction between mental disorder prevention and mental health promotion. The former aims to reduce symptoms and ultimately mental disorder. The latter is to promote positive mental health and increase psychological wellbeing. Mental health, as it currently stands, is on a continuum from treatment and prevention of mental health disorders to promotion of mental health. Treatment and prevention models continued to the disorders and at-risk population are equally important and necessary. Early preventive interventions can shelve an increase in occurrence of new cases, in the severity of potential problems, and it can uphold strengths and optimal human functioning. In our views, early prevention such as counseling psychology function like a “detector”. Its main goals are to detect potential psychological and psychiatric risk. Early and effective interventions reduce the risk of mental illness and the cost to health system.

The issue of our thesis is to investigate the services for child mental health. Recent studies have found that the number of children diagnosed with mental health problems has increased significantly over the past three decades (Bricker, Davis & Squires, 2004). The treatment of psychiatric disorder children has quickly advanced over the last thirty years, but that treatment conditions in young children or preschool children remains limited (Egger & Angold, 2006). Kendall-Taylor and Mikulak (2009) identify main themes the scientific discourse on child mental health. There exist the gaps between expert and public understanding of child mental health. The following review is to represent the wide scope of scientific research focusing on the central questions, and issues of child mental health.

1. The influences of child mental health are complex. The number of actual researches recognize the interplay between nature (individual biological influences) and nurture (environmental influences) in child development. We could find many articles talking about that theme. However the key question is not always to identify whether individual or environmental characteristics, but to analyze those individual and environmental characteristics interact in producing mental health and illness outcomes (Kendall-Taylor & Mikulak, 2009). There is already an overwhelming

majority of focus on child mental illness. The scientific community is in great efforts to develop explicit model and treatment plan while the implicit model of mental health is mostly to conceptualize sources or causes of mental illness. Taking actions for mental health promotion is still limited.

The literature reveals a common understanding that child mental health and illness are shaped by complex interactions between the individual (child), his biological characteristics, his caregivers' characteristics, his family environment, even the broader social culture context around him. As the saying goes "take a whole village to nurture a child", a baby cannot exist alone, but is essentially part of a relationship (Winnicott 1964, p. 88, as cited in Hughes 1989, p. 133). Campbell (2006) argues that it's the interaction between child characteristics and caregivers' characteristics that largely predicts child mental health outcome. Caregivers, in our opinions, are not a limited parent context. They could be a child's grandparents, teachers and others who are around with that child. Gelfand (2003) emphasizes the importance of the transactional relationship between child and caregiver. He considers the child and caregiver as a single unit of analysis in clinical child mental health practice. In the meantime some research transfer attention to aspects of home life, for example quality of parents' marriage, family composition would have an influence on child's social-emotional development (Campbell, 2006). The above review show that child mental health is influenced by a number of social environment factors. It seems to be those factors influence on a child's mental health through complex interaction.

2. It's recently acknowledged in the field of child development about the possibility of mental health problems in young children (Luby, 2007), while the public maintain the idea that early childhood is a happy time and mental health problems are not issues in this younger population. They argue the happiness time prevent children from mental health illness. Because of the idea that the child is too young to exhibit mental health problems, many parents believe that the disruptive disorder of their children is not a symptom of psychiatric problems. The word

“infant” means innocent and hope, while “mental health” is equal to mental illness. The term “infant mental health” seems a contradiction to people. The juvenile courts think children in the welfare system under the age of six to be immune to mental health problems, despite these very young children are generally vulnerable population (Lederman, Osofsky & Katz, 2001). The emerging science of early childhood development clearly note that during the first few years child develop the foundation and capabilities for his subsequent development. Those young children in the welfare system usually have experienced in emotional and environmental impoverishment, which provides a poor foundation for healthy development and may exist emotional disorders. Furthermore the practitioners still hesitate to identify or assess mental health problems in babies and toddlers, which we could find a growing rate in referral for mental health problems after children turn at the age of three (Cordeiro, Da Silva & Goldschmidt, 2003). It’s important to note that “interventions that begin earlier in development and continue longer afford greater benefits to the participants than do those that begin later and do not last so long” (Ramey & Ramey, 1998). Early and planned interventions can help to find the problems and give a timely treatment.

Awareness of communication with the public about the science of child mental health is increasing. Researchers and practitioners do not reach a consensus about how to approach mental health issues in young children, but they argue that treatment models of adult mental illness cannot apply to children. Infants and toddlers are not “little adults” (Sturner *et al.*, 2007). Moreover, child mental health should be importantly viewed through a developmental lens and in the context of development. Cordeiro, Da Silva and Goldschmidt (2003) propose to provide the “sensitive care” for children between ages two and three, as in this stage children undergo a particularly vulnerable point. This period can have serious consequences on children’s socio-emotional development.

3. In the context of child mental health, the literature relies on the concepts of risk and protective factors. In exploring the determines of child mental illness, risk



factors refer to the factors that increase the probability of negative mental health outcomes. Protective factors, on the other hand, are those aspects that promote positive mental health outcomes. Through a somewhat instinct interaction, these risk and protective factors combine to determine a child's vulnerability to develop mental illness.

The specifics of that calculus of risk and protection, however, are not evident. Literature does not clearly indicate the relative weights of specific risk and protective factors or model their interaction, beyond the cumulative effect of multiple risk factors. It is universally agreed that the greater the number of risk factors a child is subject to, the more likely he is to suffer mental health problems (Zeanah, Boris & Larrieu, 1997). It's not possible that exposure to a single risk factor significantly compromises a child's future mental health outcomes, while concurrent exposure to multiple risk factors in combination is clearly associated with increased likelihood for mental health problems (Sameroff *et al.*, 1998). Researchers importantly note, however, that even a combination of multiple risk factors does not necessarily eliminate a child from healthy social-emotional development. It remains clear that multiple protective factors can "directly reduce the effects of risk, enhance competence, or immunize an individual against adversity" (Zeanah & Zeanah, 2001). The probability of occurrence of mental health problems is more plausible if the risk high. Protective factors could moderate the effects of risk exposure. Increasing awareness of the importance of a treatment to child mental health is to develop child mental health promotion that will be implemented in communities, schools and in primary health care, as an African proverb says "it takes a whole village to raise a child". An entire community of people must interact with children for those children to experience in a safe and healthy environment.

In conclusion, there are three points that should be particularly mentioned. In the first place, the objective of child mental services should consider the wellbeing of child health and promote positive mental health. Every child is not merely individual biological unit. The treatment should put into consideration his or her

relation context and social environment. It is indispensable to make a broader approach with more attention to family support. In practice, children's behavior development is increasingly emphasized, while their social-emotional development is decreasingly considered. Secondly, the treatment to child mental health is particularly complicated. The treatment to child mental disorder is implicit and not normalized. Thus, it is very necessary to develop interorganizational and cross-disciplinary collaboration in order to provide "sensitive care". The collective value should be emphasized in child welfare system. Thirdly, prevention and early intervention are quite important to child mental health, while such services are very limited.

### **8.3 Accountability Devices: Rational-Technical Instrument Focus and Corroding Collective Creation of Value**

The control system seeks to make public services more accountable to citizens (efficiency and effectiveness) by the use of private-sector business techniques with a strong focus on competition and performance measurement approach to evaluation.

#### **8.3.1 Private market model and competition**

The market mechanisms are utilized in public sector: either in the form of quasi-markets to introduce competition between public providers, or by contracting out or privatizing services which are directly undertaken by the state. Thus, the poorly performing providers are far way of financing opportunities. It results in an increasingly fragmented institutional environment, creating inter-professional and organizational competition rather than collaboration. Furthermore, it corrodes the value of collective action.

In France, there are varieties of medico-social institutions which offer the social care to the most fragile person, such as the disabled and the aged. Our study is centered on the dominantly medical-social services treating the children and teenagers with intellectual disabilities at any degree. They work with patients and families in need of psychosocial help. The interventions may include preventative

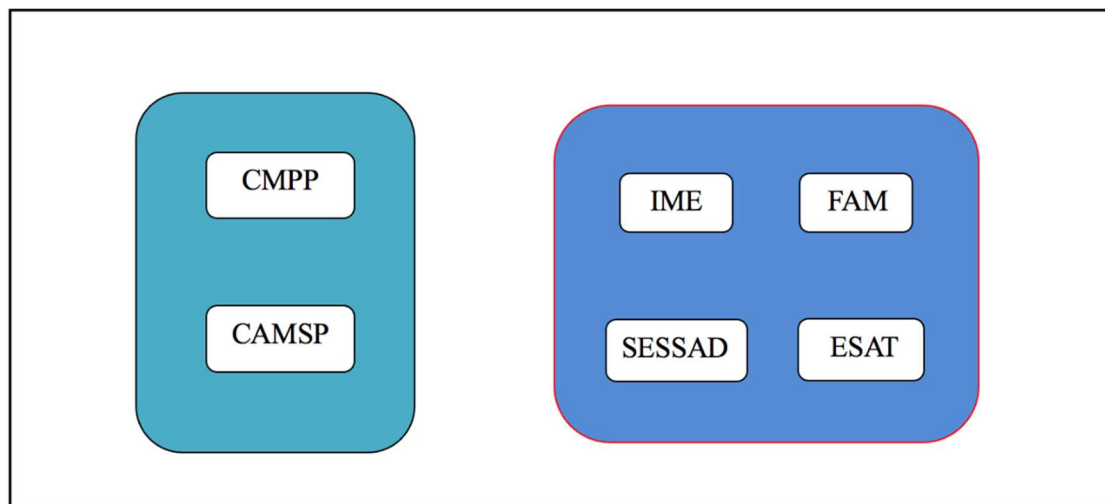
care, psychotherapy and counseling, or helping patients to connect to the society and develop the patients to restore working ability. The intellectual disabilities are those who need have to a long-term support. The support is composed of medical treatment, but the most important is to strengthen patients' ability to adapt and reintegrate into society. The following presents the six main institutions for children mental healthcare (see figure 10):

1. Medico-educational institution (Institut Médico-Educatif, IME): the aim is to receive the children and adolescents (from 3 to 20 years old) who are mentally disabled in any severity of disability. They are educated in the special courses and programs with an emphasis on psychological and psychopathological aspect. Besides of the pedagogical section (IME pedagogy), they have the professional training in the section of IME profession.
2. Medico-psycho-pedagogical Center (Centre médico-psycho-pédagogique, CMPP): the service is to provide the psychological consultation, diagnosis and ambulatory treatment for children and adolescents of age 0 to 20 years old. The center is frequently regarded as the first counseling when the parents find that their kids tend to have psychological problems.
3. Centre for early medico-social action (Centre d'action medico-sociale précoce, CAMSP): its mission is to detect and offer an outpatient clinic and rehabilitation for preschool children (0-6 years old) with sensory-motor, verbal and cognitive disabilities.
4. Specialized home education and healthcare service (Service d'éducation spéciale et de soins à domicile, SESSAD): the service is to promote school integration and the acquisition of autonomy through the appropriate medical, paramedical, psychosocial, educational means. The interventions would be taken in different places such as children's nursery, house or school. Thus the target patients are often the preschoolers or children at very young age.
5. Medical-care residence (Foyer d'accueil médicalisé, FAM): an accommodation facility for severely disabled adults who don't have self-care ability. They need the third-party assistance for their daily life or regular medical care. Those

disabled adults are sometimes obliged to get out of the IME because they reach the age of 20 and have very severe mental disorder.

6. Support and work assistance institution (Établissement et service d'aide par le travail, ESAT): its main service is to integrate the adults into the social and professional environment. Some of the adults are from the IME or other institutions. They are potentially able to develop some working ability.

**Figure 10: Main institutions for children mental healthcare**



(Source: author's conceptualization)

In practice, CMPP and CAMSP (on left side) could work independently or seek to work in collaboration. The other four institutions (on right side) often work together: IME is the special school for mental disabled children and teenagers; SESSAD is generally for the preschoolers; FAM could be the next step for the patients who are above the age of 20 and still have the paramedical assistance. ESAT is for some patients who could be possible to restore the working ability.

The French medico-social institutions are non-profit organizations. They are funded by the central and department-level government. The rising costs of social welfare have obliged the state to make cutbacks. The following table 13 is to review the financial aid of each institution, and the authority in charge. For example, CAMSP and FAM are financially supervised by two authorities: ARS and CD. In our

view, NPM-related reforms attempt to cut down public services into independent units and make them in competition each other. The key governance is a combination of competition, price mechanism and contractual relationships, which is based of value that market could provide more efficient service at lower cost or better services at the same cost.

**Table 13: Financial aid of service provision for children mental healthcare**

<b>Institutions</b>	<b>Financial aid</b>	<b>Authority in charge</b>	<b>Pricing methods used</b>
IME	100% OGD <sup>52</sup>	ARS <sup>53</sup>	Price-per-day
CMPP	100% OGD	ARS	Price-per-day
CAMSP	80% OGD +20% social aid funds of department	ARS+CD <sup>54</sup>	Global grant
SESSAD	100% OGD	ARS	Global grant
FAM	OGD+ social aid funds of department	ARS+CD	An annual overall flat charge for the healthcare (OGD)+flat rate for lodging (CG <sup>55</sup> )
ESAT	100% OGD	ARS	Global grant

(Source: author’s conceptualization)

### **8.3.2 A critique of performance measurement approach to evaluation**

The reason for development of performance measurement is linked with NPM approaches to government administration, which involves in marketization and deregulation, contracting and competitive tendering, standard setting to regulate service delivery, redefine the public as “customers”, output-based budgeting and performance evaluation systems (Martin & Kettner, 1997). Performance measurement is particularly associated with the rise of managerialist accountability, shifting from relatively narrow scope of financial accountability to a broader notion

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52 OGD (Objectif général de dépenses): overall aim expenditure

53 ARS (Agence régionale de santé): Regional Public Health Authorities

54 CD (Conseil départemental): Departement Council

55 CG (Conseil général): General Council

of management accountability through the use of evaluation, audit and inspection (Carter, Day & Klein, 2002). The emphasis on performance is as the basis for accountability and performance figures dominantly in the managerialist form of accountability. The traditional reliance on hierarchical authority relationships as a basis for control has been replaced by quasi-market and contractual relationships. The power from professionals to managers and administrative accountability has become more dependent upon managerial performance than professional trust. As such, it results in totally thorough challenges for the traditional faith in professions' commitment to public service. Accountability through the use of performance appraisal has become increasingly tied to a panoply of forms of "surveillance" and has become synonymous with control and sanction. The "audit explosion" results in the erosion of professional autonomy and trust. Could performance measurement from the private sector (so technical rationality) cope with public sector, particularly such complexity of social world and of the effects of public policies? The following is to argue the relevance of performance measurement approach to evaluation in child mental care sector.

Performance measurement system is a set of measurable indicators used to quantify the efficiency and effectiveness of public actions. The performance could be calculated in order to help managers to determine whether the expected results are being achieved. In company with the market-based concepts, performance measurement shifts its power in public sector, away from the traditional focus on budget allocation (inputs) to a focus on outputs and outcomes (Barratt, 1997). The so-called "output" and "outcome" are not easily defined in care institution. Output means a recording of activities the public institution could express in a quantitative manner (ex. the number of children who need to be vaccinated against some disease). Outcome (i.e. objective) means an assessment of the results of a program compared to its intended purpose (ex. the number of children effectively vaccinated). This result-oriented approach is centered on the effective and efficient use of public resources. With the pressure of performance-boosting, "cure" (the end of a medical condition) seems to be accordant with "good" performance or desired outcomes, as

“cure rate” is quite susceptible to easy quantification and measurement. But medical-social institution is not only to give treatment (cure people of a disease), but also to provide social service (such as compassionate help and accompany). The latter is relatively complex and intangible to be counted, while it represents greater value in medical-social sector. Moreover the full passage of healthcare, in our view, is composed of two parts: prevention and care. They are equally important and prevention is even better than cure, while prevention<sup>56</sup> is also not easily measured. In doing so, an excessive reliance on performance measurement to secure accountability would result in “distorting and potentially dysfunctional consequences” (Smith, 1993). The importance of process in social work would yield outcome, and it would be far from the core value of public health.

Performance indicators have also played a particularly important role in establishing a culture of measurement in the public sector (Jacobs & Manzi, 2000). Indicators are composed of rules or information collected, which could be assigned meaning. Thus, performance indicators mean more social construction than objective truth (Tilbury, 2004). Following this line of thoughts, performance measurement could be understood as an ongoing interaction between indicators and child mental health practice. It would result in a “negative interaction” when indicators are just with reference to fulfil their measurement role (i.e. indicators are merely technical). In order to reinforce formalization and allow more direct outside control<sup>57</sup>, performance measurement often applies multiplying accounting indicators in medical-social sector. These clearly identifiable and measurable indicators through which assessment and control authorities seek to set in care sector are so-called “good practice” standards in order to ensure transparency of the service offered to the public. It results in more standardized procedures in work practices and disregard for the diversity of modes of treatment. In the meanwhile, indicators could legitimate a particular form of knowledge and finally enable certain ideas to dominate the

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56 For example, a therapist spends amount time exchanging viewpoints with a mother when she talks about what she sees her kid’s behavior in family.

57 Outside control is more from non-medical professions, such as auditors, inspectors, supervisors.

discourse (Jacobs & Manzi, 2000). In the previous Chapter 5, we have argued that behaviorist approach is increasingly dominant in treatment to child mental disorder. Comparing with psychodynamic orientation, behaviorist approach seems to be more technical and formalized indicators in changing patients' behavior (clearly have desired outcome). But this approach seeks to evade patients' feeling, life experience and interpersonal relationships in order to orientate more explicitly and specifically. Thus, when performance indicators are seen as objective information (i.e. indicators are considered as rational technique), they represent viewpoints and values that would shape the formulation of policy decisions and medical practices. Lastly, Performance indicators are often narrowly defined to detect "outcome". The treatment is complex in child mental disorder. Lack to attention to wellbeing of child health is particularly reflected in performance measurement. In doing so, indicators need to be developed to involve in various relevant actors (participants and stakeholders). The core issue is on reducing ambiguities around performance, and creating certainties about the values of stakeholders.

In conclusion, NPM resorts to private-sector business principles in public sector through the use of private-sector business techniques (competition and performance measurement approach to evaluation) with a focus on effective and efficient service provision (emphasizing outcomes). Not much attention is paid to the physical and emotional health (i.e. wellbeing) of children and various stakeholders in child welfare system. Thus, it increasingly erodes collective action in creating public value.

#### **8.4 NPG, Relational Governance and Unresolved issue**

Main issues of our study are centered on assessment and surveillance. From the above review, much of the debate of NPM is on narrow techniques directly applied in public sector with a pressure on performance-boosting. Reforms are described at aiming to undermine professionals' power and reinforce the control of their activities by introducing and promoting rationality, standardization and accountability. It would result in a decline in collective creation of public value. Being an opposite



orientation to NPM, New Public Governance (NPG) is firstly mentioned in 1998 (Toonen, 1998) as a mode of Public Administration Management (PAM). From the standpoint of Osborne (2006), PAM has actually passed through three modes. The first is traditional Public Administration (PA) from the late 19 century to the late 1970s/early 1980s. The second is NPM that begins at the start of 21 century, which is considered as a transitory stage in the evolution from PA to the third emergent mode NPG. The aim of this section is to stress that NPG's pluralism and coproduction of public value, comparing with NPM's limited and one-dimensional ability to management to public services. In doing so, the following part is at the first place to review NPG, particularly by comparison with NPM. Secondly, we move to argue (public value assessment) which is seen a unresolved issue from NPM to NPG.

#### **8.4.1 Making a review of NPG**

NPG as a new paradigm is composed of the following source of theory: governance, public policy governance, administrative governance, contract governance and network governance Osborne (2006). Compared with NPM (see the table 14), the predominant features of NPG are on building trust and legitimacy which are devalued by NPM. The theoretical roots of NPG are organizational sociology and network theory. Organizational networks involve two sets of features: structural and relational. Structural feature means the design, size and level of goal consensus between network members, and relational feature refers to the relationships that take place between actors (including individuals, work units and organizations) (Brass *et al.*, 2004). Thus, network theory has a focus on trust and relationships, and relational capital is the core element of network theory. In doing so, NPG is more concerned with "relational organization", while NPM is a focus on regulations, output and intra-organization (Osborne, 2006).

NPG is centered on inter-organizational relationships where the trust and relational contracts are considered as the core governance mechanism. It is quite different to the governance mechanism of NPM. NPM is concerned with the market, competition and neo-classical contracts. Rational, economic man and standardization

are seen as the core elements. It is particularly mentioned that both NPM and NPG posit plurality, while they present two forms of plurality. NPM seeks to produce competition in plurality (compete with each other) and stresses effectiveness, efficiency and outcomes. It results in more fragmented and disaggregated society. While NPG stresses organizational network in which a much wider range of stakeholders (policy makers, service users, citizens and etc.) involved interact, negotiate, compromise and cooperate. Thus, it does not result in isolation but more inter-organizational relationships.

The above reviewing needs to be mentioned two predominant features of NPG. Firstly, NPG seeks to create public value, i.e. the larger common good. But NPM is a focus on performance-boosting, particularly the implementation of rational technique in public service delivery. Secondly, the focus of NPG is on process not result and seeks to invite more actors in the negotiable process. It emphasizes the importance of creating processes that facilitate the generation of negotiable agreements among much wider range of stakeholders who may disagree on what course of actions will produce the maximum public value (Larsen, 2008). This is because NPG view politics as the politically mediated expression of collectively determined preferences (O'Flynn, 2007) rather than simply an aggregation of individual preferences. This process could be seen to coproduce public value. In doing so, public professionals treat performance and accountability not as a set of rational and planned objectives, but as a process of political mediation among competing stakeholders who may hold differences to public value. Meanwhile the role of government also has been changed. The government does not simply regulate, but is served as a catalytic agent to invest private and public stakeholders in shared ownership of the public good (Bao *et al.*, 2013).

#### **8.4.2 Unresolved issue from NPM to NPG**

NPM-related reforms seek to exert the limited and one-dimensional approach to regulate public services, particularly the rise of managerialist accountability implements instrumental rationality to cope with social world. It results in more

focus on result than process, more isolated institutional environment and de-qualification of public services. NPG seeks to go to the opposite direction, develop relational contracts rather than competition and price mechanism. The core approach of NPG is organizational network theory. As such, NPG seeks to break individual organizational outcome and develop network-level outcome. Much wider range of relevant stakeholders are involved in organizational network (see the table 14). Its advantage is quite evident that network coordination could increase capability to address complex social problems and develop public value. We argue there exists still unresolved issue about competing values between actors. It is well argued that NPM-related reforms have introduced two competing logics in public sector (as we have argued in Chapter 5) and generated unintended consequences. And NPG seeks to contribute multiple inter-dependent actors, i.e. much wider range of stakeholders (private and non-profit actors) involved in public services delivery. Thus, the argument about how to cope with competing logics to develop public value and assess the value of public sector would be made in the following section.

**Table 14: Elements of the NPG, in contrast to the NPM (Osborne, 2006)**

Paradigm	Theoretical roots	Nature of the state	Focus	Emphasis	Relational to external (non-public) organizational partners	governance	Value base
<b>NPG</b>	Organizational sociology and network	Plural and pluralist	Inter-organizational governance	Service processes and outcomes	Preferred suppliers, and often inter-dependent agents within ongoing relationships	Trust or relational contracts	Neo-corporatist
<b>NPM</b>	Public choice theory and management studies	Disaggregated	Intra-organizational management	Service inputs and outputs	Independent contractors within a competitive market-place	The market and classical or neo-classical contracts	Efficacy of competition and the market-place

## **8.5 Relational Governance and Language-Based Accountability**

The aim of this part is to explore about how to cope with competing logics to develop public value and assess the value of public sector. There are two parts in this section. In the first place, we will make a description of our case les the association A. We will particularly summarize two predominant features: its relational governance and coproduction of public values. In the second place, we argue that accountability and evaluation as “dialogue encounter” to cope with conflicting logics and public performance.

### **8.5.1 Presentation of Association A**

#### **1. What is the association A?**

Association A is a support and listening’s place for parents/children/teens created in 1999 by the psychologist and psychoanalyst Sophie Marinopoulos in order to meet to the concerns of parents to their questions, their incomprehension in the face of the manifestations of their children, but also to unravel conflict situations. The reception in a kitchen-a part of family house, which makes people want to talk and feel comfortable just like staying at home. The job of professionals is to host a place for speaking, thinking and discussing. Moreover the professionals will accompany the family and give the parents some favourable recommendations during a two hours’ observation of their children’s behaviour. *“You are welcome in our kitchen, you do not need to make an appointment, you do not need to leave your name, and you could come with or without your kids and, whatever his age, a psychologist and psychotherapist will be there for you.”*

The association A is established along lines of the concept of the “maison verte” developed by Françoise Dolto in 1970. It is an important place for social contact and building support for parents/children especially for mothers/children, because at that time the women barely had a job. The association A devotes of the role of prevention to the relationship of families and children because we must head off the family crisis.

After having spent twenty-five years in the Medico-psycho-educational centres (Centre medico-psycho-pédagogique, CMPP), the Founder (she is psychologist and

psychoanalyst) decides to create a support and listening's place for families in order to reduce the consultation's waiting time and intervene early with families before they reach in harder situation. In this new concept, there is the notion of anonymous and free hosting without appointment, which remains to the changing needs of families, the possibility of coming here with or without their kids, at any age.

The association promotes several types of exchanges: exchanges between parents, families and professional exchanges, exchanges within families. There is no diagnosis or prescription. In order to facilitate the communication, the team of A is always at the disposal of responding for mails or phones calls. The opening hours are flexible and very adapted to the family's life. Every professional must be qualified: a diploma in relevant is a must. At the beginning, because of the structure being new and risky adventure, the recruited professionals must have 10 years of seniority, and this requirement is gradually applied to at least five years' clinical practice. This expanding shift could be effective for transmission of working experience within the team, and also better for keeping working dynamic. There are twelve members in Nantes: the Founder and Director leads a team of professionals of A since 1999. The Psychologist works as Assistant Director since 2004. The secretary works with them and assures the effectively functional administration. The rest is composed of two psychomotor therapists and seven psychologists. Table 15 presents the network of the association and its opening time.

**Table 15: The network of the association A and its opening time**

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>Nantes (44000)</b>	17h-19h	15h30-17h30	10h-12h 18h-20h	16h30-18h30	
<b>Carquefou (44700)</b>					16h30-18h30
<b>Vannes (56000)</b>			18h-21h		
<b>Paris (75015)</b>		9h-11h			
<b>Les Mureaux (78130)</b>				17h-19h30	
<b>Boulogne billancourt (91000)</b>			18h-21h		
<b>Plaisir (78370)</b>	every second Monday 17h-19h				

(Source: the association A)

Meanwhile, an individual consultation is possible and available in Nantes, a paying service on request and by appointment maximum 10 days. Team work, easier communication and organizational learning hold a very important role in this

association. Once month's meeting for the team address three important issues: daily working life, clinical consultation, and theme scientific research in order to build group thinking and organizational culture. Making cards and books provide some means for self-funding. The association A has increasingly received attention and reputation from the public, the infant-parent psychotherapist and the government. Founded in 2014, National Federation for the Prevention and Promotion the Mental Wellbeing (Fédération National pour la Prévention et la Promotion de la Santé Psychique, FNPPSP) set out to work in 2015 with the opening of three new centres in Vannes, Les Mureaux and Paris. At the national and international level, the objective of FNPPSP is to bring together the professionals and specialists who would like to promote early parent-child intervention and work on family's well-being. The notion of the association A is a supply with a therapy around the kitchen table hosted by two professionals. It's well known for a high degree of anonymity, without appointment and free service to users. In consistent with the concept of the association A, team members of FNPPSP in Nantes make an effort to transfer their knowledge, share their experience and promote the psychoanalytic therapy. Every year FNPPSP the association A Nantes also offer a complementary training for the members of Federation. They work together to identify the needs of children in vulnerable situations and help them to have positive social interactions with others.

Being partly funded by the state and regional government, the association finds the resources themselves and tends to be self-funding at full stretch (see the table 16). The public financing: CAF (Caisse d'allocation familiales)<sup>58</sup>, mairie<sup>59</sup>, Conseil Général<sup>60</sup>. The private funding: institution, bank, mutual insurances.

The self-funding: the external intervention and service (lecture, coaching, training, internship for professionals, conference and meeting); game card conceived and designed by team being on sale; the individual consultation being pretty compensated (45€).

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58 Family Allocations Office

59 City hall

60 General Council



**Table 16: Funding resources of the association A (in the year of 2014)**

<b>Public (50%)</b>	<b>Private (25%)</b>	<b>Self-funding (25%)</b>
CAF Mairie Conseil Général	Bank Mutual insurance Private institution	External intervention and service
		Game card conceived and designed by team being on sale
		Individual consultation being pretty compensated (45€).

(Source: the association A)

Inspired by an American psychoanalyst Selma Fraiberg, the association A provides the parents and their children with “kitchen table therapy”. This technique helps parents facilitate communication, feel comfortable just like at home and comfort their feelings. There are three different approaches:

- Brief crisis intervention, at time of crisis, acute phase of the crisis being around the baby, the ability of parents to react quickly to the care is essential;
- Supporting treatment, which is a form of guidance, provides emotional support and strength parenting skills in informative approaches, discussions and interpretations;
- The infant/parent psychotherapy is proposed when the baby represents in his parents’ mind figures belonging to their past, connected to a denied or refused parental inner-being. The treatment allows two concerns: one devoted to parents and their problem, and the other to the child.

## **2. Why is the association A founded? What is concept and cornerstone of the model?**

In France, services of mentally ill people are provided by both the health sector and the social and health care sector. Psychiatric ambulatory care centers (Centres medico-psychologiques) are present in almost every mental health care area, providing primary ambulatory mental health care, including home visits and directing patients towards appropriate services. Care is organized separately for adults and children.

The great advantage is that all child-mental health institutions are financed by government national health insurance. After paying the doctor's fee, a proportion is reimbursed. Under the social security system, health-care services are accessible and almost "free" to patients. Critics of the child mental health care systems cite the lack of coordination among the health and social care sector, self-employed medical professionals and specialists and private profit-making sector. There is in need of attention that the system does not sufficiently offer early intervention programs. What is more, the long waitlist many families are facing is a barrier to access a treatment. The long wait times mean that younger children do not always receive the support they need as early as they should get it. This means they are missing out on a crucial time to be treated. The following three institutions<sup>61</sup> (see the table 19) providing children with mental health-related services are typical and the most frequently mentioned. A growing demand for service and increasing wait times put more pressure on the child mental health treatment. The family, normally, should wait six months or even one year in order to have first appointment.

- **Medical and psychological centre (Centre medico-psychologique, CMP)**

Medical and psychological center refers to a French public institution and offers a mental health care service. CMP is multidisciplinary and regroups a number of mental health specialists, such as a psychiatrist, psychologist, nurse, social worker, occupational therapist, psychomotor therapist (developmental therapist) and

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61 We make a survey of people coming to the association A and find that most of them cannot receive immediate treatment of three main-stream institutions (CMP, CMPP and CAMSP)

educators. The institution usually provides consultations, home visits or nursing care. Contrary to self-employed professionals, fee paid by patients could be totally reimbursed by the global system (Social Security system). There are CMP adults (from 16 years old) and CMP children-adolescents (up to 16 years of age).

- Medico-psycho-educational centres (Centres medico-psycho-pédagogiques, CMPP)

In France, Medico-psycho-educational centers are medical-social institutions and mostly run by an Association Loi 1901<sup>62</sup>. Their mission is to ensure the diagnosis and treatment of children with mental disorders. Most specifically, the mission of CMPP is to take into account the suffering of the child and to facilitate relations with his family, school and social environment for the purpose of prevention. Their action may be primary and interventional in a family and social environment in order to prevent the appearance of mental disorder. In this context, it's necessary to develop child-centred health care and work directly with the external partners (institutions and services of health, education, justice...). The CMPP treat the full spectrum of children with psychiatric difficulties.

- Early social activity centres (Centres d'action medico-social précoce, CAMSP)

Early social activity centers could be in France under the category of social or medical-social institution. CAMSP offer the test, diagnosis, treatment, rehabilitation and follow-up of children with disabilities before they enter the school system (for the children aged between 0 and 6). The following table 17 makes a comparison of CMP, CMPP and CAMSP.

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<sup>62</sup> An Association Loi 1901 is the term used in France for a not-profit-making organization of two or more people. The name comes for the convention having entered into French law on 1 July 1901.

**Table 17: Comparison of three institutions**

<b>CMP</b>	<b>CMPP</b>	<b>CAMSP</b>
affiliated with hospital	run by an Association Loi 1901, non-profit-making organization	affiliated with hospital or is a public institution
medical institution	medical-social institution	social or medical-social institution
CMP adults (from 16 years old), CMP children-adolescents (up to 16 years old)	children-adolescents up to 18 years old	children with disabilities aged between 0 and 6
consultation and outpatient treatment with appointment	treatment the suffering of the child and facilitation relations with his family, school and social environment for the purpose of prevention with appointment	test, diagnosis, treatment, rehabilitation and follow-up of children with disabilities before they enter the school system with appointment
psychiatrist, psychologist, psychomotor therapist, speech-language pathologist, social worker, nurse	child psychiatrist, psychologist, psychomotor therapist, speech-language pathologist, social worker, nurse, educator	paediatrician, child psychiatrist, psychologist, psychomotor therapist, nursery nurse, occupational therapist, speech-language pathologist, social worker, nurse, educator of young children

(Source: author's conceptualization)

In consideration of endless waiting time and a lack of preventive therapy in France, the psychologist and psychoanalyst founded the association the association A in 1999. The model is an innovation and inspired by the concept of the “maison verte” of Françoise Dolto and “kitchen table therapy” of Selma Fraiberg.

- Françoise Dolto and her Maison Verte

As a French pediatrician and psychoanalyst, Françoise Dolto has devoted all her life to prevention and training rather than cure, by conducting individual and group supervision, and by publishing, lecturing, and make radio and television broadcasts. In 1979, Dolto founded the Maison Verte, a “nurture centre” for the social education of infants from birth to three or four years old. It is a place where the child, accompanied by one or both parents or grandparents, will find a professional team of three, one of whom is a psychoanalyst. A Maison Verte is a place for talking, playing and reducing tension, even as early parent-child intervention is involved. Sometimes young children experienced social-developmental problems are referred to the place for further observations. The professionals observe children and their parents and help them if needed. Maison Verte is not only for kids (preschool children) who are brought to adapt slowly to prepare transition from home to kindergarten, but also for some parents (or even grandparents) come to and connect with others in their social life.

A child’s development, Dolto stressed, occurs within a very early triangulation between its mother and its father. The fact reflected Dolto’s constant concern to undertake preventive care, especially psychoanalytical work with tiny children, and new-borns. That was extremely important because she saw it as means of preventing later problems.

In a spirit of prevention rather cure, many institutions nowadays inspired by Dolto’s philosophy are springing up in France and the rest of the world. Call in when you like, there is no need to make an appointment, and there is no charge. Maison Verte is providing a service for pre-school children (aged 0-3 years) and their families. The

aim is to introduce infants into a stable and safe social environment with small steps. Both children and adults begin to explore the pathways of separation and social engagement. Three 'welcomers' (all qualified psychoanalysts, educationalists, counsellors, psychologist etc.) work at the centre and listen and respond to the children and the adults during playing activities and conversation.

- Selma Fraiberg and her kitchen table therapy

Selma Fraiberg was an American child psychoanalyst, author and social worker. She not only devoted her studies in infant blindness, but also developed new techniques for mental health treatment of young children. One technique was called "kitchen table therapy". Fraiberg would go into the homes of parents with young children, typically under the age of two. The aim of this technique is to strengthen well-being of infant and develop secure and stable parent-child relations.

The research of Fraiberg discovered the treatment to reduce the likelihood of serious development failure and relationship disturbance should be returned to "the source"-the home. With the context of the emerging parent-child relationship, the infant mental health practitioners are in effort to understand the capabilities of the child and family. Sitting beside the parent and infant at the kitchen table, the specialists are observant of their relationship and give them emotional support and developmental guidance.

### **3. What is the innovation brought by the association A in mental health system?**

- A revolutionary therapy room (see the picture 1)

Improve user experience is a priority. Designed by Founder and Director, it promotes people who come to the association A relaxation during treatment. The welcome is thus user-centred. For the people who come for the first time there is an introduction to the association A: kitchen, connecting room and play room.

Room 1 is the main treating place-kitchen. Normally, the kitchen would provide service for three families (maximum 12 person). Father, mother, children...are welcomed there by the two staffs (psychologist and psychomotor therapist). The adult,

usually, enjoy coffee and chat to other families and two professionals. They don't cook meals. The kitchen offers soothing, empowering atmosphere and a feeling of home. The children could sit beside to their parents or go to play room (number 3). Room 2 is like a half-way room and connects to kitchen and play room. These three spaces are symbolically separated. Thus this design behind is intended to prepare children and their parents gently for the separations demanded by nursery schools. The association A is meant for the child, especially for the young child, to experience autonomy for the first time in complete safety. The parents thus could give confidence and relieve anxiety. A is a place for leisure, play, meeting, experiencing social life and moreover early childhood intervention.

**Picture 1: Interior structure drawing**



(Source: the association A)

- Reception and treatment

- a) Prevention rather cure

As we have already, maison verte was created in 1979. At that time, non-working mothers took care their children. Maison verte was thus set up as an intermediate environment between the family and the nursery school. It could be as a laboratory in humanising the mother-child separation. We have to reflect on transformations of family ties that have deep effects on the psychic development of children in contemporary society. The phenomena of a growing isolation of the nuclear family, an increasing number of working mothers, and more often of single parents, highlights a form of decline of the paternal function, along with a transformation the maternal one. The problems have become much more complex. And yet, our child mental health system doesn't delivery enough attention to these changes. The questions and problems have been arising on the parents' side:

- ✓ Women are exhausted by the demands of a career, motherhood and running a home.
- ✓ A marital separation, the impact of parental breakup and well-being pf children.
- ✓ Parental authority.
- ✓ Father involvement, parenthood and co-parenting practices.
- ✓ Incomprehension towards children, transition to parenthood.
- ✓ Understanding children change, their behaviour and their attitudes...how to handle changes in child's behaviour.
- ✓ How to help a child cope with family's grief change: death of grandparents, parental separation and divorce?
- ✓ Children exposed to inter-parental conflict are at risk of a range of negative outcomes. How to reduce the negative effects on them?
- ✓ Children show reluctance to with the parent. The parents feel distant and alienated from their children.
- ✓ Parents are eager to understand stages of psychological development in a



child.

- ✓ Preadolescent growth and development, especially concern on emotional changes.
- ✓ Mental health problems in adolescents, such as mood disorders, anxiety disorders. Learn about adolescent mental health changes and tools to prevent mental health disorders.
- ✓ How to handle parenting burnout?
- ✓ How to establish healthy family relational boundaries?
- ✓ A psychodynamic perspective in sibling position and sibling relationship...

The problems have been exposed on the children' side:

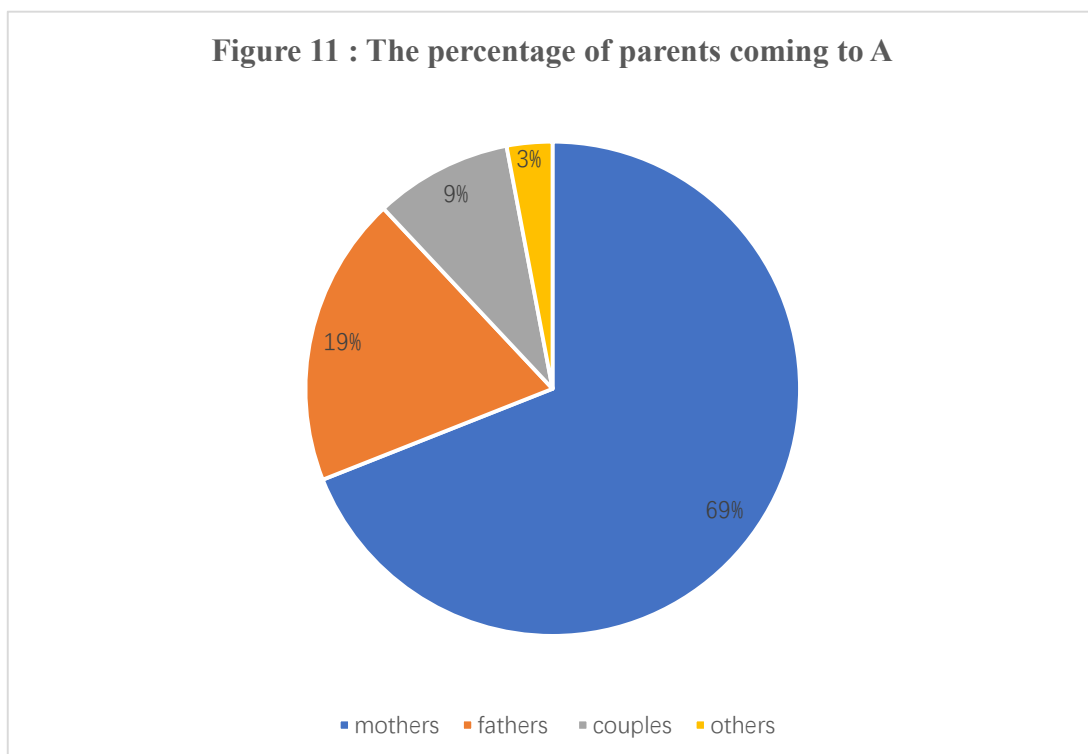
- ✓ Problems across a variety of setting, such as at school, at home, or with peers;
- ✓ Decline in school performance, poor grades despite strong efforts;
- ✓ Signs of being upset, sadness, depression irritability or tearfulness;
- ✓ A lower self-worth, self-confidence and self-regulation;
- ✓ Addiction to violence or drugs;
- ✓ Constant worry or anxiety;
- ✓ Repeated refusal to go to school or to take part in normal activities;
- ✓ Persistent nightmares or changes in appetite;
- ✓ Frequent temper tantrums, aggressive behaviour or fighting;
- ✓ The appropriate boundaries should be set between parents and children.
- ✓ Notion of early separation and identity.

The work report (see the figure 11, 12, 13 and 14) of the association A of the year 2015 identified and confirmed:

- ✓ Depression, anxiety and burnout in mothers assess the effects of the severity on the mothers' mental health, and directly or indirectly exert an influence on child mental health. Fathers' involvement appears to be urgent need for childrearing ( 19% fathers comparing to 69% mothers, see the figure 11).
- ✓ The increasing number of parents would love to talk about their "family tale",

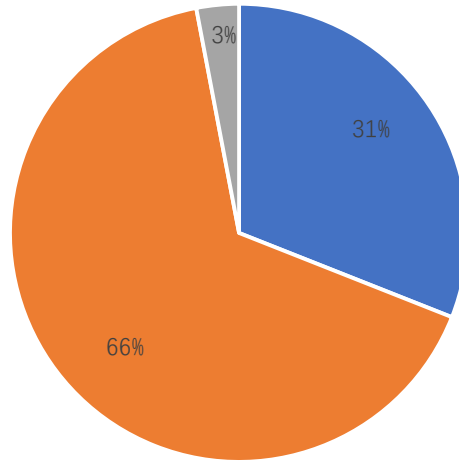
share their experience in childrearing and enjoy instructive moment. Instead of the consultation sessions, A offers a place so that all families feel comfortable, safe and welcome accessing early intervention whether they need.

- ✓ The association A is able to respond to changing demands and needs of the communities they serve: a full range of age, a various kind of patients, families and users...



(Source: the association A)

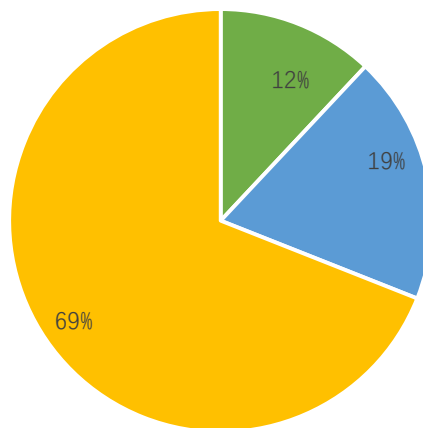
**Figure 12: The frequency of people coming to A**



■ have already come here ■ first time ■ we don't know

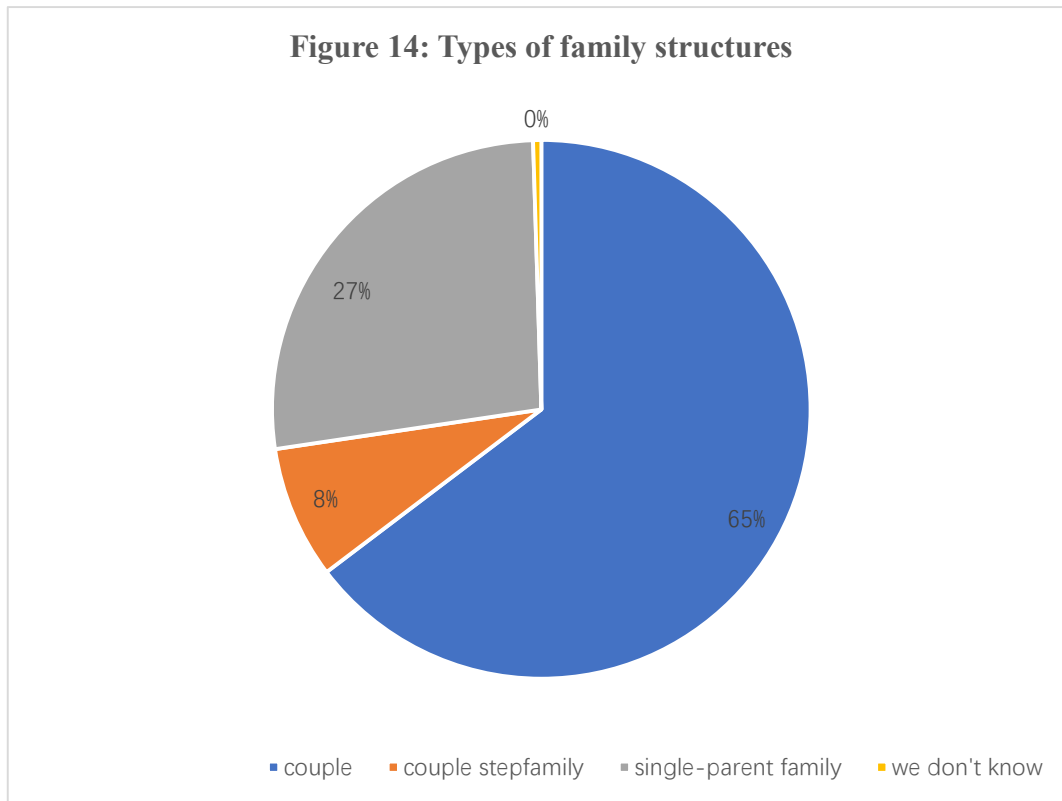
(Source: the association A)

**Figure 13: The percentage of children coming to A**



■ Adolescent from 12 years old ■ children aged between 7 and 11  
■ young children aged between 0 and 6

(Source: the association A)

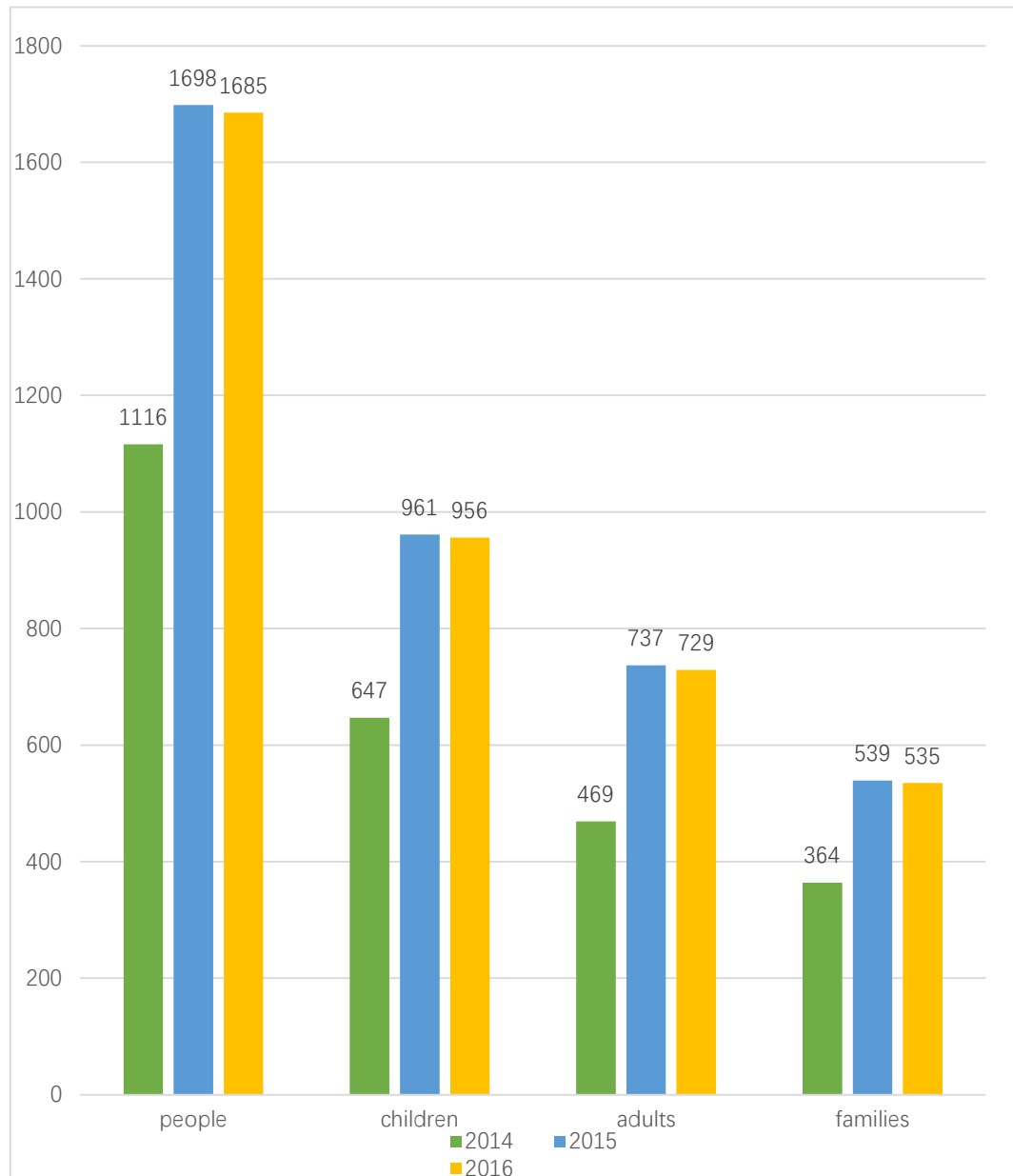


(Source: the association A)

b) Welcoming style: no registration, no charge, no appointment and no age limit the association A is well famous for a high degree of anonymity, without appointment and free service to users. The association is for everyone, no age limit. A is hosted by two “welcomers”. They are all qualified psychoanalysts, psychologists and mental health clinical consultant. Being a continuation of notion of maison verte, A is a place for words, for play and for meeting people. Babies, children, and adults may enjoy an experience of conviviality. It’s a place not only for individual or group therapy, but also for re-education or treatment. We know that children and their families need to early intervention programs as soon as possible based on the family and child’s needs. Early interventions programs are most effective when a child accesses them as early as possible. There is a grow demand for accessible care (see the figure 15). Waitlists issue is the most barrier across the road. In this context, A is there to comfort parents and pull them out of burn out. The “welcomer” is not exactly counsellor. People

pushing the A's gate do not come to receive regular treatment. They might come to meet and talk with other families, they might find help to identify signs of child mental health problems...In this house no educational instructions and no psychological advice are thus directly given. Accompanied by specialists, the parents or adults are invited to find their own solutions and to follow their institution. The following figure shows the evolution of numbers of people coming to the association A.

**Figure 15: The number of people coming to A from 2014-2016**



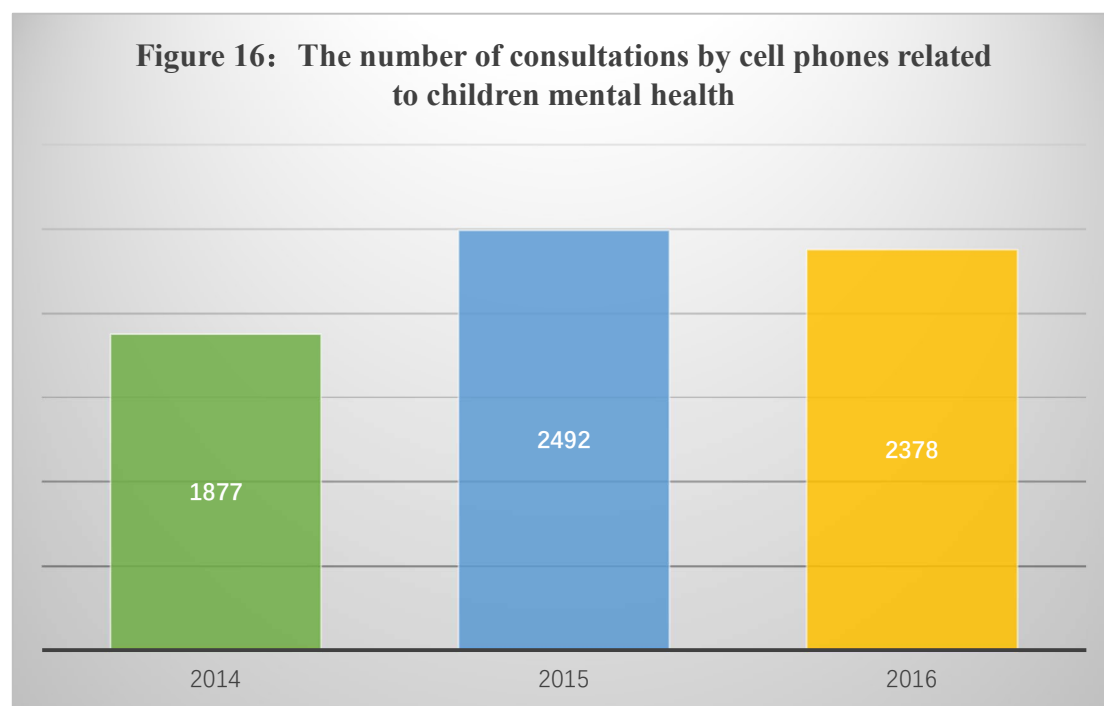
(Source: the association A)

c) Prevention and positive support with distance

Far from the association A, growing numbers of people contact with association by phone calls (see the figure 16) or emails. There are some attentive problems parents are facing with:

- ✓ Numerous barriers make access to mental health care extremely difficult in rural communities and urban environments.
- ✓ Accessing to mental care service with appointment make many parents frustrated, almost six months or one year wait list in CMPP. In this situation, it worsens child health.
- ✓ When confronting with child mental-health problem, most of parents feel worried and do not know how to cope with.

A is there to respond to every email and all the phone calls. It's an alternative way to comfort patents in trouble.

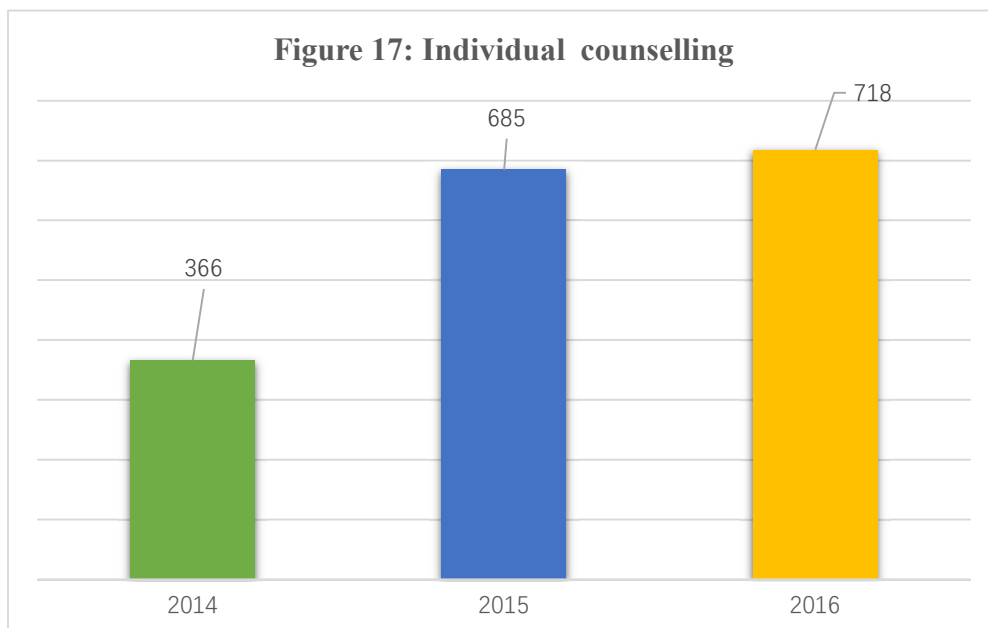


(Source: the association A)

d) Personalised consulting and facilitating service delivery

A is well known as people-centred association and they respond at full stretch to the individuals, couples, families or other professionals interested in child mental health.

- ✓ Individual counselling is an opportunity to improve mental health in a confidential, caring space. Being parallel to group counselling, a demand to individual counselling is soaring in these years (see the figure 17). Meeting and talking with other families could be one of the most effective strategies to address most issues experienced in child mental health. Many families report having positive and impactful experiences from participating in the groups, and feeling improvement in the areas of concern that motivated them to cope with their problems. For some people, yet the idea of joining a group discussion may sound intimidating and anxiety provoking. Or some people would like to seek solutions-focused methods for their family. They offer services tailored to the particular concerns of each individual, couple and family. Different to CMPP, people could access to individual treatment in 10 days and have to pay 45 euros. While waiting in their appointment, they may access to kitchen and connect with others in a safe and supportive space.



(Source: the association A)

#### e) Collaboration- prevention beyond walls

With the conception of preventive in child mental health, the association A has been working with the association “le Carrefour des Familles” since 2012. The parents in Saint Sébastien sur<sup>63</sup> Loire may follow up free individual consulting at most six times. This preventive approach (no age limit) could timely intervene a family through a difficult period of time, a major transition, or mental or behavioural health problems in family members. The association A also attend to the meeting of le Carrefour des Familles and work with them in order to deliver better intervention to families.

Further, the association “le bac à sable” in Pellerin<sup>64</sup> has been requesting A for group counseling three times a year on Saturday morning since 2014. The objective of the collaborative action is to address issues that impact prevention and help families deal with potential problems. What is most important is to offer a place of words for parents.

In conclusion, there are two predominant features that should be summarized as follows. The first one is that association A lays compromising to the main-stream child mental care institutions and A could be seen as a “complement” to them. Thus, seeing child mental health sector as the organic wholeness is particularly emphasized. This view is also mentioned as the starting point to advance public performance. The second is that A develops a cross-culture framework (multiple actors involved) to coproduction public value (namely collective action to cope with the complexity of child mental care). This framework lays a focus on process-related public performance and inter-dependent agents within ongoing relationships.

#### **8.5.2 Accountability and assessment as “dialogue encounter”**

As described above, the concept of accountability is not a new topic in medical-social professions. As a social care profession, professionals are supposed to be primarily accountable to the service users as well as to the profession. Thus, the

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63 A city next to Nantes

64 Urban city of Nantes



core sense of accountability means being called to account for one's actions. NPM seeks to lay increasing emphasis on accountability in terms of performance and results, namely one-dimensional and technical measurement to the relatively broader social welfare impacts. It cuts down social welfare into isolated units. NPG seeks to develop trust and relational contrast as the core governance mechanisms. We accept this organic wholeness approach to develop public value (NPG's focus), while our argument in the paper is about how to govern and assess the public value involving in multiple stakeholders. In doing so, our objective is to propose accountability as dialogue (Day and Klein, 1987; Mulgan, 2000) and interpretive approach to evaluation.

### **8.5.2.1 Language-based nature of accountability beyond normalized context of control**

Accountability as dialogue implies dialectical activity and demands actors involved to answer, explain and justify their behavior. This approach requires a "shared set of expectations and a common currency of justifications" including "agreement about the language of justification" (Hill, 1988)).

*L'association A donne un moyen qu'il est possible de sortir des cases, d'arrêter de remplir des cases, d'expliquer pourquoi on ne veut pas remplir ces cases-là. Pour moi, quand je pousse la porte de A, je me suis dit « enfin un endroit où on pourrait penser et réfléchir! Tout n'est pas normalisé. C'est comme ça et on ne n'a pas de choix, on doit faire telles choses que la direction nous demande parce que c'est l'ARS lui demande de faire comme ça ...on pourrait proposer des choses et comment on pourrait des choses, pour moi c'est vraiment une alternative, ces systèmes sont très loin du cœur de métier. (...) Au niveau de l'association A je veux bien montrer que l'alternative est possible, on peut vraiment faire fonctionner du soin, du thérapeutique et d'éducatif autrement comme ce qui s'est passé dans de grosses institutions. Une case pour moi c'est une standardisation du travail, par exemple dans certaines institutions on a une chose qui s'appelle « une procédure », c'est-à-dire que comme dans une usine presque chaque situation vous allez rencontrer, on vous dit comment faire, arrêter de penser, c'est comme ça vous allez travailler pas avec d'autre façon. (Interviewee: P1)*

Language-based accountability involves an open discussion and debate about matters of public interest. Relevant stakeholders could explain and justify their actions if it involves in competing logics<sup>65</sup>. This dialectical exchange may be seen as a core element of deliberate democracy. The interpretive accountability entails a key role to make sense of context and investigate a full range of performance indicators. Moreover, the dialogue of accountability implies an equal relationship, compared with managerialist accountability implying sanctions or rewards. This equal relationship is quite important to decrease tension between actors, extend beyond normalized context of control and develop negotiable agreement about public policy. It is evident that government as a gate guarantor of public values, but citizens as well as private and nonprofit organizations are also important as active public problem solvers. And it also transfers more attention on “subordinate voices”. The approach advocates contingent, pragmatic and goes beyond the formal rationality and “economic man”. Accountability as dialogue seeks to maintain and enhance the overall effectiveness and a broader approach to accountability. As the following therapist mentions:

*(...) ça c'est intéressant d'être nourricière, au sens de pouvoir donner de la nourriture, sur la philosophie, sur l'expérience, sans formater. Vous, vous êtes vous, et nous, on peut vous aider. Et nous, on existe parce que vous êtes vous. Il y a une reconnaissance de l'individualité permettant de faire un ensemble. Alors que l'autre système, c'est que chaque individu n'est pas reconnu comme un individu. Il est une chose, mise dans un ensemble où il n'y a pas de liens. Alors que là (association A), chacun est reconnu comme étant un morceau constitutif, mais qui a son individualité, qui existe par lui-même et s'enrichit de s'allier avec les autres. Chacun est un individu autonome, qui est plus riche quand il est avec les autres. On est un élément constitutif, sans être prisonnier. C'est une fédération, chacun est autonome, tout en appartenant à un ensemble d'individualités reconnues dans leur entièreté. Pour moi, l'humanité devrait fonctionner comme ça. (Interviewee : P7)*

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65 The focus of NPG is on a plural state. Multiple actors (business and nonprofit stakeholders) may have competing logics about the delivery of public services.

### **8.5.5.2 Evaluation as “practical discourse”**

As above mentioned, NPG seeks to relational governance and coproduction process of public values. It emphasizes on the overall effectiveness, namely it is not like to the contract management that result in fragmentation and neglect of the broader and cross-service quality. However we argue that there still exists unresolved issue about how to evaluate or assess the performance of the relational governance. We accept the idea of evaluation as “practical discourse” (Sanderson, 1998). In the first place, this approach moves away the rational measurement of outcomes to an understanding of the appropriateness of action in the public sector. Thus, it develops an interpretive conversation between all the relevant stakeholders. Secondly, the concern of dialogue approach is more on selection the goals and collective decision-making. It moves away the “objective proof” (Fischer, 2019) to negotiation and argumentation towards consensus. The aim of evaluation is to judge the appropriateness of behavior in certain context. Finally, various groups and stakeholders may have different or conflicting interest in public services. Evaluation as “practical discourse” develops participative approach and puts a focus on impacts of process (a detailed understanding of how impacts are being achieved).

## **8.6 Conclusion of the Chapter**

The objective of Chapter 8 is to propose multiple inter-dependent actors and relational governance to cope with the complexity of social world and engage a mix of people to develop public values. We firstly characterize the complexity of treatment to child mental health, the importance of prevention than cure and the developing social relationships. Secondly, we argue that the rational and one-dimensional performance measurement system lay emphasize on effective and efficient service provision (outcomes-boosting). Not much attention is paid to overall wellbeing of children and various stakeholders in child welfare system. This approach results in eroding collective action and more fragmented social world. Thirdly, we make a description of our case the association A, particularly about the organic structure, relational governance and language-based accountability. Finally, we propose the model of evaluation as “dialogue encounter” to incorporates different values and coproduct public values.

## 9 DISCUSSION

### 9.1 Introduction to the Chapter

Chapter five have been presented the contextual managerial techniques for accountability purpose. These technological and managerial developments have created renewed possibilities for managerialism, which is in the form of surveillance of professional practice and micro-level control. The accountability mechanisms as disciplinary power aims at rationalizing medical process led to largely covert attempts at increasing surveillance, subjugation and standardization (chapter six). The healthcare professionals' work is increasingly being medicated by standards-based accountability (chapter seven). Thus chapter six and seven have been indicated that the implementation of accountability mechanisms and the process of reconfiguration of power relations in the medical-social establishments. These attempts are met with counteraction in various forms through a “care of the self”, including overt resistance, e.g. openly challenging and arguing, and covert resistance, e.g. persistence and creating workarounds. The accountability mechanisms are introduced and initially implemented within existing power structures. They result in considerable problems. Meanwhile, the application of accountability devices shows signs of transformation of the field knowledge and discourse. There is an increasing number of human actors (care staff) who are empowered by these managerial devices and lead to a qualitative change in power relations.

This chapter will discuss the findings enlightened by Foucault's work, especially his notion of power, the concept of power/knowledge nexus, the theorizing of disciplinary control, and the “care of the self”. In this chapter, we will develop the argument towards answering the raised research questions, as follows:

1. How are various forms of exercise of power and control enacted through the managerial techniques implementation and use in clinical practices and medical-social establishments?
2. How do these enactments reconfigure power relations and reconstitute the

regime of truth?

3. What is the role of the technical-managerial accountability mechanisms in such a process of power reconstruction?

To answer these questions, a new concept of power-technology<sup>66</sup> nexus inspired by Foucault's work is proposed. It is defined as the medium of human actions which enables and limits human actors' ability to exercise power by using technology, the condition for accountability mechanisms to become transformative agent, the means of reconstitution of social and power structure by introducing new-material discourses. This new concept helps to explain the mutual between the accountability mechanisms and human actors within the social and political context. It indicates how the managerial devices implementation and utilization impact on the social and political relations, as well as the distribution of power in the medical-social sector. In short, this chapter proposes a new theoretical concept of power-technology nexus and outlines the major theoretical argument about the managerial techniques implementation and the role of accountability mechanisms in power reconfiguration.

## **9.2 Major Argument**

The major argument made in this chapter is that the outcomes of the technical-managerial accountability mechanisms implementation do not result from the perception of technological misfit or the interpretation by powerful groups, but more importantly, spring from mutual constitution of the accountability mechanisms and human actors in a social and political context. This process is complex, involving the materiality of managerial techniques, the discourse, knowledge and power techniques embedded in the mechanisms, the existing social and power structure, the power/knowledge nexus and the dominant discourses in the

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66 Our study highlights the application of managerial techniques as technologies of domination (accountability mechanisms as disciplinary power archives control over medical-social institutions). The individual is placed in the relations of power inherent in the technologies of domination, which produces "subjected and practiced bodies and docile bodies" (Foucault, 1977).

organization, which would be described as an emergence of power-technology nexus. The power-technology nexus transforms and at the same time embodies power/knowledge nexus. Because modes of modern government rely on detailed knowledge of individuals (Foucault,1977). In the case of patient files, the depth of information (patient's condition, diagnosis, clinical practices etc.) is required to constitute and displays the chain of accountability.

The emergence of the power-technology nexus limits human actors' ability (especially care staff's creativity) to exercise power within the accountability mechanisms. It results in standardization clinical process and reification phenomenon in the medical-social sector. The "double-edged" nature of power also makes creative use of space for self-construction, i.e. empowering human actors to constitute themselves. The power-technology nexus introduces a new social-material discourse. Emergence of such a nexus is a principal means through which existing regime of truth including dominate discourse, social and power structure become challenged and reconstituted. As the new social-material discourse becomes dominant we see the evidence of the social and power structure being transformed.

In emergence of power-technology nexus, the technological materiality of the managerialist logics play a vital role in accountability mechanisms implementation which cannot sperate from the exercise of power. The individual rationality of human actors is also crucial in accountability mechanisms implementation and the corresponding social and political changes. It is the trigger for the power-technology nexus to emerge. Moreover, the resistance by human actors is unavoidable and not necessarily negative. Power and resistance in accountability mechanisms implementation cannot be separated from each other; rather, they are intertwined, dependent on each other. Our case the association A presents a possibility to create workarounds and provide an alternative strategy in face of managerial accountability. In sum, the technical-managerial accountability mechanisms present the outcomes of the mutual constitution between the human actors, the organizational structures and public policy.

### **9.3 Power-technology Nexus and regime of truth**

Chapter five presents how the contextual managerial techniques are introduced into the sector for strategic purpose to be accountable. The accountability mechanisms are implemented within the exiting power/knowledge context and discourse in the social and medical establishments. They become the technologies of domination in which individuals are subject to the controls and regulations. These technologies operate through the process of objectification of the subject via regulation of time, process and results to produce the normalized practice and care workers, particularly the competitive individual who is responsible for her or his own success or failure. During this process, the accountability mechanisms intertwine with the human actors in the power structures. In the following part, we will summarize this process into three phases.

#### **9.3.1 The first phase**

The emergence of power-technology nexus starts with the managerial uses of the idea of accountability. The accountability mechanisms derive from the discourse of the market economy and neoliberal reforms. Public sector is highlighted by efficiency and effectiveness. Following this idea, overseeing authorities enact a series of policies and regulations. Law 2002-2 is one of the most important laws in medical-social establishments. Performance management shows signs of new culture towards efficiency and effectiveness. To be able to measure, there is a need to identify, isolate and facilitate accurate measurement of both process efficiency and effectiveness of the results. The major challenge is thus that, lack of such a mechanism enables to deal with issues about accountability requirements in these disadvantaged communities. Law 2002-2 develop regular internal and external evaluation, despite it does not mention specific criteria. The other great number of policies seek to make a guide for decision-support tools in practice. In doing so, there has been a wave-upon-wave of “management fads” that have come and gone in the public sector. These have included management by objectives, total quality management (Pun, 2002), reinventing government, quality circles, performance



budgeting and business process re-engineering, programme-based systems, activity-based costing, ISO 9000, Excellent Models (UK Public Sector Excellence Programme, 1996) and the Balanced Scorecard (Kaplan & Norton, 2005). These techniques are primarily developed for the private sector and imported into the public service. In short, the first phase seeks to develop approaches to performance improvement that is driven by the accountability.

### **9.3.2 The second phase**

When the managerial techniques are coercively implemented in the sector, both managers and healthcare professionals start to learn how to use them in the working processes, and to apply them into daily practice. This is when the potential of developing the power-technology nexus begins. The rising application make managers and care staff to make sense of the technology and its drivers. The implementation of contextual managerial techniques can be thought as a deliberate and sequential set of activities directed towards putting into effect according to definite plan. This sense making process involves the technologies of domination over the human actors who participate. The technical-managerial accountability mechanisms as technologies of domination are concerned with controlling the conduct of individuals, which render them docile, obedient and governable. The materiality of the accountability mechanisms is gradually unfolded, which force the human actors to rethink their ways of managing the expertise, clinical practices and doing their jobs. The professionals within the healthcare sector, actively make their judgement as to what working life they should aspire for; accordingly, they act in a way that either strengthen or weaken the promoted discourse and rationality which form the basis for accountability mechanism implementation and the emergence of the power-technology nexus. The following is one of the examples of problematization that happen during this phase.

*On réunissait plusieurs institutions en pôle, il fallait uniformiser ces institutions pour qu'elles répondent aux mêmes exigences qu'un directeur de pôle avec une normativité de pôle etc. Là, ça a commencé à être un peu bancal parce qu'on a perdu un peu en identité et en spécificité, mais on est quand même*

*venu continué à raconter que, attention ! chaque institution était différente puisque chaque enfant était différent donc on ne pouvait pas avoir le même type de soin etc. Malgré tout, on a commencé à voir apparaître des protocoles de soin qui racontent comment faut faire... (Interviewee: P12)*

The above conversation reveals that at the very beginning of the implementation, care staff perceive that the contextual managerial techniques as accountability mechanisms show the potential of reconfiguring power relations. Technical-managerial accountability mechanisms are perceived by the top management as a technical tool to achieve their goals which aligned with the government's modernization discourse.

### **9.3.3 Organizational reconfiguration phase**

The enactment of the power techniques embedded in the accountability mechanisms enable the restructuring of the existing clinical processes and work practices. In this sense, the emergence of power-technology nexus gradually transformed social-material practices in the medical-social sector. The accountability mechanisms have become embedded in the organizational processes and decision-making exercises, which gains “power” over medical processes and operations. It results in normalization and standardization process during the treatment. Moreover, standards-based accountability constitutes a core concept of neoliberal policy-making in treatment, normalizing what counts as medical practice, professionalism and relations between the professionals and patients. The neoliberal discourses in medicine are that, in putting emphasis on medial performance, the idea of a socially responsible care staff has been replaced by a “managed” professional. As such, the regime of standards-based accountability reifies care works through the increased regulation of their work, performance evaluation, reporting of clinical processes and results, and the other surveillance and disciplining mechanism. The accountability mechanisms reify the clinical practices, professionals and patients are treated as measurable, instrumentalized objects of scrutiny.

#### **9.4 Care of the self and resistance**

Resistance to accountability mechanisms that derive from the flows of neoliberalism is different from past struggle. In Foucault's term- "care of the self" plays an important role under neoliberal surveillance. Our case the association A highlights a "different" approach to the issue of resistance through Foucault's notion of "the care of the self". Care staff resistance to the accountability mechanisms in which the regime of truth is transformed through the disciplinary power. However, our case indicates that care staff do not only resist the accountability mechanisms, but also be empowered by using the technology. This "different" approach takes as a starting point specific forms of resistance, that is, as Foucault suggests, we want to examine resistance to practices "as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used" (Foucault, 1982). All of this involves recognition of the possibilities of power, and the limits of contingency and domination, while seeking a space within them. Our focus of study is on care profession and their struggles to recognize different possibility of power. One such possibility is clearly offered in relations with others who share the same discomforts. These others might available in the association A and develop a dialogical approach over what it means to be a clinician and what it means to be treated to children with mental disorder.

#### **9.5 Conclusion to the Chapter**

This chapter has analyzed and discussed the empirical findings by reflecting on the managerial techniques implementation. The main issue of how technical-managerial accountability mechanisms implementation and use impact on, the power distribution has been addressed. To clarify this issue, a concept of power-technology nexus inspired by Foucault's work (1980) is proposed. The study indicates that the medical-social sector is under the dominations of technologies (disciplinary power) which seeks to normalization and governance. The technical-managerial accountability mechanisms become dominate and integral into the existing power/knowledge nexus. As a consequence, the regime of truth is

transformed through the disciplinary power, which result in industrialization process and reification phenomenon in the care sector. As the professionals are gaining more knowledge and experiencing with the accountability mechanisms, they are more likely divert power to their own ends by modifying and reflecting their interests. It is then that the professionals can begin to take an active role to think what they do not want to be, and do not want to become, in other words, begin to care for themselves.

## **10 CONCLUSION**

### **10.1 Introduction to the Chapter**

This chapter provides a brief summary of the thesis and outlines its major theoretical contributions and practical implications to the accountability regime in healthcare organizations. It also outlines the research perspectives.

### **10.2 Summary of the Thesis**

The objective of this thesis is to study how the implementation of technical-managerial accountability mechanisms impacts on the power reconfiguration, reconstruction and exercise. The medical-social establishments deal with the complexity of social relations and the complicated care issues of disadvantage communities. The debates about the way to improve the quality and safety of care, the control of costs, raise the issue of accountability. However, the role of accountability mechanisms implementation and use in construction, distribution, and exercise of power in organizations remains under explored. It is suggested that policies in healthcare implies a theory of causal relationship and are increasing focused on delivering technical-managerial accountability. This politic of accountability is understood as evidenced in individual, institutional and national comparative measures of performance, so the shifting power relations are redesigned and supported by data use. The technical-managerial accountability mechanisms as technologies of domination render the individual to be self-disciplined and behave in the desired ways. They result in the industrialization process and reification phenomenon in the medical-social sector.

In order to provide deeper understanding to the process and the phenomenon, contribute to the knowledge about the politic of accountability, this study is initiated. Managerialist accountability is chosen as the research object because its profound implementations are exercised through the twin technologies of domination and of the self. Managerial accountability uses technical-managerial techniques to monitor inputs and outputs or outcomes. This accountability regime will always be based on

a clear definition of desired objectives, the ability to measure and monitor goal achievement, a set of consequences for organization. In doing so, technical-managerial accountability is supported by data-driven and evidence-based approach. As a consequence, the regime of truth is transformed through disciplinary power (technologies of domination) enabled by technical-managerial accountability mechanism. The emergence of power-technology nexus enables and limits care staff's ability to master their expertise and exercise power. The power-technology nexus introduces a new social-material discourse. Emergence of such a nexus is a principal means through which existing power relations and regime of truth become challenged. Thus the professionals resist to the accountability mechanism. Our case goes further to examine those practices of resistance. We consider them as a chemical catalyst. The research examines how these care workers make sense of their work, particularly in terms of how they understand the concept of child mental health. The case study provides an investigation into non-normalizing organizational practices and the development of alternative form of "care of the self".

### **10.3 Theoretical contributions**

This research holds several theoretical contributions, which may be of interest to researchers in power and accountability regime in healthcare systems, particularly Foucauldian theoretical exploration in technical-managerial accountability and dialogical approach accountability. These contributions and their implications are detailed in the following subsections.

#### **10.3.1 Power-technology nexus in accountability mechanisms implementation**

Our research study contributes to a new and innovate theoretical concept-power-technology nexus for examining how the implementation of technical-managerial accountability draws from and impacts on power exercising and power relations in organizational contexts. This theoretical perspective directly makes a link between power and technology, and provides a tool for analyzing the medical-social establishments. Power is conceptualized as a network of relations

deeply embedded in the very fabric of the social system (Hardy & Leiba-O'Sullivan, 1998). It is invested and incorporated into the materiality of technology (Foucault, 1982). Technology is viewed as the material artifact that is embedded in and the embodiment of the social and organizational structures. In this sense, power and technology are intertwining leading to organizational culture changes through enactments by human actors. This innovative concept contributes to research on power and technical-managerial accountability mechanisms by addressing the deficiencies of rationalist views on technology, care staff and organizational culture transformation. The rational use of accountability regime result in standardization process and instrumental-rational core of reified relations between clinician and patient.

This study (our case study) sheds new light on the understanding of the role of technology in power dynamics. Constructivist view sees technology as the product of social actions (Hardy & Leiba-O'Sullivan, 1998). Our case presents that care staff do not only resist to the instrumental-rational core of accountability mechanisms, but also be empowered by using the technology. The study approach question of resistance to neoliberal modes of medical accountability in a different way, through Foucault's notion of "the care of the self". This "different" approach takes as a starting point specific forms of resistance, that is, as Foucault suggests, we want to examine resistance to practices "as a chemical catalyst so as to bring to light power relations, locate their position, find out their point of application and the methods used" (Foucault, 1982). All of this involves recognition of the possibilities of power, and the limits of contingency and domination, while seeking a space within them. The focus of our case study is on care profession and their struggles to recognize different possibility of power. One such possibility is clearly offered in relations with others who share the same discomforts. These others might available in A and develop a dialogical approach over what it means to be a clinician and what it means to be treated to children with mental disorder. Moreover, in the light of NPG theory, we argue that dialogical approach to accountability could make sense of the situation, address complex social problems, and collective response to

organizational value.

### **10.3.2 Foucauldian Application in accounting**

Michele Foucault introduces a number of ideas, such as power, knowledge, governmentality and etc., which has received attention in accounting research. The approach of Foucault enriches and highlights the accounting research. Many studies attempt to identify accounting as a mechanism of power and domination (e.g. Kalpagam, 2000; Edgley, 2010; Mckinlay & Pezet, 2010; Nikidehaghani & Hui, 2017; Fabre & Labardin, 2019; Marx, 2019; Silva *et al.*, 2019; Magliacani & Di Pietra, 2019)) Consequently, it may spread its influence (repressive power or normalizing power) across organization. However, there is still considerable room for developing a deeper study and understanding managerial accounting techniques related power phenomena. Our work can go further and deeper application of Foucault's idea of power/knowledge nexus, regime of truth, ethics and "care of the self". The study firstly explores the resistance to rational-instrumental of accountability mechanisms. The materiality of accountability mechanisms is argued. The focus is on the technical rationality, model of organizational reality and medical expertise. How materiality of accountability techniques embodies technique of power and how this power is enacted by particular groups of actors (care staff in our case). Secondly, Foucault's notion about resistance through self-construction may be an alternative explanation to standardization process and reification phenomenon. In other words, our study presents the twin interaction between technologies of domination and care of the self.

### **10.4 Practical implications**

The practical contributions of this thesis stem from the theoretical foundation proposed and the findings of our case study. In studying power, managers could use the power-technology nexus to analyze power relations in organizations. By focusing on the dynamic intertwining between power and technology we learn how an accountability regime is going to affect power exercising, the mode of control and



power relations. Although the case study is not empirically generalizable, it could provide an alternative approach to examine how to search for forms of organization and management control that are as far removed from the technologies of domination as possible. The case study describes that healthcare workers whose struggles are shared and common experiences recognized seek to develop non-normalizing organizational practices and an alternative form of “care of the self”. Rather than presenting itself narrowing as a science of healing, the care of the self is more concerned with the day-to-day practice of living and a relational governance.

Moreover, two practical recommendations could be made to top managers. The first one is that the dominant accountability mechanisms are incompatible with the treatment to children with mental disorder. The second one is that public managers should make more communication with the frontline healthcare professionals.

### **10.5 Strengths and Limitations**

The dissertation uses qualitative research in order to investigate the introduction of the NPM reforms in the medical-social sector into critical perspective. The study makes a focus on the experience of professionals with very rich and exceptional empirical materials. The use of an alternative case study model highlights some features of the way by which professionals experience NPM devices in institutionalized sites.

Meanwhile, two limitations are summarized below. In the first place, our empirical materials have not yet been completed for analysis. Secondly, the discussion of the contributions to the existing literature are not complete.

### **10.6 Research perspectives**

Building upon the findings, approach, Strengths and limitations, the research perspectives could be summarized as follows:

First of all, the research strategy in our study could be replicated in other sites in France. The study uses an inductive analysis strategy to examine the dominant accountability devices in institutionalized sites. We begin the research with the

question why professionals escape the main-stream institutions and work in the association A. The empirical materials present the industrialization process and reification phenomena in the medical-social structures, which makes a link with Foucault's concept on power, technology and domination. It makes us to characterize the alternative model (association A) with the features of care of the self.

As for the internalized surveillance culture in medical-social sector, it may be interesting to go further to document. Our empirical materials investigate the way by which healthcare professionals are under the discipline and surveillance in organizational life.

Third, our study may contribute to develop Foucauldian works in management control research in China. As a Chinese researcher, we find that there is not so much research about Foucauldian theory used in management control. The dissertation mobilizes the Foucault's concept on power to examine the accountability devices as technologies of domination, and further explore the alternative model of care of the self. The study develops a link of accountability framework with the Foucauldian theory, which makes a contribution to Chinese academic research on management control.

Finally, the study may contribute to favor the development of a more integrated way to address child mental health care in China. The analysis indicates a dynamic picture of how French medical-social institutions provide an integrated way in treatment to children with mental disorder, which could be useful for us in related fields.

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**APPENDIX 1-**  
**SEMI-STRUCTURED INTERVIEW SCHEDULE**  
**(IN FRENCH)**

Yuna LI  
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**Au**

**XXXXX**

Nantes, le 20 janvier 2018

Monsieur le Directeur,

Je m'appelle Yuna Li, et je suis doctorante à l'Institut d'Economie et de Management de Nantes (IEMN-IAE), de l'Université de Nantes. Ma recherche se penche sur les voies permettant de développer des organisations de soins intégrés d'un point de vue managérial et organisationnel dans le secteur médico-social, et notamment la mise en œuvre de nouveaux dispositifs de gestion. C'est dans ce cadre que je me permets de vous solliciter. Je serais en effet ravie de pouvoir vous compter parmi mes interviewés, si vous acceptez de me donner un peu de votre temps que je sais précieux.

En vous remerciant par avance de l'attention que vous voudrez bien accorder à cette recherche ainsi qu'à la présente sollicitation, et en espérant vivement que vous accepterez cet entretien, je vous prie d'agréer, Monsieur le Directeur, l'expression de mes respectueuses salutations.

Yuna Li



## **APPENDIX 2-**

### **INTERVIEW GUIDE (IN FRENCH)**

**Entretien avec XXX du 1<sup>er</sup> mars 2017**

#### **Guide d'entretien**

Rappeler le contexte : recherche universitaire (these de doctorat), recueil anonymisé des matériaux empiriques recueillis. Enregistrement de l'entretien pour nous permettre de réfléchir sur ce que vous nous dites, plutôt que d'être concentré sur la prise de notes (l'enregistrement est une obligation qu'on nous impose en terme d'exigence méthodologique d'une recherche de haut niveau).

Il y a deux objectifs sur cet entretien : a- caractériser l'apport de l'association A par différence par rapport au reste de l'offre existante et b- caractériser le fonctionnement interne (la prise en charge et fonctionnement de l'équipe) qui le différencie des autres organisations du secteur santé-social. Avant de rentrer dans le vif du sujet, nous allons vous demander de nous en dire un peu plus sur vous-même en tant que professionnelle :

1. Nous nous sommes rencontrées lors de la journée de l'association A organisée au printemps 2015 et à laquelle la directrice nous avait conviées, et fait intervenir. Du coup, vous en savez beaucoup plus sur nous que nous sur vous ! Pouvez-vous nous en dire plus sur vous (parcours professionnel) ?
2. Comment en êtes-vous arrivée à intégrer l'équipe de l'association A ? Pourquoi et comment ? depuis quand ?
3. Vous travaillez en parallèle dans une autre structure ? Pouvez-vous nous parler de ce cadre institutionnel et de ce que vous y faites. Depuis quand y êtes-vous ?
4. Qu'est-ce qui fait la différence entre l'assoication A et cette structure (la nommer) :
  - a. en terme de la prise en charge du patient, d'accès au système de soins,

b. en terme de management, d'animation de l'équipe.

5. Que pensez-vous de la façon de travailler à l'association A ? Qu'appréciez-vous et que n'appréciez-vous pas ou moins ?

6. En quoi consiste le travail en équipe ici ? Quelle est sa place ? Est-ce important ? En quoi ?

7. Que vous apportent exactement les réunions mensuelles ? Collectif, espace à penser.