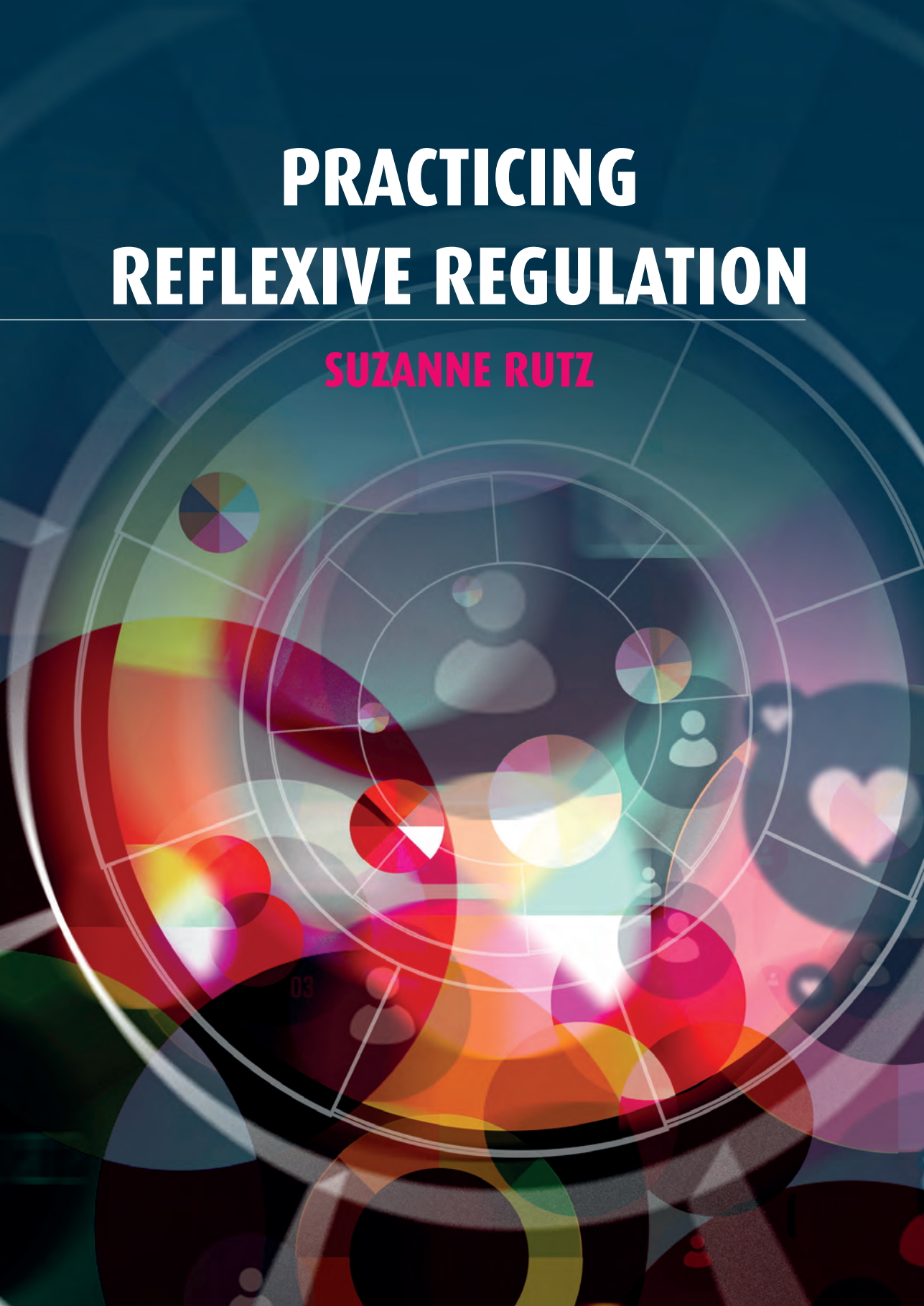
PRACTICING REFLEXIVE REGULATION

SUZANNE RUTZ



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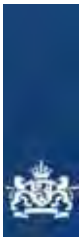

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Practicing reflexive regulation

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Introduction

This thesis is about how inspectors practice reflexive regulation. To gain an understanding of this subject, I studied the practice of a partnership of inspectorates, the Joint Inspectorate for Youth (*Samenwerkend Toezicht Jeugd*) in the Netherlands. This chapter first explains the quest for reflexive regulation and how reflexive regulation was introduced as an alternative to traditional command and control regulation. What follows introduces the characteristics of reflexive regulation and various reflexive regulation theories. After that, I set out the research questions, the case I studied and the research methods. The chapter ends with an outline of the following chapters.

THE QUEST FOR REFLEXIVE REGULATION

Nowadays, inspectorates need to demonstrate their impact. Many inspectorates are urged to shift their focus from compliance with laws to tackling social problems (Van Montfoort 2010; IRGC 2015). These problems do not necessarily correlate with breaking the law (Sparrow 2008). Examples of social problems that inspectorates focus on are homicide (Sparrow 2000), environmental damage (Gunningham 2012), terror in mineral mines (Braithwaite 2013), and lifestyle issues, such as alcohol abuse (IRGC 2015).

Regulating social problems poses a serious challenge for inspectorates. These problems often cut across sectors and organizations, and across the traditional jurisdictions of inspectorates. Moreover, the problems are often cloaked in cognitive and normative uncertainty. Cognitive uncertainty refers to a lack of comprehensive knowledge about the extent and nature of the problem. The causalities are difficult to understand and it is unknown whether action should be taken and if so what action. Normative uncertainty signifies that values, assumptions and judgments of the problem and the desired prospects are debatable. What the problem means to those affected and what action should be taken are both controversial (Koppejan & Klijn 2004; WRR 2008). Cognitive and normative uncertainty are often closely connected. Hence, in these situations, inspectors are confronted with uncertainty about what is best to do.

In addition to tackling social problems, the multiplicity of the institutional contexts of inspectorates also poses a challenge (WRR 2013; IRGC 2015). Many inspectorates have overlapping scopes as well as multiple tasks, multiple goals and multiple loyalties which all leads to unpredictable and complex interactions between inspectorates (Baldwin & Black 2007; Heimer 2011; Grabosky 2013; Van de Bovenkamp et al. 2016). Hence, the regulatory contexts often demand multiple arrangements that co-exist simultaneously, forming layered systems (Heimer 2011; Van de Bovenkamp et al. 2016). These systems are not stable but in continuous transition; the actors are 'moving targets' (Ford & Affolder 2011). Moreover, new layers – with new regulatory

actors and regulatory instruments – are often added on top of or alongside the existing ones (Van de Bovenkamp et al. 2016). The multiplicity of the regulatory system is also mirrored in the diversity of actors and their actions. These actors may be public or private, acting worldwide, in Europe, nationally, regionally or locally and using all kinds of instruments to influence regulated services.

The multiplicity of the regulatory system can have both negative and positive consequences. For instance, that regulated services exploit the diversity of the system to pursue self-interested goals could be a negative consequence (Heimer 2011; Overdevest & Zeitlin 2014). In contrast, that multiplicity reduces the chance of failure of any single regulator and may stimulate cross-fertilization and horizontal learning could be a positive consequence (Overdevest & Zeitlin 2014). For inspectors, the multiple regulatory system means having to work with a changing diversity of regulators and regulatory instruments. Inspectors cannot impose their own preferred action that ignores the perspective of others. They cannot control or manage the quality of services on their own (Heimer 2011; Overdevest & Zeitlin 2014).

In sum, inspectors are challenged to tackle social problems that are surrounded by uncertainty on what to do, while working in a complex multi-actor context with other regulators. Reflexive regulation is brought up as an answer to these formidable challenges. Reflexive regulation is also called 'next generation' regulation in order to emphasize that it is designed to overcome various insufficiencies of traditional command and control regulation in uncertain situations and multi-actor contexts (Perez 2011; Gunningham 2012).

Both reflexive regulation and command and control regulation are regulatory approaches, but they have many differences (see below). To allow for diverse regulatory approaches, I use a broad definition of regulation. In this thesis, I use 'regulation' as a broad overarching concept, covering the full policy cycle from rule-making through supervision, inspection and enforcement to evaluation and review (Zeitlin 2013). I use 'inspectorate' to refer to public-sector regulators, 'inspections' to refer to the activities pointed at the services inspectorates regulate and 'inspectors' to refer to the people conducting the inspections.

COMMAND AND CONTROL

Command and control is characterized by direct state regulation to control the execution of public tasks. In this regulatory approach, inspectorates rely on coercive powers and a firm sanctioning regime (Braithwaite & Fergusson 2013). Central is a regulatory framework, which sets standards and criteria that define the desired conduct and describes the measures to ensure compliance with these criteria (Baldwin et al. 2012;

Braithwaite & Fergusson 2013). This regulatory framework follows the law (Baldwin et al. 2012; Ottow 2015). Inspections take place in a one-to-one relationship between the inspectorate and the regulated service. This relation is characterized by vertical enforcement; conduct is dictated top-down (Ottow 2015).

For inspectors, command and control means collecting information to decide whether a regulated service complies with the criteria. If the service complies, no action is needed. If the service does not meet the criteria, inspectors take the prescribed measures (Perryman 2006; Braithwaite & Fergusson 2013).

One strength of command and control regulation is that it uses the force of law to impose fixed standards and criteria with immediacy and prohibits activity that does not conform to the criteria. By designating some forms of behavior as unacceptable and establishing sanctions for offenders, the inspectorate is seen to be acting firmly, taking a clear stand to protect the public (Baldwin et al. 2012). Regulation by command and control works well when criteria and regulated services are clear and well-defined. A worry is its inflexibility (Bardach & Kagan 2002; Baldwin et al. 2012; Gunningham 2012). The framework may not be responsive to specific circumstances. Also, the regulatory framework is not easily adapted to developments, such as innovations and emerging problems. Command and control becomes challenging when laws, rules, tasks and roles are unclear and inspecting does not take place in a one-to-one relationship, but involves other actors too. In these situations, reflexive regulation is an alternative option.

REFLEXIVE REGULATION

Reflexive regulation links reflexivity to the governance of risks and the notion that these are man-made. The social problems inspectorates are challenged to deal with are often connected to these risks that are no longer imposed by exogenous factors, but are increasingly the result of human decisions and actions. Therefore, a great deal of the energy is allocated to counterbalancing and managing these problems and dealing with the disadvantages of its own results and side effects. Beck (1994) calls this 'reflexive modernity', when modern initiatives no longer lead to success but to side effects that affect a broad range of citizens, from the poor to the rich (Baldwin et al. 2012; Dahler-Larsen 2012).

The literature on reflexive regulation distinguishes first- and higher-order reflexivity (Voss & Kemp 2006; Perez 2014). First-order reflexivity entails the evaluation of the problem, the regulatory model and the results of the methods used to deal with it. Special attention is paid to the induced side effects. After evaluation, methods are adjusted to deal better with the problem. Adjusted practices may produce different

results and lead to new side effects, which then need evaluation. The side effects also pose new problems that need to be remedied, and the methods to deal with these also need evaluation (Voss & Kemp 2006). First-order reflexivity is also called reflection. Higher-order reflexivity not only entails evaluating the method applied to deal with the problem, but also the attempt to identify the underlying principles, conceptualizations and assumptions of the regulatory models and methods. Their appropriateness is subject to criticism too. Moreover, higher-order reflexivity strives to critically observe the reflexive process itself; its own working, conditions and effects (Voss & Kemp 2006; Perez 2014). In the process, higher-order reflexivity disrupts any taken-for-granted problem-solving routines. Higher-order reflexivity cannot be called problem-solving anymore. Only confined and well-defined problems can be 'solved' but, as explained above, social problems lack this clear definition. Hence in higher-order reflexivity the emphasis is on the process of experimenting and enhancing understanding of the problem in ongoing societal developments (Voss & Kemp 2006).

CHARACTERISTICS OF REFLEXIVE REGULATION

The notion of reflexive regulation is used for various regulatory formats that are based on three common insights (Perez 2011). The first is that reflexive regulation is equipped to deal with uncertainty. Reflexive regulation explores and develops regulatory methods and tools that acknowledge that knowledge is unavailable or contested. According to the literature on risk governance, an essential aspect of dealing with cognitive and normative uncertainty is the inclusion of experiences and knowledge of experts, stakeholders and the general public. Participation and deliberation of various groups has an important function in creating an overall picture of the options, interpretations and potential actions connected with the social problem (Renn 2004; Van Asselt & Renn 2011). Participation and deliberation may lead to responses that better fit the specificities of the problem and the circumstances (Gunningham 2012).

Second, reflexive regulation is sensitive to the limits of state regulation, and acknowledges the role of multiple actors (public and private) in advancing regulatory aims. Including stakeholders through participation and deliberation is not only necessary to deal with the uncertainty, but also because no single actor can manage the social problem alone. Dealing with the problem needs to take place interactively, engaging both public and private actors, citizens, experts, the media, and other stakeholders (Overdevest & Zeitlin 2014). Interaction between all these actors results in greater stakeholder ownership and 'buy in' (Gunningham 2012).

Thirdly, reflexive regulation is characterized by learning. Drawing on the notion of reflexivity, learning is achieved through a continuous process of self-observation

and self-critique. Effective learning processes are considered essential, both in view of the absence of knowledge and as a measure against taken-for-granted routines (Perez 2011). This allows inspectors to learn, rather than to know, about emerging problems. Although creating an overall picture of the options, interpretations and potential actions that are connected with the problem is key to dealing with cognitive and normative uncertainty, reducing the number of options is necessary in order to create learning opportunities. Various scholars argue that it is important not to reduce the options to one, but to create a set of reductions and to experiment and learn with the options for improvement related to these various reductions (IRGC 2005; Voss et al. 2006; Sabel & Zeitlin 2008).

REFLEXIVE REGULATION VERSUS COMMAND AND CONTROL

In the literature on regulation, the reflexive approach is often set against command and control. Various differences are emphasized (see also Table 1.1). Compared to command and control, which typically has fixed standards and criteria describing the desired conduct based on the law, in reflexive regulation, due to uncertainty, standards and criteria cannot be specifically defined and may need adapting. In many cases, it uses broad principles or process-based criteria (Baldwin et al. 2012; Overdevest & Zeitlin 2014). Whereas in command and control, inspectors can impose compliance with the law on regulated services in a vertical relationship, reflexive regulation takes place in a multi-actor network, consisting of horizontal relationships between inspectorates, services and all kinds of others. Command and control regulation uses prescribed formats for what inspectors should do. In contrast, in reflexive regulation inspectors experiment with potential options to discover what is 'best' to do. While in command and control regulation non-compliance is seen as the starting point for intervention, the horizontal relationships in reflexive regulation open up possibilities to strive for improvements and for prevention (Ottow 2015).

Table 1.1 *A comparison of reflexive regulation and command and control regulation*

Command and control	Reflexive regulation
Key features: • Law-based criteria • Prescribes actions to ensure compliance • A firm sanctioning regime	Key features: • Equipped to deal with uncertainty • Involves multiple actors (public and private) • Creates learning opportunities
Well-defined criteria	Criteria open to adaptation
Vertical one-to-one relationship between inspectorate and regulated service	Multi-actor network of horizontal relationships that include the inspectorate, regulated services and others
Prescribed formats for what inspectors should do	Inspectors continuously learn what is best to do
Non-compliance is starting point for intervention	Prevention and generating options for improvement may be starting points

Although in theory there is a sharp distinction between the two approaches, they are not necessarily opposites. Both approaches, consider inspection processes to contain three main activities (Hood et al. 1999; Bundred 2006; Perryman 2006; Nutley et al. 2012; Koop & Lodge 2015):

- set standards and criteria,
- collect information to assess whether the service complies with the criteria, and
- take action to meet criteria and make improvements.

In practice, regulatory forms may be more diverse, as inspectors explore different possibilities to deal with the situation at hand and combine various approaches. The literature on street-level bureaucrats describes how inspectors use their discretion to respond in cases when generic rules and fixed scripts related to command and control do not seem to fit (Bardach & Kagan 2002; Lipsky 2010). Another example is found in the literature on sociological citizens (Silbey et al. 2009). Sociological citizenship refers to reflexive inspectors who are pragmatic, experimental, and adaptive, who go beyond and outside the prescribed rules and processes to involve all kinds of relevant others to broaden their repertoire (Coslovsky 2011). Sociological citizens are considered a distinct group of inspectors, who work alongside the group of rule enforcers (Silbey 2011; Coslovsky 2011; Canales 2011). They broaden their repertoire on their own initiative – often covertly (Coslovsky 2011) – to achieve regulatory aims in organizations that use a command and control approach. Hence, while the organization holds to the command and control approach, in practice the inspectors may add activities related to the reflexive.

THEORIES OF REFLEXIVE REGULATION

In this section, I introduce prominent reflexive regulatory theories, describing their features, and highlighting the related criticism. The theories vary considerably. At the end of the section, I provide an overview of how each theory acknowledges uncertainty, facilitates interaction with multiple actors and opens up learning opportunities.

Meta-regulation

In meta-regulation (the term 'enforced self-regulation' is used as a synonym) the management of social problems is not carried out directly by inspectorates; it is delegated to the regulated services. Regulated services are given the freedom and incentives to work out what, for their mode of operating, would be the best way to deal with a given problem (Baldwin et al. 2012). Each service writes a set of rules attuned to their organization and establishes a management system to monitor these rules. For inspectors' role this means encouraging regulated services to set up rules and (safety) management systems and ways to audit, monitor and stimulate these systems, instead of merely checking on compliance with criteria (Baldwin et al. 2012; Gunningham 2012; Stoopendaal et al. 2016).

The underlying assumption is that the regulated services know their own operations and facilities better than external inspectors. Moreover, the assumption is that giving regulated services the responsibility to govern their own behavior will encourage them to go beyond compliance with minimum standards and make ongoing improvements (Gunningham 2012).

In some respects meta-regulation is the quintessential form of reflexive regulation. It recognizes that the capacity to deal with uncertainty through rules alone is limited and offers an alternative strategy that induces regulated services to learn and acquire for themselves the specialist skills and knowledge required to deal with uncertainty and minimize the problem (Gunningham 2012).

Meta-regulation is criticized for placing too much faith in the capacity and commitment of the regulated services to reflect on their own working practices. High levels of expertise and regular monitoring by inspectorates are necessary to ensure that the management systems are properly implemented in practice (Zeitlin 2013; Stoopendaal et al. 2016). Moreover, criticism points to the presumption that regulated services always act in the public interest, given that public interests do not necessarily coincide with the services' aims (Baldwin et al. 2012).

Responsive regulation

Responsive regulation (Ayres & Braithwaite 1992) focuses on enforcement, stimulating the intended conduct of regulated services. An important principle of responsive

regulation is that the regulatory system should be seen as a 'benign big gun' wielded by inspectors acting with respect and concern who are allowed to coerce compliance if they choose (Ayres & Braithwaite 1992; Braithwaite & Fergusson 2013). Another vital principle is that less intrusive actions, based on opening a dialogue, always come first. This is based on the idea that governments must be cautious with severe interventions, acting dominantly only if needed (Braithwaite 2011).

The best-known strategy of responsive regulation is the enforcement pyramid (Braithwaite 2011; Mascini 2013; Parker 2013; see also Figure 1.1).[1] The pyramid includes options for enforcement that escalate towards the top. At the base are persuasive instruments, which are open and cooperative and include opportunities for the regulated service to correct itself. The inspector's role is to open a dialogue with the regulated service and motivate it to make changes. At the top are punitive instruments with severe sanctions, such as criminal prosecution. Each inspectorate and sector may construct a different pyramid, as each has its own characteristics and (legal) possibilities (Braithwaite 2011). Inspectors are allowed to be responsive to an individual encountered situations and apply the enforcement measures they consider most suitable, within the boundaries of the options in the inspectorate's pyramid. They also need to be able to switch between persuasive and punitive instruments; scaling up and de-escalating if necessary (Ayres & Braithwaite 1992; Mascini & Van Wijk 2009; Braithwaite 2011).

Less well-known is the pyramid of support that was added to the theory later (Braithwaite et al. 2007; Ford & Affolder 2011; Mascini 2013). The pyramid of support is designed to encourage learning by recognizing and rewarding innovation and improvement. It is supposed to urge the regulated services to expand their strengths in order to raise the performance of actors, breaking through new ceilings, and to tackle problems of concern to inspectorates (Braithwaite 2011).

In addition to the pyramids, responsive regulation entails the strategy of tripartism to involve and empower other stakeholders, mainly public interest groups (Ayres & Braithwaite 1991). Giving these groups a voice and letting them participate in the inspection process forms them into a countervailing power to the otherwise dominant parties (the inspectorate or the regulated service) and is a way to prevent regulatory capture (Ayres & Braithwaite 1991; Ford & Affolder 2011). Inspectors, then, work consciously within a web of relationships with others, using others as resources when ascending and descending the pyramids (Ford & Affolder 2011; Braithwaite 2011).

Responsive regulation is considered a part of reflexive regulation (Perez 2011) as it promotes regulation through engagement and dialogue, is committed to learning and

1 Responsive regulation entails four enforcement methods; the enforcement pyramid, tripartism, enforced self-regulation and partial industry regulation (Ayres & Braithwaite 1992).

engages and empowers other stakeholders (Braithwaite 2011; Ford & Affolder 2011). Although responsive regulation has gained support for its richness and capacity to develop in time, it also has its critics. Some scholars state that responsive regulation is mainly about how to respond in the case of non-compliance but says little about how to design inspections when goals are unclear or contested, or when inspectorates lack punitive methods (Baldwin & Black 2007; Baldwin et al. 2012). Also, in order to deal with non-compliance, inspectors need a lot of knowledge about the regulated service's willingness and capacity to comply in order to determine which pyramid would fit best to the situation they encounter. In practice this knowledge is often lacking and not easily gained (Perez 2011). In addition, scholars state that responsive regulation is most convincing in a one-to-one relationship between the regulated service and an inspector in the context of one inspectorate (Gunningham & Grabosky 1998; Baldwin & Black 2007; Heimer 2011; Baldwin et al. 2012). In a multi-level system, responsive regulation faces important challenges as the capacity of inspectors to act responsively depends on whether other parts of the system support responsiveness. In practice, these pieces are often not coordinated and responsiveness is disarticulate (Baldwin & Black 2007; Heimer 2011; Baldwin et al. 2012).

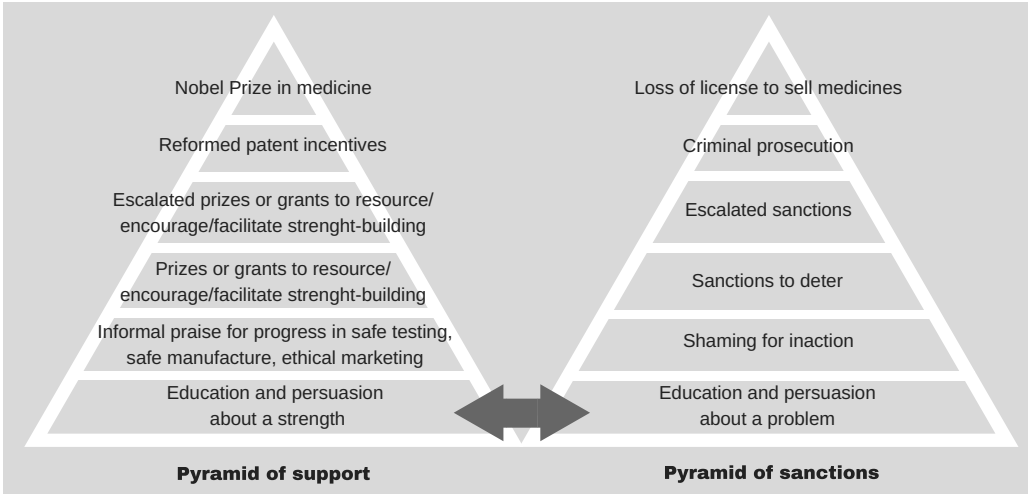

Figure 1.1 *An example of pyramids of support and sanctions on the regulation of medicines, developed by Braithwaite, Dukes and Maloney (Braithwaite 2011)*

Various authors have built on the theory of responsive regulation. Here, I describe the two most prominent. Firstly, Gunningham and Grabosky (1998) developed 'smart regulation' to broaden the scope of responsive regulation. They extended the one

dimensional pyramid to a three-sided one; with the two new sides related to the instruments of the regulated services and other stakeholders, respectively (Baldwin et al. 2012). Smart regulation seeks to engage private actors to advance regulatory aims, for instance via self-regulation (see also meta-regulation) or via the involvement of third parties. The idea is that involving a broad range of actors opens up opportunities to develop mixes of instruments that are better tailored to achieve the goals (Gunningham & Grabosky 1998; Baldwin et al. 2012; Gunningham 2012). Challenges arise as these instruments may have divergent logics; they embody different relationships between the inspectorate and the regulated service and assume different ways of interacting. Hence, it is essential to consider how instruments are mixed, whether they will be compatible and whether there are tensions or undermining (Gunningham & Grabosky 1998; Baldwin & Black 2007).

Secondly, Baldwin & Black (2007) developed 'really responsive regulation' to broaden the scope from selecting enforcement methods to enhance compliance to include other regulatory tasks as well. They added five factors that inspectorates need to consider when they identify instruments to advance their aims and make decisions about the intensity of their activities (Baldwin & Black 2007; Baldwin et al. 2012): 1) behaviors, attitudes and cultures of regulated services, 2) organizational setting of the inspectorate, 3) interactions of different regulatory tools and strategies, 4) performance of the inspectorate, 5) sensitivity to change. As with responsive regulation, an important challenge in 'really responsive regulation' is that the approach makes considerable informational and analytical demands to determine and anticipate on the five factors, while this knowledge is often lacking and may not be valid under continually changing circumstances (Perez 2011).

Problem-centered regulation

Problem-centered regulation places tackling problems at the heart of the regulatory practice. In other words inspectorates should '*pick important problems and fix them*' (Sparrow 2000). These problems are related to (potential) risk, harm, hazards and dangers. They are not necessarily connected with lawbreaking (Sparrow 2008; Ottow 2015).

The idea is that problems are carefully defined in such a way that they are manageable within the scope of a regulatory project. Hence, broad purposes must be broken into manageable pieces. Regulatory practice is then organized in projects which develop tailor-made instruments that fit the character and specificities of a problem and can either tackle it or cushion its effects. These instruments are developed by experimenting, monitoring and adjusting if necessary to attain results. One of the core elements of problem-centered regulation is that in the projects, inspectors initiate partnerships with all kinds of stakeholders to broaden the range of possible solutions (Sparrow

2000). The inspectors have to use their intelligence, analytical abilities and creativity to develop these tailor-made instruments and built networks with relevant others. This is what Sparrow calls 'regulatory craftsmanship' (Sparrow 2000; Sparrow 2008).
Problem-centered regulation is considered a part of reflexive regulation as beforehand it is not clear how the selected problems ought to be dealt with. Inspectors learn how to deal with the problem while carrying out the project. Problem-centered regulation is criticized for assuming too readily that regulation can be parceled into problems and projects to be addressed by project teams. Defining a target problem is not easy when causalities are hard to understand and interactive effects play a role. Moreover, a clear problem definition may not help inspectors to develop suitable strategies for responding to it (Baldwin & Black 2007; Baldwin et al. 2012).

Experimentalist governance

Learning, particularly learning from difference, is a central component of experimental governance. It establishes broad regulatory aims and gives interdisciplinary teams the discretion to develop innovative methods to pursue these goals in their own way. Teams share their experience through coordinated deliberation, and learn from comparing the various approaches to advance the same aims in different contexts. Learning processes are recursive, which means the teams constantly revise both their way of working and the central goals in light of the results of the comparisons (Sabel & Zeitlin 2012; Overdevest & Zeitlin 2014).
Rules are not a given in this approach. Experimentalist governance focuses on translating regulatory goals to various local contexts and tailoring to localized circumstances rather than enforcing uniform fixed rules and sanctions (Sabel & Zeitlin 2012; Stoopendaal et al. 2016). In this approach, acting under uncertain conditions is a forward-looking process in which a sequence of correctable and temporary decisions replaces a single all-conclusive judgment (Sabel & Zeitlin 2012).
Experimentalist governance is considered to have a reflexive design as it aims to deal with these problems under conditions of uncertainty and in multi-actor contexts and emphasizes learning (Sabel & Zeitlin 2012; Overdevest & Zeitlin 2014; Perez 2014).
According to commentators, experimentalist governance is related to various difficulties. Two comments are specifically important here. The first is that although experimentalist governance relies on open deliberation with a broad range of actors, in practice it excludes some stakeholders (Eckert & Börzel 2012; Fossum 2012; Wengle 2015), for instance, when actors do not share the central values of the others, when entrenched parties are not flexible enough or when actors' knowledge and experience is not recognized (Wengle 2015). The second comment says that learning patterns and options for experimenting are often not entirely open, but are skewed towards the

Table 1.2 *A comparison of reflexive regulation theories in terms of three characteristics*

	Dealing with uncertainty	**Multi-actor context**	**Learning**
Meta-regulation	Regulated services and inspectorate share responsibility for dealing with uncertain problem	Two main actors: the regulated service and the inspectorate	Regulated services learn how to deal with the problem within their mode of operating
Responsive regulation	Deals with uncertainty on how to encourage compliance	Main actors: the inspectorate and regulated service. Public interest groups are involved via tripartism	Learning is encouraged via the pyramid of support
Smart regulation	Uses a mix of instruments to deal with uncertainty	Involves regulated services, public interest groups and other stakeholders to broaden the range of possible instruments	Learning focuses on finding the best mix of instruments
Really responsive regulation	Sensitive to the changing context of the inspectorate	Two main actors: the inspectorate and regulated service	Learning to match the inspectorate's instruments and organizational setting to the characteristics of the regulated service
Problem-centered regulation	Selects uncertain problems as starting point for regulatory projects. Deals with uncertainty by experimenting	Initiates partnerships with all kinds of stakeholders to broaden the range of possible solutions	Learning how to deal with a problem by experimenting in projects
Experimentalist governance	Deals with uncertainty by experimenting and sees decisions as correctable and temporary	Involves all kinds of relevant stakeholders in multidisciplinary teams	Learning by experimenting and comparing with others striving to achieve the same aims in different contexts

dominant methods and strategies, which hampers the potential to innovate (Eckert & Börzel 2012; Fossum 2012).

This section described the prominent reflexive regulatory theories. These theories vary considerably with regard to their design and how they acknowledge uncertainty, facilitate interaction with multiple actors and open up learning opportunities (see Table 1.2). This diversity may underline the idea mentioned above that the distinction between command and control and reflexive regulation is not that sharp. Nonetheless, I consider this an empirical question which I reflect on that in the concluding chapter.

PRACTICING REFLEXIVE REGULATION

To summarize my argument so far, reflexive regulation is proposed as an alternative to command and control regulation to deal with uncertain situations in multi-actor contexts. The idea is that reflexive regulation can open the possibilities to act, to involve multiple stakeholders and to learn – rather than to know – about the problem at hand. Reflexive regulatory theories vary considerably in terms of design and how they acknowledge uncertainty, facilitate interaction with multiple actors and create learning opportunities.
Notably, the literature on reflexive regulation and the governance of risks connects reflexivity to the level of organizations; the theories may be implemented in inspectorates, or parts of inspectorates. Except for responsive regulation, which has been studied in practice (see for instance: Braithwaite et al. 2007; Mascini & Van Wijk 2013), it is unclear what the theories mean for the day-to-day work of inspectors, what advantages and difficulties they experience while practicing the theories and how they deal with these. This thesis aims to advance the understanding of what inspectors do when they carry out reflexive regulation. Therefore, the central question that guided the research was:

How do inspectors practice reflexive regulation in the context of their inspectorate?

Three sub-questions follow the three characteristics of reflexive regulation:
- How do inspectors deal with uncertainty?
- How do inspectors act in multi-actor contexts?
- How do inspectors learn and generate options for improvement?

A CASE OF REFLEXIVE REGULATION

To gain insight into these questions, I studied the case of the Joint Inspectorate for Youth (JIY), a partnership of five government inspectorates in the Netherlands: the Health Care Inspectorate (*Inspectie voor de Gezondheidszorg*), Inspectorate of Education (*Inspectie van het Onderwijs*), Inspectorate for Youth Care (*Inspectie Jeugdzorg*), Inspectorate for Safety and Justice (*Inspectie Veiligheid en Justitie*), and Inspectorate of Social Affairs and Employment (*Inspectie Sociale Zaken en Werkgelegenheid*). These inspectorates initiated the partnership after a critical incident in Roermond in 2002. Six children between the ages of three and ten died in a fire that was started by their father. Inspectors of the various inspectorates investigated the quality of services given to the family members prior to the incident, each in their own sector. After their assessments,

the inspectors put their results together. It turned out that although 24 professionals had provided services, each had been unaware of the others dealing with the family. The local priest was the only one who knew which organizations were involved. The inspectors realized that no one inspectorate could oversee the wider picture, since they all inspected services in specific sectors. Consequently, the inspectorates initiated the partnership.

The JIY was founded in 2003. Instead of assessing the service quality of a specific organization in a specific sector, which the inspectorates had done traditionally, a pioneering team of inspectors developed an approach that crossed organizations and sectors. They aimed to put children center stage and to look at how organizations and professionals contribute to the outcomes for the children. They were inspired by problem-centered regulation and decided to '*pick important problems and fix them*' (Sparrow 2000). They chose social problems concerning children that required contributions from organizations in various sectors as themes for their inspections, for example, child abuse, obesity, youth offences, high school dropout, and growing up poor.

Theme-based inspections are carried out in municipalities. The partnership's intention is to help find options to deal with the social problem that are tailored to the local municipality's circumstances (Van Eijk 2004; ISYA 2009). To achieve this, the JIY inspects a broad range of local services in all sectors providing services to children, including health, youth care, education, police, and social affairs. In addition to theme-based inspections, since 2012 inspectors also investigate complex critical incidents involving young people. These are outside the scope of this thesis.

Multidisciplinary teams of three to eight inspectors conduct the inspections, which include methods focused on engaging stakeholders, for instance brainstorming and consensus-building sessions with professionals, managers of providers, and young people, to create solutions that match young people's needs. For their assessments the inspectors use a regulatory framework with criteria focused on the provision of coherent care. The framework and methods can be adjusted to the specific circumstances of the theme under scrutiny. If providers are found to be non-compliant, they are encouraged to take concrete steps to create better outcomes for children and their families (ISYA 2009). Although the partnership lacks official enforcement powers, individual inspectorates in the JIY can take enforcement measures if required to stimulate compliance and service improvement.

When the partnership developed this approach, they did not have a strong legal base. They referred to the broad Convention on the Rights of the Child to account for their inspections. The Youth Act (*Jeugdwet*) that came into force in January 2015 gave the inspectorates in the partnership the task of assessing local care systems for young people and they developed a new framework accordingly (STJ 2015). This and two

other acts, the Act on Participation in Employment 2015 (*Participatiewet*) and Act on Social Support 2015 (*Wet maatschappelijke ondersteuning*) decentralized various tasks related to care for children, active participation and social support from the national government to local municipalities. This decentralization challenged municipalities to provide integrated care and support to their inhabitants in their daily lives. Consequently, since 2015, the partnership's scope has broadened; JIY inspectors no longer assess care and support systems for young people only, but also for adults and the name of the partnership changed to Joint Inspectorate Social Domain/Joint Inspectorate for Youth (*Toezicht Sociaal Domein/Samenwerkend Toezicht Jeugd*).

The JIY can be considered to have a reflexive approach as its methods focus on the participation of multiple stakeholders and the teams of inspectors continuously adjust and develop their methods, tools and frameworks based on their experiences. Also, the social problems central to the thematic inspections are not directly related to lawbreaking.

STUDYING REFLEXIVE REGULATION IN PRACTICE

This study was carried out within the Academic Collaborative Centre on Supervision (*Academische Werkplaats Toezicht*), in which researchers from four research institutes cooperate with the Health Care Inspectorate on research themes that arise in regulatory practice. The JIY offered the opportunity to undertake this research project as they wanted to gain insight into options for improving their regulatory strategy. This section explains my research methods and discusses my dual outsider/insider role as researcher and inspector.

Methods

In this study the focus was on exploring how reflexive regulation works in inspectors' daily practice. To study daily practice, I began in the middle of the action and 'zoomed in' on the process of a thematic inspection (Nicolini 2009). I selected the thematic inspection of services for children growing up poor as I expected this theme to include the inspectors' uncertainty on how to act. From 2009 to 2011, I followed this thematic process through a combination of participant observations, informal interviews and document analysis. This helped me to gain an understanding of the inspectors' activities, their interactions with one another and with others, and their capacity and competence to conduct inspections.

Also in 2012, I conducted semi-structured interviews with 17 inspectors in the partnership. I asked the inspectors to portray their work by describing three situations

they encountered in practice: one where the inspector has been able to make a change, one where things did not go according to plan, and a third situation that the inspector considered routine.

In addition, I studied two methods that the inspectors use to assess services and to involve multiple actors in their inspections. The assumption was that inspection methods steer both the work they do and their assessment of the services provided, signifying what they consider important and what not (Perryman 2006; Dahler-Larsen 2014). The first inspection method was participation of young people. I conducted a document analysis of the material created and used by inspectors to involve adolescents in the thematic inspection on care for children growing up poor and organized a meeting with inspectors to discuss the participation method. The second method considered the journey tool. Inspectors use this tool to reconstruct and assess children's journey through the organizations providing services and to create a network of the organizations involved. To study the journey tool, I analyzed the documents belonging to 24 reconstructed journeys between 2004 and 2012 as well as the parts of the semi-structured interviews that concerned the journey tool.

Understanding the particularities of a practice is not only gained through zooming in on a specific practice, but also by comparing practices (Wrede et al. 2006; Bourgeault et al. 2009). Hence, I compared the inspectors' role in both the JIY and a vastly different inspectorate, the Care Quality Commission (CQC) in England. Specifically, this comparative analysis studied the discretionary room that inspectors have for reflexivity, and how they use it. I conducted this analysis jointly with Dinah Mathew, an inspector in the CQC. We analyzed 17 semi-structured interviews with JIY inspectors and used the same format to interview 11 CQC inspectors. We also collected documents relevant to the role of inspectors, the inspectorates, and the broader organizational context. In addition, we held two meetings with inspectors (one each at CQC and JIY) to discuss the results.

These research methods are discussed in more depth in the empirical chapters (Chapters 2-5).

Practicing insider research

During this study I had a dual role of inspector and researcher. Since 2006, I have worked as an inspector of Health Care and as such I was seconded to the JIY. Then, in 2009, I began working on this PhD project on reflexive regulation, thus conducting insider research, applying the insights I gained from lived experience in the research (Van Heugten 2004; Brannick & Coghlan 2007). I had intimate knowledge of the worldview of inspectors and their working practices in the context of the JIY and also had access to the confidential circuits of the organization. This helped me to develop an understanding 'from within'. However, being so familiar and close to the research

subject may create bias and inability to see the rich variety of potential others ways of interpreting one's organization. Hence the dual roles of inspector and researcher called for additional efforts to deal with the issue of methodological distance (Van Heugten 2004; Alvesson 2009).

First, I managed any tensions in the two roles of inspector and researcher by working with a theoretical framework. This enabled me to interpret the data from a given distance and to shift perspectives between roles; from the role of inspector to the role of researcher. Second, I involved outsiders to the JIY to enhance the reliability and validity of the analysis. In every part of the research, I involved and closely cooperated with a team of researchers who were not affiliated with the JIY. Our meetings to discuss interpretations formed an important part of the analysis. The others' lack of insider knowledge helped me to question my interpretations. I also discussed the analyses in various meetings with yet other researchers and representatives of various other inspectorates. Besides this, the empirical chapters of this thesis (Chapters 2-5) were peer reviewed. Third, writing memos assisted self-reflection, challenging taken-for-granted forms of understanding and following up surprises. In these memos, I reflected on situations which made the tensions of the dual role of inspector and researcher tangible.

Although these strategies were intended to create objectivity through distance, I also took care to stay close to the practice of the inspectors. For instance, I relied on the closeness to select topics for the research and also used it to provide meaningful suggestions for improving the inspectors working practices (see also Chapter 6).

OUTLINE

The rest of the thesis is organized as follows. Chapter 2 explores how inspectors conduct thematic inspections. Using the literature on risk regulation (characterization and governance of risks), I focus on how inspectors deal with normative and cognitive uncertainty.

The inclusion of stakeholders is a vital aspect of dealing with uncertainty and also important because no single actor has the capacity to manage social problems alone (Renn 2004; Van Asselt & Renn 2011; Gunningham 2012; Overdevest & Zeitlin 2014). Chapter 3 focuses on the inclusion of one stakeholder, namely young service users. The rationale for involving them in inspections is that their distinct perspective offers new options for improving the quality of services and dealing with the social problem. In practice, incorporating young people's views in the inspection process may be difficult, as they their views on good care differ from the inspectors' own views. This chapter compares the views on good care of young people and inspectors,

seeking to understand what the differences and similarities mean to incorporating the users' views in inspections. To discuss how adolescents' views are incorporated in inspections the chapter draws on the literature on service user participation and the regulatory literature.

Effective learning processes are considered essential in reflexive regulation (Perez 2011). Chapter 4 focuses on the journey tool, an inspection instrument that aims to enhance stakeholders' learning to improve the outcome of services for children. The instrument is meant to put children and their problem center stage, bringing stakeholders together to generate options to improve the services. In this chapter I analyze how inspectors create and define the child's problem with the journey tool. Here I apply an ontological theoretical framework (Mol 2002) to discuss that the journey tool is based on one form of problem definition; creating a hierarchy. I also explore 'patchwork' – an alternative problem definition that allows multiplicity – and what it means to the inspectors' assessments and opportunities to reflect on the outcomes.

Chapter 5 focuses on how inspectors involve other stakeholders and create learning opportunities when they use their discretionary room. In a decentered comparative analysis, I compare the working practices of the JIY inspectors with the practice of inspectors in a vastly different inspectorate; the CQC in England. Drawing on the literature on street-level bureaucrats (Lipsky 2010), relational regulation (Silbey et al. 2009) and experimentalist governance (Sabel & Zeitlin 2012), the chapter develops the notions of collective discretionary room and collective discretion. Collective discretionary room refers to the space that is granted to teams of inspectors in which they reach consensus on their judgments. The label 'collective discretion' is used for individual inspectors who pragmatically involve others on their own initiative. I argue that collective discretionary room offers possibilities to enhance learning and develop responsive and consistent working practices.

Finally, in Chapter 6, I answer the research questions of the thesis. I combine and discuss the findings of Chapters 2-5, discuss the theoretical and practical implications and provide recommendations for future research and practice.

Chapters 2-5 of this thesis derive from four papers published in or submitted to academic journals. Some overlap between the chapters is inevitable, as each paper has been written to be read independently of the others.

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2

Hiding complexity, uncertainty and ambiguity

How inspectors simplify issues to create enforceable action

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INTRODUCTION

This article focuses on how inspectorates inspect services for children and young people. After various tragedies concerning children and their families (for example, the high-profile deaths of baby Peter (Warner 2013) and Victoria Climbié in the UK and the Roermond case, Savanna, Gessica and Baby T in the Netherlands (IJJ et al. 2003; Kuijvenhoven & Kortleven 2010)), central government authorities proposed minimizing risks in care for children by strengthening the role of inspection agencies (see Lord Laming (2009), Bevan (2008), and IJJ et al. (2003)). This strengthened regulatory role is primarily focused on the development of rigid standards by which organizations can be judged and strict enforcement of regulations. In addition, inspectorates are expected to show the added value of their work for society and to tackle social problems through the prevention of incidents and the minimization of risks (Van Montfoort 2010).
In this article, we examine how inspectorates deal with meeting these two expectations, strengthening the regulatory role and tackling social problems in situations that lack certainty. We studied a partnership of five Dutch inspectorates that was established to oversee the broad range of services for children and young people and to focus on social problems. We describe one of their joint inspections, which focused on care for children living under poverty conditions. Using this case, we show that inspectorates wavered between accepting complexity, uncertainty and ambiguity and minimizing the lack of certainty. This tension tends to be resolved through the minimization of uncertainty by the reconstruction of simple problems, thus facilitating evaluation and enforcement.

INSPECTORATES, RISK AND UNCERTAINTY

Inspectorates

As governmental tasks have increasingly been decentralized, that is, transferred from central government to administrative agencies and local governments, inspectorates have been positioned in between central governments and the organizations or institutions performing public tasks. In this mediating role, inspectorates function as regulatory bodies that gain insight into and exercise control over the execution of public tasks (Braithwaite 1999). Traditionally, inspectorates have deemed organizations successful if they conform to predefined criteria (Bundred 2006). These criteria form a set of standards by which the organizations can be judged. Organizations that do not meet this rigid set of criteria are considered to be ineffective, and must make changes to meet the prescribed standards (Perryman 2006). To ensure strict regulatory enforcement, inspectorates need to create certainty regarding whether or

not the service of the organizations that they inspect meets the specified standard. However, strict regulatory enforcement becomes more complicated as public services are increasingly delivered in new ways. Public services use a wider range of providers for delivering services, including the private and voluntary sectors (Bundred 2006). As a result, new partnerships between public and private parties develop with new organizational forms. In the Netherlands, for example, various services for young people, health and social care services are joining forces in youth and family centers to provide help on parenting at the neighborhood level (NYI 2011). Because Dutch inspectorates are organized by service sector, these joint organizations are inspected by different inspectorates. Hence, the possibility of overlap and conflicting demands increases (Walshe et al. 2001). To synchronize demands, cooperation between inspectorates is required. To do so, they must leave their own specialist regulatory areas. This creates tension because strict regulatory enforcement is only possible within inspectorates' own specialist regulatory area.

In addition to strict regulatory enforcement and a focus on rules and regulations, inspectorates have been encouraged to broaden their scope by adding value for society (Van Montfoort 2010; Munro 2011). They have been challenged to add value for society by tackling social problems through preventing incidents and minimizing risks. However, in this broader area, inspectorates often find themselves in situations that cannot be considered certain, as knowledge is either unavailable or contested, or the tasks and roles of the organizations under inspection are unclear. In these situations, inspectorates cannot easily define criteria to judge the organizations that they inspect. Inspectorates are being challenged to assess situations that lack certainty. Although a strict regulatory enforcement appears to be compatible to tackling social problems, in practice, these objectives pose important dilemmas to inspectorates, especially in uncertain, complex and ambiguous situations. Until now, researchers have paid little attention to how inspectorates deal with a lack of certainty.

Risk and uncertainty

To enable strict regulatory enforcement, inspectorates must judge with certainty whether the service of the organizations meets the requirements or not. The set of standards, which inspectorates traditionally use to make these judgments (Bundred 2006), are primarily based on effectiveness research (Perryman 2006). However, evidence for clear-cut effectiveness is often not available when the main subject of an inspection concerns a social problem. Many social problems stubbornly resist being framed in traditional terms because: the causalities are difficult to understand; the possible effects of interventions cover a wide range; values and beliefs vary considerably; and the desired results are contested. Problems that lead to these situations can be characterized as 'wicked problems' (Rittel & Webber 1973). One of the features of

these problems is that they cut across the traditional jurisdictions of organizations and cross the traditional boundaries between sectors. Furthermore, the wickedness manifests itself in the uncertainty surrounding these problems; consisting of cognitive and normative aspects, which are often closely connected. Cognitive uncertainty refers to a lack of comprehensive knowledge about the extent and nature of the problem, whereas normative uncertainty signifies values, assumptions and judgments about the risk problem and the desired prospects that are debated (Koppejan & Klijn 2004; WRR 2006).

These cognitive and normative issues can also be used to characterize risk problems. Four types of risk problems can be identified (Douglas & Wildavsky 1983; IRGC 2005): simple, complex, uncertain and ambiguous. A simple risk problem can be conceptualized in terms of the value of defined outcomes and their relative probability; causes are known and there is an agreement about which interventions are suitable. Both cognitive and normative aspects of the risk problem are certain. For the second type of risk problem, complex problems, it is difficult to determine the cause-effect relationship between a risk agent and its potential consequences because the risk problem is multi-causal, and interactive effects play a role. The third type of problem, the uncertain risk problem, includes not only situations in which knowledge is incomplete or unavailable but also situations in which the problem cannot be quantified in a reliable manner. Finally, ambiguous risk problems are signified by different legitimate viewpoints about what the risk means for those affected and about which values should be dominant in judging interventions (Renn 2008). Ambiguity relates to cognitive aspects of the risk problem and to different interpretations of knowledge and information. Ambiguity may also indicate normative aspects, different concepts of the risk problem and what is considered tolerable with regard to issues such as ethics and quality of life (IRGC 2005).

This typology uses the degree of certainty to characterize risk problems; simple risk problems are considered to be the most certain, while ambiguous risk problems are the least certain (both cognitively and normatively). In this approach, the nature and type of uncertainty differentiates between types of risk. However, the relationship between uncertainty and risk is the subject of much debate. There is no agreed definition of risk and heterogeneous definitions are used. Yet, these can be divided into definitions that express the risk either by means of probabilities and expected values or through events, consequences and uncertainties (Aven & Renn 2009). From the first viewpoint, risk is associated with well-identified dangers and situations in which rational decisions can be made and research efforts can be aimed at exploring effective solutions. From this viewpoint, risk and uncertainty are clearly distinguished (see Knight 2005). The second viewpoint includes the aspect of uncertainty in the term 'risk' (for example Van Asselt & Vos 2008; Aven & Renn 2009). From this perspective, dealing with risks

is not just a rational process, but also demands a variety of strategies that focus on the complexities, uncertainties and ambiguities involved.

In this article, we acknowledge this broader approach. We consider uncertainty as one of the possible aspects of risk and examine how uncertainty characterizes risk problems and is dealt with. We do not presume that the complex, uncertain and ambiguous nature of a risk problem is given, but rather that any specific case can shift between categories. Uncertain risk problems, for example, can be transformed into simple risk problems and vice versa, depending on how the risk problem is framed and which strategies are used to deal with the risk problem (Douglas & Wildavsky 1983; IRGC 2005; Beck & Kropp 2011).

Although, in theory, uncertain, complex and ambiguous risk problems can be sharply distinguished, in practice they are often interrelated; uncertainty can result from complexity, while complexity can induce controversy and thus ambiguity (IRGC 2005; Van Asselt & Renn 2011). Therefore, various authors argue that 'simple' risks should be treated as a type of special case, in which uncertainty, complexity and ambiguity are minimal (WRR 2009; Van Asselt & Renn 2011). The routines, procedures and structures that work quite well in the regulations of simple risks are not just inadequate, but may even hamper responsibly dealing with the other types of risk problems (Van Asselt & Vos 2008). An essential aspect of dealing with complexity, uncertainty and ambiguity is the inclusion of experiences and knowledge of experts, stakeholders and the general public. Participation of various groups has an important function in creating an overall picture of the options, interpretations and potential actions that are connected with the risk problem (Renn 2004; Van Asselt & Renn 2011). Law and Mol (2002) emphasize that in dealing with risk problems, simplifying or accepting complexity are not necessarily opposites. They argue that the issue is often not so much a choice between simplifying or accepting complexity, but of bringing them together. Although a single simplification reduces complexity, such a frame or repertoire does not exist in isolation. For instance, at places where different simplifications meet, complexity is created (Law & Mol 2002). As a consequence of this multiplicity, it becomes important to identify and discuss what such simplifications foreground, as well as what they relegate to the background.

In the governance of risk problems, researchers have found that most risks, regardless of type, are often treated as if they were simple (Van Asselt & Renn 2011). One example is found in policy documents, where it is common practice that rhetorical strategies minimize uncertainty in their representations of risk, especially when they make a strong claim for policy action (Hooker et al. 2009). Risks can be reframed and simplified in various ways to minimize uncertainty, for example by adopting a precise set of procedures or allocating formal responsibility for making decisions about dealing with risk problems (Van Asselt & Vos 2008). Van Asselt and Vos (2008) call this 'technocratic

handling' and point to how decisions are made in a technocratic manner and regulations clearly delineate the respective actions of actors with regard to these decisions.
Dealing with risk problems is often not an overt process, but is often based on invisible infrastructures, including routines of problem solving, social beliefs and technical systems, that confine the regulation of risk problems (Taylor-Gooby 2008). The scope of risk governance is arranged and restricted by specific discursive or institutional rules and given risk indicators (Beck & Kropp 2011). These infrastructures are often based on the assumption that risk problems can be managed, reinforcing 'myths of controllability' (Power 2004). Yet, a retrospective review of risk scandals highlights that most risks arise from the connections that remained unseen or were even concealed during previous risk assessments (Beck & Kropp 2011); hence it is important to pay attention to the complexity, uncertainty and ambiguity that accompany risk problems and proposed actions.

METHODS

Context of the case study

Many organizations and practitioners play a role in caring for children and their families in the Netherlands. As in many other European countries, supervision of these services is organized by sector; for example, the Inspectorate of Education reviews the schools and the Health Care Inspectorate sees to the quality of health care for children and young people. The various inspectorates are all part of the Dutch central government but they have different backgrounds and practices. They have distinctive traditions that are rooted in long histories, as well as their own legal authority (Mertens 2011).
As we noted above, in this article we analyze a joint inspection conducted through a partnership of five inspectorates. This partnership was known as Joint Inspectorate for Youth (JIY; *Samenwerkend Toezicht Jeugd*), and included the Health Care Inspectorate, the Inspectorate of Education, the Inspectorate for Youth Care, the Inspectorate of Security and Justice, and the Inspectorate of Social Affairs and Employment. The partnership's challenge was to contribute to solutions to social problems that could not be addressed effectively by a single organization or sector, but require the synchronized contribution of organizations in different sectors. Since the inspectorates entered into partnership in 2003,[2] they have conducted 30 joint inspections on various social

2 In 2003, the inspectorate for Health Care, the Inspectorate of Education, the Inspectorate for Youth Care and the Inspectorate of Security and Justice started their partnership. In 2005, the Inspectorate of Social Affairs and Employment entered into the partnership.

problems (including obesity, high school dropout, youth prostitution and homeless children). The partnership aimed to address (and ideally, find a solution for) these issues by stimulating local organizations to improve their cooperation and to take concrete actions that produce better results for children and their families. As part of this process, inspectors from the participating inspectorates examine how the various youth services involved cooperate to prevent and solve the social problem under investigation (ISYA 2009). Their joint inspections include methods that particularly focus on the involvement of all stakeholders and the creation of solutions that match young people's needs.

Methods

The joint inspection provided an opportunity to examine how the inspectorates reconciled their commitment to strict regulatory enforcement with the challenge to tackle social problems. In order to explore this tension, we used a single case study design. This design is appropriate to study a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin 1994, p. 13). This was relevant as we aimed to develop a more in depth understanding of the phenomenon of the characterization and governance of risk problems in relation to the regulatory context.

We studied the case of a joint inspection conducted by a partnership of five inspectorates concerning the care for children living under poverty conditions (for a description of this joint inspection see Box 1). This case was particularly interesting for our research because it concerned a joint inspection with the focus on a social problem. Both the cooperation between inspectorates and the broadness of the social problem challenged the inspectorates to leave their regulatory area, which increased the chance of getting into complex, uncertain and ambiguous situations. The case could be considered typical as it was conducted as an ordinary inspection (preparing, collecting data and making judgments) in a regular regulatory context.

Case study methodology is characterized by collecting data through multiple methods in order to build up a rich picture of a phenomenon and the context. In this study, data were gathered through a combination of participant observations, informal interviews and analysis of documents.

The first author (Suzanne Rutz) participated in the team that conducted the joint inspection on poverty. She had access to the research site because she has been an inspector of the Health Care Inspectorate and seconded to the partnership of inspectorates since 2006. Additionally, since 2009, she has been working part-time as a researcher. Hence, she had a dual role of inspector and researcher, which raised the issue of methodological distance and a number of considerations related to this issue.

Box 2.1 *Information on the joint inspection on tackling the consequences of poverty for children*

In the Netherlands, 11% of the children live in poverty. Care for poor children was placed on the partnership's inspection agenda because inspectors had identified poverty as an underlying issue in their earlier inspections (such as obesity and high school dropout).

The inspection team consisted of five inspectors and one project assistant. The members of the team were seconded from the five participating inspectorates: two from the Inspectorate for Youth Care, one from the Inspectorate of Social Affairs and Employment, one from the Inspectorate of Education and one from the Health Care Inspectorate. Four of the team members also continued to work part-time in their original Inspectorate.

The team initiated their inspection with a pre-study which included a literature scan, database survey and (local and national policy) document analysis. The purpose of these activities was to identify organisations that might be involved in the care of poor families. Based on the indicators from national databases, the inspectors constructed a list of 20 municipalities in which children had a relatively high risk of growing up under poverty conditions. Four of these municipalities were selected for joint inspection because these had not been inspected intensively before. Key characteristics of the four municipalities varied, such as the number of inhabitants (75,000–180,000), the percentage of children living in families receiving social assistance (9–16%) and children living in deprived areas (5–44%).

In each of these four municipalities, the inspectors conducted interviews and focus groups with children and parents, studied case files, conducted a vignette study, and organized meetings with professionals, managers, policymakers and elected members of the local governments (see also Figure 2.1). The inspection team reported its main findings, evaluations of the findings and recommendations for improvement in an inspection document. Five reports were written; one for each municipality, plus one report based on the overall findings, in which the inspection team addressed recommendations at all local municipalities in the Netherlands and at the central government.

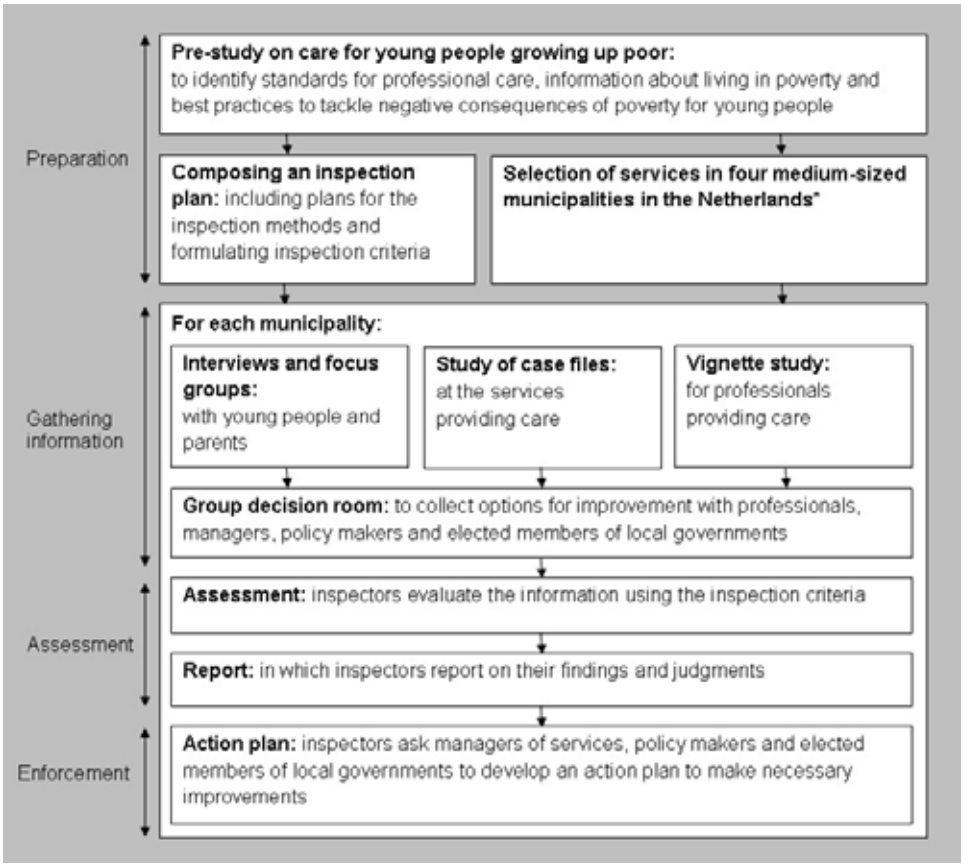

Figure 2.1 *A scheme of the joint inspection on care for children living under poverty conditions*

Although familiarity with subjects and incorporation into the closed and confidential circuits of the organization is linked with intimate knowledge about the situation, which is essential to develop an understanding 'from within', familiarity and ordinariness can also pose problems of myopia and subjectivity due to the proximity to the case and situation. Being too close can therefore create bias and the inability to see the rich variety of potential ways of interpreting one's organization. Hence, the dual roles of inspector and researcher called for some additional efforts to escape the specific traps facing the insider position of the researcher. Alvesson (2009) indicates several ways in which one may create distance. We applied three of these strategies. First, tensions in the dual roles of inspector and researcher were managed through working with a theoretical framework. This created the possibility to interpret the data from a given distance and to shift perspectives; from the role of inspector to the role of researcher. Second, cooperative research was conducted with outside researchers. Data were

analyzed by three of the authors, two of them (Samantha Adams and Antoinette de Bont) being outside the partnership. Their lack of insider knowledge enabled the first author to question interpretations. Third, writing memos assisted in self-reflection, challenging taken-for-granted forms of understanding and following up surprises. Also, situations in which tensions in the dual roles of inspector and researcher were tangible were made explicit during conversations with the managing director of the partnership and the two outside researchers. This was also reflected on in the memos. Over the course of 20 months (June 2009–March 2011), the first author (Suzanne Rutz) observed and participated between 2 and 3 days a week (about 185 days total). At the time the observations started, the chief inspectors of the five participating inspectorates (steering committee) had already decided that poverty was on the inspection agenda of the partnership, but the subject was not yet explicitly defined. From that point forward, observations took place during all phases of the inspection. Suzanne Rutz was located at the office of the partnership and worked there in a room with other inspectors. She attended meetings of the inspection team, the team of people working for the partnership, program committee (which advises the steering committee), and steering committee. Also, she was present at informal meetings (such as at lunches, and at receptions). Observations not only took place at locations in the organization of the partnership, but also at various locations in the municipalities that were selected for inspection. The observations focused on important aspects of the theoretical framework; that is, how poverty was framed, whether and how complexity, uncertainty and ambiguity were addressed and how actors dealt with these situations. Field notes were taken of the situations in which aspects of the theoretical framework became visible and situations that came as a surprise to the authors (for example, the way policymakers of the municipalities tactically negotiated and interpreted their roles, as described in the findings below). Memos were produced to reflect on these situations.

If observations raised questions, Suzanne Rutz requested informal interviews, mostly with other members of the inspection team. The conversations were about their opinions of the partnership, how they perceived the partnership's work, about choices made during the inspection and how they perceived the behavior of the representatives of the organizations under inspection; professionals, policymakers and the elected members of the local governments. Also, informal conversations were started with people in the municipalities. However, Suzanne Rutz found that, in these situations, the role of inspector and the role of researcher were difficult to combine. In some instances, when she asked questions to gain information for her research, professionals and policymakers experienced these questions as if they had to justify their decisions to an inspector. In such situations, she did not ask follow-up questions, but gathered further information mainly through observations. Suzanne Rutz kept a record of the notes of

conversations and memos were written as a method of reflection.
During all phases of the inspection, documents produced by the inspection team were collected and studied: such as the inspection plan, reports on meetings, formal letters to municipalities and organizations, formats for inspection methods, evaluation framework and recommendations made. In addition, the information that the inspectors gathered in the four municipalities was analyzed. The analyses of documents and data focused on the decisions made during the inspection, how poverty was framed, whether and how uncertainty was addressed, which stakeholders were involved in which part of the inspection and also which stakeholders were not involved.
The data were analyzed iteratively in constant interaction with the theoretical framework. The theoretical framework and the analysis were also presented as a secondary check to inspectors of the partnership. Suzanne Rutz presented the theoretical framework in a meeting of the team of inspectors and asked whether they recognized issues for the partnership in the theory used; the analyses were also shown to the managing director of the partnership. Notes were taken of these conversations and these were included in the analysis. Original transcripts and texts were in Dutch. These were translated into English by Suzanne Rutz and verified by Samantha Adams (whose first language is English).

FINDINGS

We found that the inspectorates defined poverty as a risk problem for children. During the inspection of care for children under poverty conditions, the problem was reframed several times inside the inspectorates and in the municipalities that were selected for inspection. Complexity, uncertainty and ambiguity were continuously present, although not always taken into account in the framing of poverty. Inspectorates and the actors involved in the inspection dealt with this lack of certainty in various ways. On the one hand, complexity, uncertainty and ambiguity were tolerated when inspectors collected their data among a broad range of stakeholders; on the other hand, increasing effort has been made to hide the lack of certainty in order to create possibilities for evaluation and make specific recommendations for improvement.

How inspectorates created a complex and uncertain frame for poverty

The partnership's challenge was to contribute to remedies for social problems that needed the synchronized contribution of many separate sectors. To put a topic on their agenda, the partnership of inspectorates had to argue that the topic was a social problem that posed a risk to children's development and that joint efforts were necessary to remedy this risk problem. They needed to frame poverty as a serious social

problem that required an integrated answer, but in doing so, provided an entrance for complexity and uncertainty.
In the framing of poverty, the partnership emphasized the severity of the problem by stating that poverty in poor families was an accumulation of various problems with negative consequences for children's development. The team of inspectors acknowledged that it is often difficult to determine cause-effect relationships between these problems. As the team emphasized multi-causality, their definition of poverty reflected complexity:

> *'Poverty is a problem with multiple faces. Usually, it is not clear what are considered consequences and what are causes. A family living under the poverty line often has multiple problems. A low family income coincides for example with debts and health problems. This situation has very negative consequences for children, not only for their material environment, but also for their social, emotional, cognitive and physical development' (Project Plan JIY, internal document).*

Because the definition of the problem related to various aspects of a child's life, the inspectors considered poverty a problem that needed an integrated approach. Hence, by emphasizing the importance of an integrated approach towards poverty, uncertainty about effective interventions was created because knowledge about integrated interventions was lacking. This lack of knowledge became visible as the inspectors started their joint inspection with a short study of the literature on poverty that included prevalence, risk factors, consequences and effective interventions. The inspectors could only find information about single components for tackling the consequences of poverty for children, such as the tackling of health consequences and the prevention of eviction of children from their home. Little information was available about integrated interventions aimed at tackling the consequences of poverty as a whole. Moreover, the available studies also showed that knowledge was uncertain. The team of inspectors made this uncertainty explicit in their report of the literature study:

> *'Although successful initiatives exist, it is mostly unknown how negative consequences of poverty among children can be tackled' (Pre-study Report JIY, internal document).*

How municipalities introduced ambiguity into the inspectorate's frame
With the introduction of 'child poverty' as an issue in the municipalities, we observed that policymakers and elected members of the local governments started to discuss

the inspectors' framing of poverty. While the inspectorates stressed that poverty had negative consequences for children's development and needed an integrated answer, the local actors debated the prevalence and severity of poverty in their municipality. They used the ambiguities surrounding poverty to start a discussion on who was responsible for combating poverty.

We observed that the indicators used by the inspectors to select the four municipalities left room for ambiguity. Different actors interpreted the same information differently. While the inspectors showed the representatives of municipalities that the risk of growing up under poverty conditions in their town was higher than the national average, two representatives pointed to other municipalities in which this risk was even higher and used this data to minimize the significance of the issue in their town. There was also some marginalization of the issue of poverty with arguments that the consequences of growing up poor for children were not that serious. One policymaker stated that: '*Being poor in this town only means that children are not able to buy the latest mobile phone. Real poverty does not exist here*'.

The integrated element of the inspectorate's frame of poverty generated ambiguity. The local policymakers and members of the local governments tried to reframe poverty by emphasizing the link between poverty and one specific sector or issue. For example, they argued that poverty was mainly a problem of unemployment or a problem related to social exclusion. By emphasizing the importance of one sector, they were also arguing that poverty was not an important issue in their own sector which reduced their responsibility for the issue. For instance, in one of the municipalities, one of the inspectors spoke to a policymaker from the division 'work and income'. Although this policymaker considered combating poverty to be a part of his portfolio and accepted that poverty had important negative consequences for children, he stated that he was not an expert on children. He therefore referred the inspector to his colleague who was specialized in youth policy. When the inspector met this policymaker, she then referred to a policymaker in the education division who had expertise in high school dropout.

What we observed as tactical negotiation and interpretation of roles and reluctance to carry responsibility has been described by Van Asselt and Vos (2008) as one of the mechanisms of dealing with uncertainty that is strongly linked to uncertainty intolerance. To define away complexity, uncertainty and ambiguity, boundary work is being done to interpret one's role in the most formal sense and as minimal as possible, thus transferring responsibility to those who have greater expertise. These negotiations also point to what Van Asselt and Vos (2008) referred to as technocratic handling. By taking decisions in a technocratic manner and precisely following regulations on who can decide what, broader discussion is avoided about the (uncertain and ambiguous) content of the decisions that must be taken.

The team of inspectors did not reframe the subject after the discussions with the

policymakers and members of the local governments. In reaction to the policymakers, interpreting their roles formally and as minutely as possible, the inspectors responded in a technocratic way and used their regulatory powers; they emphasized legal obligations of local municipalities and used the threat of 'naming and shaming'. Eventually, the representatives of the selected municipalities decided to cooperate in the inspection.

Dealing with complexity, uncertainty and ambiguity through involving stakeholders

After the local governments decided to cooperate in the inspection, the team of inspectors temporarily abandoned the standard regulatory procedures and technocratic handling.

They used their broad and integrated frame of poverty to involve not only services that are traditionally inspected, but also other stakeholders who were able to contribute to tackling poverty. The inspectors tolerated the complexity, uncertainty and ambiguity attached to the inspectorate's frame for poverty. They created a 'participatory discourse' (Renn 2008) and acknowledged the manifold viewpoints, beliefs and values related to poverty, essential for dealing with complexity, uncertainty and ambiguity (Renn 2004; Van Asselt & Renn 2011).

In each of the four municipalities, the inspectors initiated a dialogue with children and their parents who were living below the poverty line. In focus groups and individual interviews they asked what these children and their parents considered to be poverty, how they experienced their situation, whether they had been able to access help and what the necessary improvements were from their point of view. The inspectors also studied case files and conducted a vignette study. Then, the inspectors invited various stakeholders (including service providers, special interest groups, representatives of volunteer organizations) to an open meeting. Two meetings were arranged per locality: one with professionals and service workers or volunteers and another with managers, policymakers and elected members of the local governments. In these meetings, every participant was given the opportunity to discuss aspects of the subject and give input on options for improvement. Participants were encouraged to recognize each other's difficulties in supporting children living under poverty conditions. The participants developed options for improvements, but these options generated ambiguity as they covered a wide range of approaches, from concentrating efforts on parents and children who wanted help to trying to reach all target families and persuading those who did not want help that they needed it.

In complex, uncertain and ambiguous situations, the inclusion of experiences and knowledge of different kinds of stakeholders is important to create an overall picture of the options, interpretations and potential actions (Renn 2004; Van Asselt & Renn

2011). The involvement of all these stakeholders gave the inspectors access to a diverse range of experiences, opinions and advices. However, some of the stakeholders were reluctant to participate, for example, suggesting they did not give priority to the subject of poverty or did not have time to participate. This posed a dilemma for the inspectorates because a reluctance to contribute conflicted with the basis of their usual regulatory stance that participants had a duty to fully participate in inspections. Not only did the inspectors experience this as a dilemma, but professionals and policymakers also pointed to the duty to participate. One policymaker articulated this issue in the following way in an email to the inspectors:

> *'One of the organizations does not want to give you access to the files of clients. What about your authority? I thought you are from an inspectorate and according to that you have the right to access client files, don't you?'*

Inspectors experienced difficulties in these situations. On the one hand, they knew that voluntary cooperation was important. On the other hand, the team was afraid to set up a precedent by allowing individuals and organizations a choice about whether they cooperated with an inspection. They decided (once more) to fall back on their regulatory powers and insisted that all professionals participated. For instance, the inspectors threatened a youth and family center that initially refused to participate that the center would be inspected using the powers and within the framework of a sector-specific inspection. This approach had limited success; the center did provide access to client files but did not send a representative to the open meeting, and as a result the inspectors did not have access to this center's opinions, experiences and advice on poverty.

How inspectors minimized uncertainty to evaluate and make recommendations

At the start of their inspection, the team framed poverty as a serious social problem that required an integrated answer. With this definition, they also identified lack of evidence and clarity over the causes and consequences of poverty and how to deal with it. Through involving all kinds of stakeholders, they created an overview of all aspects of poverty; causes, consequences and possible options for improvement. Although the inspectors stuck to their initial frame for poverty, they also created another frame related to the quality of cooperation between organizations providing services to poor children in the final part of the inspection process. The inspectors did this by using their standard operating procedure; they evaluated the information that was collected using a framework that focused on quality of cooperation between services. This framework has been developed and used for all previous joint inspections. The framework consisted of eight issues related to cooperation. Yet, the inspectors decided

to combine some of these aspects and developed three subjects that they considered relevant for tackling poverty:

> *'A good collaboration requires a minimum of eight quality criteria developed by the partnership of inspectorates. The partnership uses these quality criteria as a guide for judging the collected data. During the inspection the team may elaborate on and weigh these criteria. In this inspection, the aspects of quality were combined and clustered into three subjects:*
> - *degree of tailoring of services to the needs of children;*
> - *participation and coverage rates of services;*
> - *consistency of activities.'*
>
> *(Inspection Report; ISYA 2010)*

By using the framework, poverty was put in a general frame of cooperation, asserting (and pointing to certainty) that cooperation between organizations was of crucial importance in tackling the consequences of poverty for children. Moreover, the focus of the subject was narrowed to three aspects of care for poor children. By creating this frame, the inspectors shifted the focus of their inspection in two ways. They shifted from tackling the consequences of poverty for children to services for poor children. They also shifted from considering tackling poverty as a whole to tackling three process issues of services for poor children. Other aspects of tackling the consequences of poverty for children, which the inspectors collected during the participation process, were no longer considered. Although the inspectors also used their original frame for poverty in their report, for instance in the introduction of the subject, the new frame was prominently used in their evaluation of the care for poor children. The inspectors also limited their recommendations to the three process issues. This new frame simplified the subject of the inspection and created possibilities for evaluating the services for poor children. The new frame also helped to create certainty about concrete actions for improvement. This was encouraged by the chief inspectors of the participating inspectorates; they encouraged the inspectors to provide specific and concrete instructions and emphasized that inspectorates should urge the local organizations to take action. We also saw that the need to put forward certain recommendations not only arose inside the partnership of inspectorates but also arose from stakeholders in the municipalities. For example, at the end of an open meeting in one of the municipalities a professional said that although he considered the meeting very important, he often experienced that these meetings did not result in actual improvements for poor children. With a sense of urgency to find new ways to improve the life of children, he asked:

> *'We have had a nice conversation, but I wonder what will happen next. Often conversations don't change situations. Will you be able to tell us concretely what we should improve?'*

In inspectors' recommendations, complexity, uncertainty and ambiguity were not addressed. Rather, the recommendations pointed to certainty and implied common consent about the process issues of services for poor children and their solutions. However, elements of complexity and ambiguity were still present. Professionals and policymakers initiated discussions about the recommendations and asked questions concerning knowledge, for example, about causality and expected effects. Moreover, the values underlying the recommendations were contested. For example, a recommendation on coverage, looking for possibilities to reach families not known to services yet, led to a discussion about paternalism. While the inspectors emphasized that organizations should make extra efforts to reach all poor families, a policymaker asked:

> *'If people don't want to be found by professionals and do not want to use the services and help meant for them, should we oblige them accept our help?'*

Other recommendations were also debated. Hence, the efforts to simplify the subject of the inspection (by focusing on three issues related to services for poor children and making specific and concrete recommendations on these three issues) did not remove complexity, uncertainty and ambiguity.

How the creation of certainty reduced the involvement of stakeholders

Although the inspectors collected a broad range of information on the options, interpretations and potential actions, and involved various stakeholders, their reports focused primarily on actions which local authorities should take, given their legal duty to initiate activities related to poverty. Municipalities used the inspectorates' recommendations to make local action plans. However, the options articulated by the youngsters, parents, professionals and managers were largely disregarded.

In their report, the inspectors aimed to make municipalities responsible for initiating actions for improvement. The inspectors stated for instance:

> *'The partnership of inspectorates asks municipal representatives to take the initiative and begin working with youngsters, parents, professionals and other stakeholders to concretize and implement recommendations'. (Inspection Report; ISYA 2010)*

The policymakers and the elected members of the local governments mainly concentrated on the inspectorates' recommendations and used these recommendations (which implied certainty about the problem and its solutions) for the development of municipal action plans. For example, the inspectorates' recommendations were repeated in the action plans and each recommendation was followed by the aims and activities the local authorities planned to undertake. In using the recommendations, the complexity, uncertainty and ambiguity of the subject was not an issue. Rather, policymakers and elected members of the local governments interpreted the recommendations in a technocratic manner. They considered the recommendations to be a package of measures that should be implemented to meet the requirements of the inspectorates. One of the policymakers said:

> *'We have to cut back in costs and our elected member of the local government wants to know which recommendations are essential. Can you tell us which of them are needed to realize sufficient results?'*

The policymakers and the elected members of the local governments also tried to avoid implementing some of the recommendations by reconstructing them and making them fit into the existing policies. For example, in one municipality, what the team of inspectors judged as inconsistency of activities was redefined to a lack of coordinated care that could be solved by introducing a register of children, an electronic database to enable professionals to communicate their concerns about children.[3] A proposal for such a database had already been made in youth policy documents. In this technocratic manner of handling the recommendations, the other options for improvement mentioned by youngsters, parents, professionals and managers were excluded from the agenda.

DISCUSSION

In this article, we have explored how inspectors combined a focus on a social problem with the need for a strong regulatory role. Our analysis indicates that, as with many social problems, poverty among children is associated with complexity, uncertainty and ambiguity. The inspectors wavered between accepting complexity, uncertainty and ambiguity and minimizing the lack of certainty. On the one hand, complexity, uncertainty and ambiguity were tolerated when inspectors collected their data from a broad range

3 This register of children is similar to the Child Index that is being used in the UK.

of stakeholders in participation processes, on the other hand the inspectorates made simplifications that minimized the lack of certainty in order to create possibilities for evaluation and make specific recommendations for improvement. Although both strategies – accepting and minimizing uncertainty – were present, our analysis shows that in the regulatory context minimizing uncertainty is prominent. The simplifications, however, did not result in a full reduction of complexity, uncertainty and ambiguity as actors continuously debated the recommendations and negotiated their roles. We will elaborate on this in more detail below.

Initially, the inspectors framed poverty as a multi-faceted risk problem for children that required an integrated answer. They emphasized the complexity and uncertainty of poverty by focusing on multi-causality and the lack of knowledge about interventions that aim to tackle the consequences of poverty as a whole. Ambiguity became prominent in the debates with representatives of local governments on the prevalence and the severity of poverty among children and their responsibilities for the subject. The inspectorates organized participative processes to involve various stakeholders and to collect a diverse range of experiences, opinions and ideas. These processes generated a variety of options for improvement. Yet, in these processes inspectors also faced dilemmas because participation by choice conflicts with a strong inspection role. Additionally, inspectors made increasing efforts to simplify, which obscured the lack of certainty; inspectors created a frame of three process problems related to providing services to poor children which could be tackled by implementing recommendations. The inspectors relegated the stakeholders involved in the participation processes – including poor children and their parents – to the background. Consequently, little benefit was derived from the participation process. The inspectors also diverted attention from their initial consideration that poverty should be tackled as a whole. At the same time, inspectors foregrounded the need for local governments to make improvements. The more poverty was simplified, the less participation of organizations, parents and youngsters was needed, because problems were specifically defined, solutions were connected to responsibilities and responsibilities were formally allocated.

We observed how the partnership of inspectorates not only dealt with uncertainty through involving stakeholders, but also through making simplifications. During one inspection, both ways of dealing with a lack of certainty came together. Yet, within the regulatory context where inspectorates operate, the invisible risk infrastructures (Beck & Kropp 2011) are based on simplification; inspectors need to provide quick and simple solutions. In this regulatory context, the partnership created certainty in order to define criteria and to evaluate (Bundred 2006; Perryman 2006). Moreover, other actors expected inspectors to convey certainty. As one of the professionals put it, inspectors are supposed to *'tell [us] concretely what we should improve'*. In the regulatory context, certainty was also necessary for inspectorates to make a strong

claim for action (Hooker et al. 2009) because inspectors' judgments needed to ensure that organizations took action and made improvements.
However, tension arose between simplifying on the one hand and tolerating uncertainty on the other (Law & Mol 2002). The lack of certainty was continuously present in the background. The local governments were reluctant to bear responsibility for this complexity, uncertainty and ambiguity. We observed defensive strategies, which Power calls 'responsibility aversity' (2004), for example as representatives of local governments tactically interpreted and negotiated their own role as minimally as possible by emphasizing the contribution of other sectors. These interpretations can be considered another simplification; however, in the interaction between the simplification of the inspectorates and the simplifications of the local governments, ambiguity rose again.

CONCLUSION

Our analysis of the joint inspection on the care for children living under poverty conditions contributes to a deeper understanding of how inspectorates deal with complexity, uncertainty and ambiguity as well as their motives for simplifying risk problems. Our analysis shows that hiding complexity, uncertainty and ambiguity is closely intertwined with the regulatory context of inspectorates. The involvement of children, parents and a variety of other stakeholders is essential in dealing with complexity, uncertainty and ambiguity (Renn 2004; Van Asselt & Renn 2011). However, in the regulatory context, persisting with such participation processes is not self-evident. For inspectorates, the notion of including other stakeholders alone is inadequate for dealing with complexity, uncertainty and ambiguity. Hence, there is a need for alternative methods and approaches. Although the development of alternative methods challenges the current viewpoint that inspectorates must be rigid, it is an important issue to address. Inspectorates will continuously be challenged to broaden their view and contribute to preventing incidents, minimizing risks and tackling social problems. They are part of the 'myth of controllability' (Power 2004); in the regulatory context, it is assumed that social problems can be tamed and managed and tragedies can be prevented. The simplifications that the inspectorates make, contribute to this myth. However, social problems concerning children are stubborn and difficult to resolve. Hence, that the inspectorates do not realize certainty is not remarkable.

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3

Inspectors' responses to adolescents' assessment of quality care

A case study on involving adolescents in inspections

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BACKGROUND

The ideal of active citizenship has gained ground in many Western countries (Clarke et al. 2007; Trappenburg 2009; Hurenkamp et al. 2011; Van de Bovenkamp 2010; Da Roit & De Klerk; 2014). One way people can exercise active citizenship in health and social care is to voice their preferences and experiential expertise so that services can be improved (Clarke et al. 2007; Renedo & Marston 2011). With this aim, service users are increasingly invited to participate in decision-making processes on quality improvement, medical guideline development, government policymaking and inspections (Clarke et al. 2007; Bate & Robert 2007; Van de Bovenkamp 2010; Boivin 2012; Adams et al. 2013; Amstrong et al. 2013; Teunissen et al. 2013; Van de Bovenkamp & Zuiderent-Jerak 2013).

Despite its ideological appeal, research shows that involving service users is not easy to realize (Scourfield 2010; Van de Bovenkamp 2010; Adams et al. 2013; Teunissen et al. 2013; Van de Bovenkamp & Zuiderent-Jerak 2013). In the literature, difficulties are ascribed either to the service users who participate or the organizations that invite their users to participate. Studies show that participants are often no 'ordinary' service users (Boivin 2012). They need specific skills and knowledge to participate successfully. Training service users to gain the skills and knowledge to wield influence is often brought up as a solution to foster their involvement (Van de Bovenkamp 2010; Boivin 2012; Renedo & Marston 2015). While professionalization processes enable participation, they relegate service users' experiential expertise to the background, consequently triggering discussions about participant representativeness (Trappenburg 2009; Van de Bovenkamp 2010; Van de Bovenkamp & Zuiderent-Jerak 2013; Renedo & Marston 2015; Schillemans et al. 2016). On the side of organizations involving participants, the way that participation is arranged and the space provided for users' input are regarded as barriers or resources for participation. Formal rules and bureaucratic routines in decision-making processes can, for instance, pose a challenge for participants, whereas a non-hierarchical organizational culture can be a resource for successful involvement (Renedo & Marston 2011; Boivin 2012; Van de Bovenkamp & Zuiderent-Jerak 2013; Renedo & Marston 2015).

The rationale for service users' involvement is based on the assumption that they have a distinct perspective which offers new options to improve the quality of services and strengthens decision-making (Bate & Robert 2007; Teunissen et al. 2013; Pols 2014; Adams et al. 2015). Consequently, the users' perspective may conflict with organizational rules and conventions, and professional or societal standards such as safety and cost containment (Boivin 2012; Van de Bovenkamp & Zuiderent-Jerak 2013; Dwarswaard & Van de Bovenkamp 2015). Hence, the key questions are whether such conflicts are addressed and, if so, how they are dealt with.

In this paper, we aim to advance our understanding of service user involvement in practice by taking the last issue as a starting point. We focus on service user involvement in one inspectorates' assessment of quality of care. Inspectorates are expected to exercise control over care quality and protect vulnerable people from harm (OECD 2014). In many countries, user involvement is high on the inspectorate agenda (Adams et al. 2013; OECD 2014; Shribman 2014; Adams et al. 2015; Bouwman et al. 2015; IRGC 2015). In their regulatory work inspectors include all kinds of service users as lay inspectors, 'mystery guests' (Adams et al. 2015), through consultation or via analysis of social media (Van de Belt et al. 2015) and complaints (Bouwman et al. 2015). Although various forms of service user involvement in inspections have been studied (Duffy 2008; Scourfield 2010; Adams et al. 2013; Iacobucci 2014; Adams et al. 2015; Bouwman et al. 2015; Van de Belt et al. 2015), how inspectors use the perspective of services users and their input is underexplored.

We analyze how inspectors from the Joint Inspectorate for Youth (JIY) involved the perspectives of young care users in an inspection of a broad range of social and health care services that provide help for children growing up poor in the Netherlands. The following questions guide our paper: *What do adolescents who have received care consider to be good care and how do their views compare to the assessment criteria inspectors use to evaluate care? How do inspectors deal with the similarities and differences to their own views and what can explain the inspectors' ways of dealing?*

The next section describes the setting of the study and the methods used to answer the research questions. Our comparative analysis of adolescents' views and the inspection criteria is at the heart of the paper. Finally, we discuss our findings, explain the inspectors' ways of dealing with similarities and differences and relate these to difficulties described above in connection with participants and organizational contexts.

METHODS

Setting of the study

The JIY is a partnership of five government inspectorates in the Netherlands: the Health Care Inspectorate, Inspectorate of Education, Inspectorate for Youth Care, Inspectorate for Safety and Justice, and Inspectorate of Social Affairs and Employment. Since its foundation in 2003, the JIY has included adolescents in inspections. Adolescents come along on inspections in the role of lay inspectors (Adams et al. 2013; ISYA 2013), and inspectors hold consultative meetings with adolescents (including an interactive voting system), interviews and focus groups. JIY inspections are mainly theme-based and concentrate on public problems that cannot be solved by one organization or sector.

Hence, inspections follow a multi-agency approach, including a broad range of local services through all sectors, such as health, youth care, education, police, and social affairs (ISYA 2009). Examples of public problems subjected to thematic inspections are: child abuse, obesity, youth offending, addiction and poverty. In this study, we focus on the latter.

Regulatory work is considered to contain three main activities: 1) collecting information about the service under scrutiny, 2) assessing whether the service complies with a set of assessment criteria, and 3) taking enforcement action for non-compliance to meet the criteria and make improvements (Hood 1999; Bundred 2006; Perryman 2006; Nutley et al. 2012). Service users are increasingly included in information gathering (activity 1); the assumption is that they can provide useful signals and quality information, which may improve inspectors' assessments (Bouwman et al. 2015; Adams et al. 2013). During the assessment (activity 2), inspectors evaluate whether the services under scrutiny ensure their users' involvement as part of providing good care. This way, user involvement by services becomes part of the inspectors' assessment criteria. In enforcement (activity 3), although inspectors consider the consequences of non-compliance by services for clients and patients (Ayres & Braithwaite 1992; Rutz et al. 2015), the perspective of service users is often relatively implicit.

Study design

We used a single-case study design (Stake 1994), selecting a case of thematic inspection of care for children growing up poor. Poverty is an ambiguous public problem. What the problem means for those affected, whether action should be taken and if so what action, is controversial (Renn 2008). This ambiguous subject is an excellent case to study how divergent viewpoints are dealt with, as adolescents living in impoverished conditions may have other views on good care than inspectors, and thus give information that does not fit the inspectors' assessment criteria.

During the inspection, the JIY included adolescents living in poverty through interviews and focus groups. The adolescents that participated all had vast experience of receiving care and assistance from various professionals, such as social workers, psychologists, youth community workers, pedagogues, and youth care workers. Box 3.1 describes how inspectors recruited the adolescents and conducted the interviews and focus groups.

In terms of inspection, the case can be considered typical as it is conducted like any other inspection, following the three main activities of information gathering, assessment and enforcement action.

Box 3.1 *The involvement of adolescents in the inspection on care for children living in poverty*

In the inspection of care for children living in poverty, the inspectors held interviews and organized focus groups with young people in four municipalities.[4] *The inspectors were assisted by Stichting Alexander, a foundation specializing in youth involvement. Inspectors and workers from Stichting Alexander identified the organizations and stakeholders (eg, food banks, charities, youth workers and social workers) involved in services for poor families in the four municipalities concerned. They asked stakeholders to invite young people to take part in an interview or focus group. Some young people were contacted through their parents as parents were also invited to interviews and focus groups. The interviewers informed the youngsters about the goal of the inspection and the interview or focus group. If they understood and agreed to the conditions, the respondents signed an informed consent form.*

In practice, many young people were recruited by youth workers and the interview panels took place at community centres and youth clubs in poor neighbourhoods, where young men are better represented than young women (this is possibly why few young women took part in the inspection). The adolescents who did participate varied in other characteristics (eg, age and ethnicity; see Table 3.1).

The interviews and focus groups were conducted following a semi-structured format. Topics included: what young people considered poverty, how they experienced their situation, whether they had received care and assistance, how they experienced this and what they considered to be necessary improvements for young people living in poverty. The interviews and focus groups were tape recorded and transcribed verbatim. The inspectors analyzed the reports of the interviews and discussed their analysis in an assessment meeting, where the information gathered via other inspection methods was also discussed.

Data collection

We used multiple methods to study our case. Our data consisted of material created and used by inspectors during information gathering and assessment of the inspection (in total 68 documents) and a meeting with inspectors.

First, we collected the documents that inspectors prepared for the inspection to

4 The municipalities concerned were Capelle aan den IJssel, Groningen, Schiedam and Zoetermeer. This paper indicates the municipalities with C, G, S and Z respectively.

gain insight into the context and their decisions on methods and procedures. This material included the inspection plan, the set-up for interviews and focus groups with adolescents, the information given to them, minutes of the inspectors' meetings, and inspection formats.

Second, we collected documents containing the information that the adolescents, who grew up poor, gave to inspectors during information collection. This consisted of verbatim transcripts of the two interviews and ten focus groups the inspectors held and the inspectors' notes that included their reflections on the interviews and focus groups (see also box 3.1).

Third, we collected documents that inspectors created for their assessments and to communicate their decisions, material on the inspection framework and assessment criteria, evaluation reports of the information obtained from adolescents, and the inspectors' reports that communicated the judgments.

Fourth, we held a meeting at the JIY to discuss the preliminary findings and explanations of our findings. The minutes of the meeting were added to the data collection.

Table 3.1 *Demographic information on the respondents*

Method	Interviews (n=2) Focus groups (n=10)
Number of respondents	43
Gender	Male (n=37) Female (n=5)
Age	10 (n=1) 11 (n=2) 12 (n=2) 13 (n=4) 14 (n=6) 15 (n=6) 16 (n=7) 17 (n=9) 18 (n=4) 19 (n=1)
Ethnicity	Dutch (n=9) Moroccan (n=9) Antillean (n=6) Roma (n=3) Surinam (n=1) Afghan (n=1) Iran (n=1) Unknown (n=12)

Data analysis

Our analysis focused on what the adolescents regarded as good care. Interview and focus group transcripts were read closely several times and coded inductively, locating recurrent subthemes and grouping subthemes together in themes (Strauss & Corbin 1994). We identified the following themes on quality of care: 1) trustworthiness and loyalty of professionals (eg, respectful relationship), 2) adolescents' influence in the care process (eg, deciding when to ask for help), 3) use of information on adolescents' situations (eg, privacy), 4) results of the care for adolescents (eg, offering practical solutions and timeliness), 5) creating opportunities for personal development (eg, finding a suitable internship, job or education). Ongoing analysis refined the specifics of each theme. Next, we analyzed the documents that inspectors produced during their inspection and compared the content with the five themes identified, based on the adolescents' information. In this comparison, we found three striking similarities and three fundamental differences. We analyzed how inspectors dealt with the similarities and the differences and tried to explain their ways of dealing.

We had access to this data since the first author is also a JIY inspector. A disadvantage of this dual role is that it raises the issue of methodological distance. We managed this potential tension in two ways (Alvesson 2009). First, three authors analyzed the data. Two were outsiders to a regulatory context, which enabled the research team to question each other's interpretations, stimulate self-reflection and challenge locally situated taken-for-granted notions. Secondly, we presented and discussed our preliminary findings at two conferences for researchers and a conference for inspectors of various Dutch inspectorates (excluding the JIY). These meetings helped us to enhance the reliability and validity of the analysis. Although both audiences recognized our findings, they held very different views on the implications. These different views helped us to look more thoroughly into the specifics of the regulatory context in order to find explanations in this context and to come up with suggestions for improvement.

Ethical considerations

The adolescents (and their parents when the adolescent was younger than 16) all gave the inspectors their informed consent to participate, with anonymity guaranteed. Consequently, we use pseudonyms for respondents' names. According to the Dutch act on 'Medical Research involving Human Subjects', this type of research does not require the consent of an ethics committee as our study did not involve a medical intervention (VWS 1998).

RESULTS

This section first describes the similarities between the views of adolescents and inspectors. Then it describes the differences that led to tensions in the inspection process and the ways the inspectors dealt with these tensions.

Similarities: timeliness, creating opportunities for adolescents to develop and a respectful relationship

We found three similarities in views. The first concerns timeliness of the care. The adolescents' views on receiving care were rather negative; they voiced many complaints about the time it took to get results. Chantal for instance remarking on the care she received, said '*It all takes way too long'* (G2). Ahmed, who does not go to school, agreed:

> *Ahmed: 'It all goes way too slow for me. I've told them I want to go back to school, but they don't do a thing'.*
>
> *Interviewer: 'So, are they looking for a new school for you? […]'*
>
> *Ahmed: 'Yes, they said that they'd arrange it within six weeks, but that was eight weeks ago' (S5).*

For the inspectors as well, arranging services in a timely manner was important. In fact, it was one of their assessment criteria (criterion 4, Table 3.2). The second similarity concerned the perceived need to stimulate young people's participation in society. Adolescents, like Ahmed, placed great value on schooling and stressed that they wanted professional help to find a suitable internship, job or education; another assessment criterion (criterion 5, Table 3.2). The third similarity was that both adolescents and inspectors valued a respectful relationship between the young person and care professional; stimulating this was also an inspection criterion (criterion 1, Table 3.2). For adolescents, a respectful relationship meant trust. It indicated that their views were taken seriously, that professionals kept their promises, did not discriminate, and showed respect for the adolescent's choices even if they did not agree with them. For instance, commenting on his relations with professionals, Mateo said:

> *'We should be treated with a bit of respect. If professionals forbid everything and say 'the way you do things is bad, and how I do them is good', then they offend people'. (S1)*

Table 3.2 *The inspection framework to assess the quality of services for poor children and their families*

Category	Inspection criteria
Tailoring services to young people's needs	Organizations make sure their services fit the wishes and abilities of young people and their families and encourage forming good relationships
	Professionals jointly analyze the situation of young people and their families and all the conditions that affect their lives, including underlying problems and causes
	Services are tailored to the problems of young people and their families, and are aimed at preventing or solving the problems and underlying causes
	Tailored services are arranged quickly
Participation and coverage rates of services	Professionals stimulate the active participation of young people and their families in society
	Obstacles to receiving the services they need are removed for young people and their families
	Organizations know which target groups do not use the services and reach out to these groups
Consistency of activities	Professional activities are aligned with organizational strategy
	Various partners cooperate to achieve their goals efficiently. Their services are aligned and coordinated by one of the professionals
	Professionals collect, record and exchange necessary information about a young person or family

When adolescents and inspectors held similar views, inspectors used the information gained from adolescents to support their findings. They quoted adolescents in their reports to illustrate their conclusions. For instance, one report quoted Mateo and went on to state:

> *'Young people emphasize that a good relationship is fundamental to providing good care. An important part of a good relationship is that a professional shows respect for a young person.' (ISYA 2010)*

In the meeting with inspectors, the inspectors explained that illustrative quotes are important as they call on the services under scrutiny. For the service providers, it conveyed a sense of urgency to act when their 'own' users talked about how issues in the care affected them (Vennik et al. 2016). In the assessment of the inspection, such quotes and examples of adolescents' situations helped inspectors to convince the service providers of the value of the inspectors' judgments and the action needed to make improvements.

Differences: sharing information, creating solutions and the moment to offer help and assistance

We found three differences in views that led to tensions in the inspection process.

Tension 1: Privacy versus sharing information

While inspectors and adolescents both found a respectful relationship with professionals an important aspect of good care, their perspective on what a respectful relationship entailed differed in key aspects. This led to the first tension we identify here. According to adolescents, an important element of a trustworthy relationship was that professionals did not share information freely with others. On the other hand, inspectors emphasized that professionals should exchange information.

For adolescents it was crucial to control who obtained specific information about their situation. Professionals who shared information with other professionals, without asking permission, lost their trust. The adolescents explained that they put new professionals to the test and would not give confidential information on first contact. Daniel, for instance, described what he did when he discovered that his social worker had discussed his situation with one of his teachers:

> *Daniel: 'If I'd told her everything, she would've told my mentor and he would've talked about it all to the team leader, and then everything would have gone round. [...]'*
>
> *Interviewer: 'So what did you do then?'*
>
> *Daniel: 'Yeah, well fuck her, you know. She tries to make new appointments, but I don't bother showing up now I know I can't trust her. [...]'*
>
> *Winston: 'I wouldn't have talked to her in the first place'.*
>
> *Gabriel: 'I'd rather go to my parents if I'm in trouble'. (C1)*

Sharing information without asking the adolescent's permission resulted in distrust and avoidance of professionals. Yet, inspectors felt that professionals needed a complete understanding of adolescents' situation to provide good services. Inspectors reasoned that to gain a complete understanding professionals needed to collect and exchange information about the young person's situation to tackle the causes and intervene as early as possible (criteria 2 and 10, Table 3.2; see also tension 2). Inspectors dealt with the tension of respecting privacy and sharing information by subordinating adolescents' views and emphasizing that professionals needed to share information. One of their reports stated:

> *'Although young people cherish their privacy, exchanging information is important for early intervention. It would be important to discuss this problem with young people to find out what solutions they can offer.' (ISYA 2011a)*

In the meeting, inspectors explained that they had important reasons for prioritizing their view. They felt these adolescents were members of a vulnerable group that lacked the ability to protect themselves and needed protection. Although they acknowledged what the adolescents thought, they gave their own view more weight. According to the inspectors, professionals needed to share information to identify situations in which vulnerable young people needed care and to enable interventions as early as possible. Inspectors reasoned that providing help early, before young people needed it urgently, stopped problems from exacerbating (see criteria 3 and 7, Table 3.2).
However, as Daniel's quote illustrated, adolescents stated that they distrusted professionals who shared information, and consequently would not provide new information. Sharing information was then counterproductive to gaining a complete view of the adolescents' lives. Yet, the inspectors felt that sharing information about an adolescent would not automatically result in distrust between adolescents and professionals. As stated in the quote above, the inspectors found it '*important to discuss this problem with young people to find out what solutions they can offer*'. During the meeting inspectors pointed to professionals to start this dialogue. They explained that exchanging information was key and that they expected professionals to be able to maintain a trustful relationship with adolescents and share information at the same time. This signified another way of dealing with this tension, namely: passing the dilemma on to others. Inspectors did not ease the tension themselves, but asked others to do it for them.

Tension 2: Finding solutions versus finding hidden problems
The second tension was that adolescents felt that professionals needed to focus on actively finding practical solutions for the problems they presented, while inspectors

wanted professionals to look for causes and hidden problems, which adolescents associated with simply talking about problems, and not with solving them. For instance Mehmet remarked: '*Everything they tell you, you can also tell yourself' (S4)*. Adolescents did not want to talk about causes, things that had happened in the past or other problems:

> *Romario: 'Professionals just talk in circles. I don't want people to talk to me so much. Sometimes I think they only talk about everything that happened to you in the past. And why you can't change'. (C2)*

According to the adolescents, talking was only effective when communication was part of the problem. For instance, Dave was very positive about a psychologist who mainly talked to help members of his family improve their communication: '*And as a result, now we all communicate smoothly [in our family].' (G1).* Adolescents expected professionals to produce tangible results, offering practical solutions to the problems they wanted to solve, not necessarily all of their problems (including underlying causes). The problems could be about communication but also about other issues; they expected professionals to help them clear their debts, for instance or (as in the Ahmed case above) make arrangements so that they could get an education tailored to their wants and needs. Though the inspectors agreed on the importance of obtaining results (see also subsection on similarities), such as adolescents going back to school, they assumed that it was necessary to talk about the problem first, instead of focusing immediately on solutions. According to their assessment criteria, inspectors thought that professionals should jointly analyze a problem and reach consensus on its importance and causes to find the appropriate solutions (see criteria 2 and 3, Table 3.2). According to the inspectors, the fact that professionals did not conduct such an analysis was an important obstacle to the provision of good care. The inspectors' report described this as follows:

> *'The care often starts late, after problems have become severe. Only short-term help is provided to tackle the problems, and professionals fail to deal with the causes. Among other reasons, this is because professionals do not analyze the whole problem in context when the care process starts. They often lack vital information on the family situation. Because they do not deal with the causes, there is a high chance that severe problems will recur' (ISYA 2011b).*

The inspectors assumed that without problem analysis, the help provided would not address the underlying causes, which would lead to a recurrence of the problem. This matched the assumption that stopping problems from getting worse was important, as

we explained above. Although adolescents and inspectors both found quick results for young people important, they differed in the method of obtaining results; inspectors take the problem as the starting point, not the possible solutions.
Inspectors dealt with the tension of finding rapid solutions versus first identifying hidden problems by describing the adolescents' views and their own differing viewpoints in separate sections of the inspection reports. All inspection reports contained a chapter entitled 'Living in poverty', which described the perspective of adolescents in poverty, the consequences of growing up poor and the care required in this situation. In a subsection of the chapter entitled 'Tailoring services to young people's needs' the inspectors reported the adolescents' views. For example: *'Young people and their parents expect the care process to start quickly, and, that the care is concrete and practical from the start. From their perspective, only talking does not help.'* (ISYA 2011c). Another subsection of the same chapter, reflecting on the inspectors' perspective, reported that professionals needed to analyze underlying causes and hidden problems. In other words, the tension was rendered invisible by separating the conflicting perspectives in different parts of the report.

Tension 3: Care for urgent matters versus early intervention
The third tension was that adolescents only seek help when they cannot solve the problem by themselves or with their families, whereas for inspectors it was important that professionals reached out to young people and solved problems at an early stage. Above, in Daniel, Winston and Gabriel's discussion on respecting privacy, the boys agreed that they preferred to solve problems on their own or with relatives, rather than contacting a professional. Asking for help was a big step for them, which they did only for urgent matters that they really could not resolve. However, from the inspectors' view of prevention, it was important that professionals reached out to adolescents and families while the problems were still small:

> *'Professionals [do not view] various groups of people as potential clients. For instance, this applies to the working poor and to people with relatively small problems. Care and assistance are offered to these groups less often. For example, professionals are less inclined to offer families with small debts (below 9,000 euro) help than families with larger debts. However, these groups are vulnerable because a small adversity may trigger the development of severe problems. Therefore, from the viewpoint of prevention, help for the group with small problems is essential'. (ISYA 2011b)*

According to inspectors the group with small problems had special needs and was eligible for early intervention. Similar to the first tension about respecting privacy and sharing information, inspectors dealt with this third tension by giving their own view more weight. Inspectors attributed adolescents asking for help only for urgent matters to the bad experiences that many of these adolescents had had with care, which set up a negative cycle of aversion to contacting a caregiver again. They felt that adolescents would be more positive about early intervention if they had had more positive experiences in receiving care. Moreover, for inspectors the fact that young people were vulnerable was an important argument for preventive and early intervention, and an argument against waiting for them to help themselves.

DISCUSSION

In this paper, we analyzed how inspectors include the perspectives of adolescents on good care in their assessment of health and social care services. The themes on quality of care, which we identified from the interviews and focus groups the inspectors held with adolescents are congruent with research on young people's preferences in quality of care (Van Beek & Rutjes 2009; ECPAT 2011). Inspectors and adolescents agree upon the importance of timely care, opportunities for personal development and a respectful relationship. Yet, their views on quality of care clash with regard to sharing information, creating solutions and the moment to offer help and assistance.

We identified three ways that inspectors dealt with the clashes between their own views and those of service users. First, inspectors place more value on their own views. Following Mol (2002), we call this way of dealing with the tension 'creating a hierarchy'. Establishing a hierarchy creates an order for differing perspectives, which reduces discrepancies as one perspective is made to win. This facilitates decisions on how to act, while discrepancies continue to exist (Mol 2002). This dealing mechanism fits neatly in the regulatory context as in the assessment of the inspection process inspectors must often balance various views to decide whether the services under scrutiny meet the inspection criteria (Bardach & Kagan 2002; Ottow 2015; Rutz et al. 2015).

A second strategy is passing the tension onto others, in this case professionals. Inspectors state that the professionals providing care to young people should be able to act according to the expectations of both inspectors and adolescents. According to inspectors, professionals should weigh all considerations and make decisions that are appropriate to the specific situation. This requires a situational judgment in which inspectors look closely into the considerations of professionals and discuss, rather than merely assess, what good care entails in a specific situation (Rutz et al. 2014).

A third strategy is separating the conflicting perspectives. For inspectors this way of

dealing with tensions opens up the opportunity to use adolescents' information, while still applying the inspection criteria that conflict with this information. This strategy is seen in other inspectorates as well. For example, the English Care Quality Commission adds the perspective of young people and other service users in a separate section of their inspection reports (EPSO 2013).

In our data, while these three strategies limit the influence of the adolescents when their views conflict with the inspectors' perspective, they do not limit or enhance the influence of service users in themselves. The result of the first, creating a hierarchy, could potentially lead to inspectors prioritizing the view of adolescents, setting their own view aside. The second strategy passes the tension to professionals who may incorporate the views of adolescents in their decision on what to do. The third strategy describes the adolescents' perspective separately, which may draw extra attention to their voices.

The main reason to engage service users in the inspection process is that they express a distinct perspective on what quality of care is (Bate & Robert 2007; Teunissen 2013; Pols 2014; Adams et al. 2015). Inspectors do use adolescents' views in their reports; they used adolescents' information to substantiate and illustrate their view (when the perspectives were similar) and they used the information separately from the inspectors' views (when their views differed). However, our data did not include examples of inspectors changing their opinions based on the views of adolescents. We offer three explanations.

First, part of the explanation is related to the characteristics of the adolescents involved in the inspection (Van de Bovenkamp 2010; Boivin 2012; Renedo & Marston 2015), in this case their vulnerability. Inspectors consider these adolescents as members of a vulnerable group requiring protection. They tap into the widespread assumption that vulnerable people are in need of special treatment and that intervening in their lives is permitted (Brown 2014). Although they may acknowledge what the adolescents think, inspectors believe that they know what is best for this group. Hence, inspectors will not set their own standards and criteria aside.

Second, the explanation is related to the organization where participation takes place, specifically organizational rules and routines (Renedo & Marston 2011; Boivin 2012; Van de Bovenkamp & Zuiderent-Jerak 2013; Renedo & Marston 2015). In our case, the existing inspection criteria steered the inspection process (Perryman 2006). These criteria were already set before adolescents were involved. The criteria turned out to be solid and not easy to change by anyone else than inspectors.

Although the literature relates the difficulties of involving service users mainly to participants and the organization where participation takes place, we add the external context as a third explanation. A fundamental tenet of policy in the Netherlands is that it is better to prevent than to solve problems (Horstman 2010; VWS 2014; Lecluijze

2014). Investigations into the death of abused or seriously injured people have criticized professionals and care organizations for providing fragmented services, not sharing essential information and not intervening earlier (Kuijvenhoven & Kortleven 2010; Munro 2011; Brandon et al. 2011). The critique also included inspectorates who were criticized for responding too late to important signs of poor service (Bouwman et al. 2015). This criticism has had an important impact on public confidence in the accountability and legitimacy of inspectorates (Munro 2011; Adams et al. 2013; Bouwman et al. 2015). As a consequence of this external critique, inspectorates have placed greater emphasis on prevention and early intervention. Active citizenship and prevention are both part of Dutch youth policy (VWS 2014). However, in this case, the value of prevention is so dominant that any input from adolescents that goes against this value is put aside. For inspectors, the external context cannot be easily disregarded and limits their room to allow the voice of adolescents influence their decision-making. Consequently, service user involvement cannot reach its full potential.

CONCLUSIONS

Service user involvement in inspections potentially impacts the quality of care. Yet, conflicts between the views of service users and inspectors are not easily overcome in the regulatory context. We offer two suggestions to make the involvement of service users more meaningful.

Firstly, inspectors may involve service users (and other stakeholders) in the development of inspection criteria. When criteria have not yet been set, including service users' perspectives allows inspectors to discuss various views to form their opinion and prioritize criteria in the dialogue with others. Following up this suggestion, JIY inspectors are currently experimenting with the involvement of service users in the development of new inspection criteria for vulnerable families with multiple problems, which may be a subject for further study. As we found that the perspective of inspectors cannot always be changed (in situations determined by the external context), it is important that inspectors make the values underpinning their views on good care more explicit.

Secondly, inspectors should allow a situational judgment, discussing the specificities of a situation and applying their inspection criteria more flexibly. A concrete example of this suggestion is value-based inspections, which holds the values and principles underlying decisions central (Van Dalen 2012). This would mean that in one situation inspectors could decide that privacy must prevail over the exchange of information between professionals, while in another situation sharing information would have priority. Service users and other stakeholders could be part of these discussions.

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4

Children's journeys through organizations

How inspectors evaluate coordination of care

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INTRODUCTION

Recently, the inspectorates that scrutinize services for children have been criticized for concentrating too much on standardization and compliance with formal procedures rather than on outcomes for children. The inspectorates are now encouraged to put the child's journey through the organizations – from diagnosis to care – at the heart of the inspection system (Munro 2011). Accordingly, various inspectorates have developed methods to examine how professionals contribute to the outcomes for children, such as the joint inspections of multi-agency child protection arrangements evaluating overall effectiveness (Ofsted et al. 2014). In other words, the focus of inspections is shifting from procedures to practices.

In the Netherlands, a partnership of five inspectorates[5] has developed an instrument that puts children center stage and focuses on professional practices. With this inspection instrument, which is called the 'journey tool', inspectors reconstruct and assess children's travels through the organizations.

The inspectors collect information (via case files, interviews and meetings with professionals) of all the different services that provided care to a child from its birth up until the moment the inspection starts. The journey tool differs from traditional inspection instruments as it does not assess organizations separately, but facilitates inspectors to consider all involved in tackling the child's problems as a whole. Central is how well organizations and professionals coordinate their activities across various sectors to provide integrated care. The inspectorates assume that by evaluating the journeys of individual children suffering from a particular problem, they can identify options to stimulate integrated care and improve the outcome for a group of children with this problem.

In this paper, we aimed to gain insight to how children and their families can be placed more center stage in the assessments of inspectors. By analyzing how inspectors reconstruct and assess the journey of children through all the organizations providing care to them, we evaluate the inspectors' practice. Our analysis shows that the concept of coordination incorporated in the journey tool reduces discrepancies between different problem definitions to enable the construction of one shared-problem definition (Mol 2002). The inspectors consider a shared-problem definition a starting point for integrated care and outcomes for children. Inspectors, we show, do not include multiplicities in their assessments. Moreover, they always deliver the same judgment, namely that services are fragmented. Although this judgment may be true, it limits the options for improvement. In this paper, we therefore introduce an

5 Joint Inspectorate for Youth, a partnership of five inspectorates for health care, education, youth care, safety and justice, and social affairs and employment.

alternative framework for assessment. We add another mode of coordination to the instrument, 'patchwork', that allows the inclusion of diverse problem definitions. In this paper, we explore what the introduction of patchwork would mean to the assessment of children's journeys. We demonstrate how patchwork embraces multiplicity and creates possibilities for inspectors to reflect on outcomes for children.
The paper is organized as follows. The next section introduces the modes of coordination that originate from Mol's ontological viewpoint on care practices (Mol 2002). Then we describe the Dutch context and our methodology. Our analysis of children's journeys through the organizations is at the heart of the paper. We end with a discussion of our findings and conclusions.

PRACTICES FROM AN ONTOLOGICAL VIEWPOINT

In the introduction, we addressed the inspectorates' turn towards practices. Scholars working in Science and Technology Studies (STS) have focused on practices for many years. In her book *The Body Multiple* (2002), Mol developed a theoretical repertoire to explore care practices. Mol combined philosophy with empirical work in what she called 'praxiographies', to study the work that is performed in a particular situation to gain understanding in what a specific entity entails in that situation. Mol conducted a praxiography into the diagnosis and treatment of atherosclerosis in an ontological gestalt. Ontology is the branch of philosophy that explores being and existence. Gestalt refers to an entity that is greater than its individual parts. Mol showed that although the entity of atherosclerosis is a single label, it entails a variety of individual objects in various practices in different locations and among different disciplines in a hospital. For instance, for the pathologist who examines bits of arteries under a microscope, atherosclerosis is an encroachment of the vessel lumen and a thickening of the vessel wall. For patients waiting in the outpatient clinic, atherosclerosis is the pain they get when they walk. For the technician in the vascular laboratory, atherosclerosis is a loss of blood pressure measured by comparing blood pressure in the ankle and the arm. Atherosclerosis thus has multiple meanings; one hospital houses multiple versions of the disease. These versions can be separated, but can also come together. For instance, the distance that a patient can walk without pain and the measurements of the loss of blood pressure come together in a patient's file. These data do not necessarily cohere. Coordination is necessary when data do not cohere, so that professionals can come to a decision on how to handle the situation (Mol 2002).
With her praxiography, Mol described several modes of coordination. We contrast two of them in this paper: hierarchy and patchwork. Hierarchy projects a common object

behind the various data. Establishing a hierarchy reduces discrepancies between different problem definitions of an object. The discrepancies are explained away and one problem definition is made to win. For instance, when a patient claims that walking causes a lot of pain, but the loss of blood pressure is not that big, one of these problem definitions is discarded in the decision on what to do. In contrast, patchwork creates a composite object. It takes the various versions of a problem as suggestions for action: one problem definition may be a reason to act; two or three may give more or other reasons to act. For example, the social implications of treatment, such as the worries of family members, are added to the loss of blood pressure and the pain caused by walking. Coherence of care for the diverging problem definitions that coexist in a patchwork can be problematic. For instance with atherosclerosis, caring for the worries of family members and caring for the blood pressure loss do not necessarily go together. Yet, they need to be dealt with at the same time (Mol 2002). Law & Mol (2002) argue that the multiple problem definitions that form a patchwork can be understood as a list, as opposed to arranging an order, which happens when a hierarchy is created. Whereas orders align and relate the elements, lists assemble elements without necessarily turning them into sound objects. In contrast to orders, lists do not imply completeness. Emerging elements that are important can be added. In a list, multiple and diverse elements coexist. In addition to 'listing', various scholars use the notion of 'tinkering' to deal with multiplicity (Mol 2008; Law 2010). Tinkering is exploring different possibilities to deal with multiple situations, as there is often no standard effective way of dealing that can be applied in these situations (Pols 2004). Instead, it is important that professionals have room for manoeuvre and diverse options to tinker with (cf. Morgan 1988; Van Gunsteren 1994).

Timmermans & Haas (2008) argue that one of the most remarkable things about Mol's theory is that it can be used to study a broad range of objects, offering a generic sociological approach and at the same time taking the situated specificity of a problem seriously. For Mol, care practices go far beyond medical settings and the work of professionals. Care may involve parenting, washing, cooking, harvesting and even killing (Mol et al. 2010). Many scholars have used Mol's praxiographies to delve into the details of a broad range of care practices; care to prevent loneliness and isolation (Pols 2010), veterinary practice (Law 2010), quality improvement in long-term care (Zuiderent-Jerak et al. 2009), food and eating in nursing homes (Mol 2010), inspectors controlling farmers (Singleton 2010), etc.

To summarize, the methods and concepts developed in STS offer a theoretical repertoire to understand multiplicity in practices. This theoretical repertoire is relevant to inspectors now their focus is shifting from procedures to care practices. Mol (2002) shows that in care practices, multiple objects are cared for simultaneously. Hierarchy and patchwork offer different strategies to deal with this multiplicity. Hierarchy

reduces the multiplicity of problems by constructing a single object that can then be handled; patchwork starts with the multiplicity and brings up ways of dealing with them through listing and tinkering.

CONTEXT

In this section, we give some background information about how services for children and the inspectorates that scrutinize them are organized in the Netherlands. Fragmentation is a matter of concern as organizations and professionals from many different sectors are involved in caring for children and their families in the Netherlands. Traditionally, services for children have been organized per sector. For instance, in the health care sector, Youth Health Care Services give children regular check-ups and screenings. They monitor children's development, give vaccinations, advice on growing up and refer to specialized services if necessary. The Youth Care Agency indicates whether specialized care (such as Youth Care Services, Youth Mental Health Care Services and Child Protection Services) is needed (NYI 2012).[6]

Regulation of Dutch services for children is also organized per service sector. For example, the Health Care Inspectorate sees to the quality of Youth Health Care Services and the Inspectorate for Youth Care reviews Youth Care Agencies. Although the inspectorates are all part of the central government, they have distinctive traditions and their own legal authority. Yet, the increasing focus on integrated care for children has led to the emergence of new organizational forms that cross sector borders. Various services for children from health care, youth care and welfare sectors have, for instance, joined forces in Youth and Family Centers to provide help on parenting at the neighborhood level (NYI 2011). Because regulation is organized per sector, inspectorates need to cooperate to inspect the joint organizations for childcare that exceed sector borders. This takes place in the Joint Inspectorate for Youth. This partnership focuses on public problems concerning children that require synchronized contributions from organizations in different sectors, such as child abuse, poverty and high school dropout. Hence, the inspectors conduct broad inspections, assessing the contributions of all local services, including health, youth care, education, police and social affairs. The partnership began in 2003 with the development of inspection instruments and a framework for joint reviews. Following the tradition of inspectorates, the framework consists of a set of eight criteria, which the inspectors use to assess the quality of

6 The situation described here applies to the period in which our research took place. By 2015, care for children will be placed under the authority of local municipalities.

cooperation among services (see Table 4.1). Organizations that do not meet the criteria are encouraged to improve their cooperation and take concrete action that will create better outcomes for children (ISYA 2009). Reconstruction of children's journeys is one of the many methods the partnership uses to assess services for children.[7]

Table 4.1 *Eight criteria in the inspection framework, developed by the partnership of inspectorates to assess the quality of cooperation between services (ISYA 2005)*

Criterion	Description
Convergent aims	Different aims have been discussed, resulting in the pursuit of a mutual aim.
Shared understanding of the problem	Partners have analyzed the problem jointly and reached consensus on its importance, its causes and possible prevention or solutions.
Chain coordination	Various partners cooperate to achieve their goals efficiently. Their services are aligned.
Information management	Partners collect record and exchange data.
Population-based management	The population of young people who need care is known. Whether these youngsters are reached is monitored.
Continuity of care	Seamless service is provided.
Problem solving	Services are tailored to the needs of young people and are aimed at preventing or solving their problems.
Quality and improvement	Services are evaluated systematically to guarantee and improve the quality of care.

METHODS

To study inspectors' practices with the journey tool, we supplemented document analysis with semi-structured interviews. Between 2004 and 2012, the partnership had reconstructed and assessed the journeys of 24 children through the organizations, covering six subjects (see Table 4.2). We collected and studied the documentation of

7 Other methods the inspectors use are, for instance, interviews, a study of case files, a vignette study, and methods to involve young people, parents and professionals (see also Rutz et al. 2013).

these 24 journeys that was relevant to reconstructions: i.e. formats used, information the inspectors had gathered from case files, interviews with children, parents and professionals, and the inspectors' judgments.

In addition, we conducted interviews with 17 inspectors in the partnership about their daily practice. The inspectors varied with respect to age, gender and experience as an inspector. They stemmed from the Inspectorate of Education (6), the Inspectorate for Youth Care (5), the Health Care Inspectorate (2), the Inspectorate of Security and Justice (2) and the Inspectorate of Social Affairs and Employment (2). The interviews were conducted between April and July 2012, and varied in length from 1.25 to 2.0 hours. We asked the inspectors to portray their work by describing three situations they encountered in practice: one where the inspector was able to make a change, one where things did not go according to plan and a third situation that the inspector considered routine. All interviews were transcribed, read closely several times and coded inductively. For this paper, we only used the parts of the interviews that concerned the journey tool.

The first phase of our data analysis concentrated on the journey tool as part of the inspector's practice. How did inspectors create reconstructions, how did they describe the children's situation, and the professional's activities, and how did they use the reconstructions to make judgments? We wrote memos as a reflection method. In the second phase, we conducted a secondary analysis of six journeys of children that the inspectors had created. We selected six journeys that varied maximally in the subject of the joint inspection, children's age, reconstruction length and professional disciplines involved (see Table 4.3). We analyzed the selected reconstructions from an ontological

Table 4.2 *Subjects and number of children's journeys assessed (2004–2012)*

Subject	Number
Child abuse and domestic violence	5
High school dropout	4
Homeless children	3
Linguistic and developmental disorders	10
Obesity	1
Young offenders	1
Total	**24**

Table 4.3 *The selection of children's journeys*

Selected journey*	Subject	Length of journey (in terms of child's age)	Organizations involved
Khadija	Child abuse and domestic violence	4–17	Youth health care, primary school, school for vocational education, senior secondary vocational education, police, youth care agency, advice and reporting center for child abuse and neglect, child care and protection board.
Toby	Young offenders	13–16	Police, juvenile court, public prosecutor, youth probation, secondary schools, rebound facility,† municipality, welfare organization.
Jessica	High school dropout	0–18	Youth health care, primary schools, general practitioner, mental health care, secondary school, senior secondary vocational education, municipality, job center.
Anouk	Linguistic and developmental disorders	3–6	Youth health care, primary school, youth care agency, police, advice and reporting center for child abuse and neglect, mental health care, municipality, youth and family center, refuges, welfare organization, home care, social services.
Robert	Homeless children	0–18	Youth health care, youth care agency, advice and reporting center for child abuse and neglect, foster care, primary school, special school for primary education, preparatory secondary vocational education, special school for secondary education, mental health care, welfare organization, police, shelter for homeless young people.
Peter	Obesity	0–10	Youth health care, general practitioner, dentist, dental surgeon, primary school, dietician.

*The names used in this paper are not the children's real names.
†These facilities offer temporary shelter to pupils with behavioral problems for whom all possibilities of in-school services have been exhausted.

viewpoint. Which objects did the inspectors construct at what places, and how did the objects open or close opportunities to assess the professional practices and produce options for improvement? We also analyzed how the inspectors coordinated the information, which information was made visible, and which information was laid aside. Moreover, we analyzed the journeys using the notion of 'patchwork' coordination.

Again, we wrote memos to reflect on questions raised by the analysis and implications of the findings to deepen our analysis.
The first author is an inspector for health care, seconded to the partnership and works as a researcher. In her dual role of inspector and researcher, she had access to the data. One of the disadvantages of this dual role is that it raises the issue of methodological distance (see also Rutz et al. 2013). We dealt with this issue in three ways (Alvesson 2009). First, we managed any tensions in the roles of inspector and researcher by working with the theoretical framework. This enabled us to interpret the data from a given distance and shift perspectives between roles. Secondly, two authors (author 1 and author 2, an outsider to the partnership) analyzed the data. Author 2's lack of insider knowledge enabled author 1 to question interpretations. We discussed the analysis in various meetings with other researchers and representatives of the inspectorates. Third, writing memos assisted self-reflection, challenging taken-for-granted forms of understanding and following up surprises.

FINDINGS

In this section, we start by describing how the inspectors construct children's journeys by arranging the information gained from case files in a coordinated chain of events. Second, we point out how the inspectors bring together the professionals involved in a network to discuss a problem, its causes and the possibilities of tackling the problem by aligning their services. Next, we describe the limitations of the inspectors' assessments with regard to complex care practices. Last, we elaborate on coordination by composing a patchwork and discuss the consequences of introducing this composite object to the inspectors' practice.

Reconstructing a chain of events

The inspectors use the journey tool to reconstruct care for children with unresolved problems and more than three organizations from different sectors involved. As described in various review plans, the journey tool consists of a series of three actions: (i) inspectors examine case files; (ii) they interview the child[8] and his/her parents about their situation and experience with the services offered; and (iii) the inspectors arrange a meeting with the related professionals.
To examine the case files, the inspectors visited all the organizations that provided services to the child. The inspectors sourced information kept in various files at various

8 In situations where the child was older than 10 years.

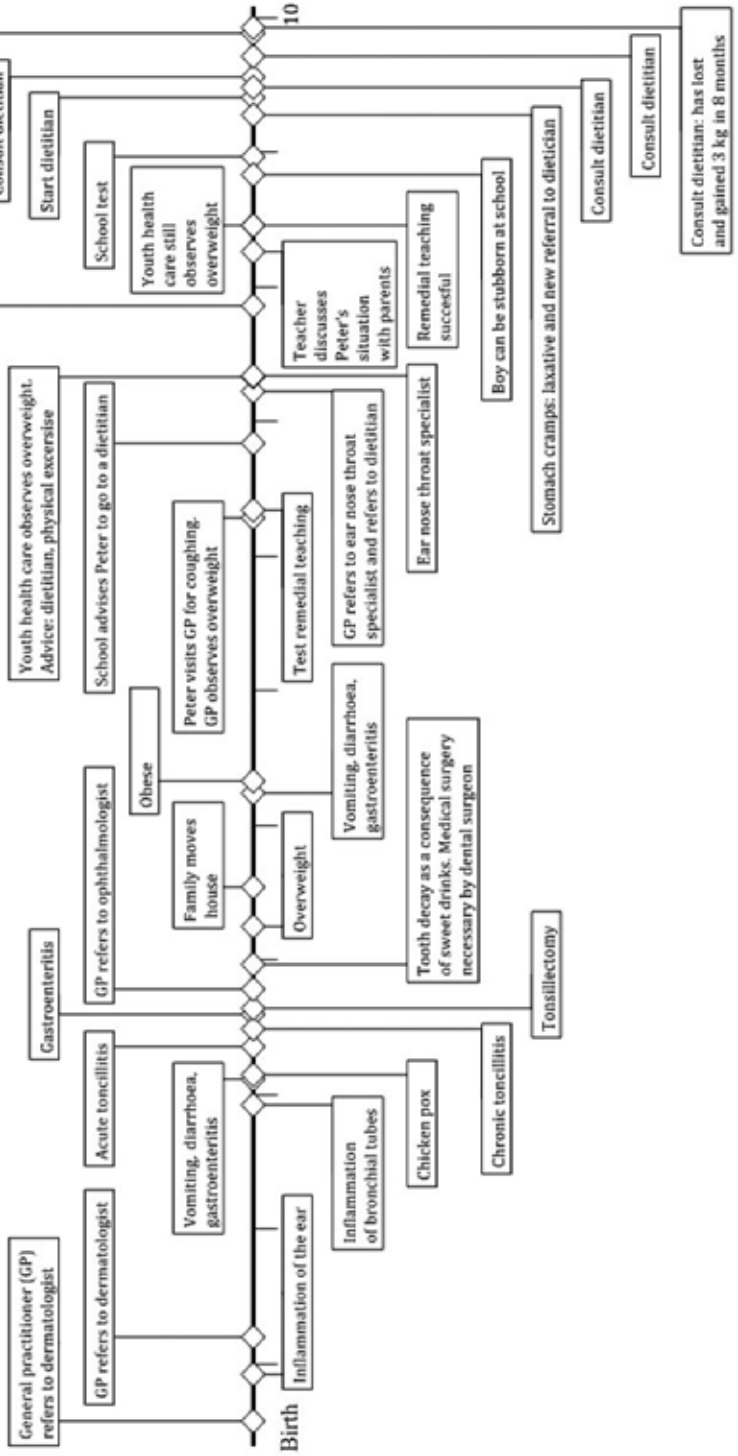

Figure 4.1 *Timeline of Peter's journey through the organizations from birth until the age of 10*

sites (offices of organizations), copied and then brought all the pieces to one site (the inspectors' office). The data that the inspectors copied concerned professional's activities, such as evaluations of the child's situation and needs, reports on the care provided and cooperative work (e.g. joint activities).

Rather than arranging the information per organization, which inspectors are accustomed to doing when they inspect individual services in a specific sector, the inspectors of the partnership chose time as a common denominator to correlate information from various services. Thus, information is coordinated chronologically on a timeline (see Figure 4.1). The timeline implies professionals working in a chain, providing services in sequence. In chains, services are delivered seamlessly by coordinating the providers' activities. Each partner is assigned strict tasks and responsibilities, which are settled in standards and formal agreements. The provision of services in chains has proven valuable in tackling well-defined problems for specific groups of people (Shortell et al. 1994; Minkman 2011).

By connecting the professional activities on the timeline, the inspectors created a new object: a shared problem. Up until the moment the inspectors visited the sites of the different organizations, each problem the child had in his life existed in its own site. For instance, the inspectors met Peter (presented in Figure 4.1) during a joint inspection on obesity. At school, Peter had trouble with physical exercise, whereas at the dentist, Peter had treatment for serious tooth decay resulting from too many sweet drinks. Inserting both elements into the timeline, the inspectors used them as underlying problems to create the problem of obesity. As the problem of obesity was central, other problems were placed lower in the hierarchy.

Constructing a network around the problem of fragmentation

In a meeting with all the related service-providing professionals, the inspectors presented the timeline and their account of how the child and parents experienced the services and the coordination of services. During this meeting, the inspectors and professionals discussed the outcomes, indicated complications and suggested improvements. The inspectors considered the meeting as a jump-start for professional organizations. Bringing professionals together created a new network. One inspector explained the need for a network as follows:

> *'It gave the professionals a lot of energy. They thought, now we are really going to make a change. When we introduced the professionals to each other, we made them aware that they did not know the people working at the other organizations [. . .]. The moment when professionals introduce themselves personally, you connect organizations.' (Interview 10)*

When it is mostly unknown which professionals and methods will be able to make an impact, networks have been proposed as better than chains for cooperative work. Whereas in chains, the problem must be specific and well defined, networks accommodate changes in the problem definition. Depending on what object is considered the problem, partners are invited to join the network (Engeström 2008; Hagel III et al. 2010). Yet, both chain and network approaches are based on the assumption that a shared-problem definition is essential for cooperation, unlike coordination by patchwork, where various problem definitions can coexist simultaneously.
The meeting with professionals is aimed at generating options to improve the outcome of care for children. Although, at the start of the meeting, in the presentation of their findings, inspectors emphasize the many problems of the family, and the often not so positive outcomes of the services that were provided, in the rest of the meeting they focus on one of many aspects of the child's problem: i.e. reducing fragmentation. The problem definition that the inspectors put forward in the meeting concerns uncoordinated, fragmented care. In one of the interviews, an inspector explains how he made professionals realize that the services they provided to Toby, a young offender, had been fragmented:

> *'We showed them how the organizations provided disintegrated services. I remember at the time [. . .] how all the professionals were astonished by how it [the help provided] could fail so miserably. [. . .] That's one of those moments – I think – that your work [as an inspector] matters. Because you reveal a situation no one intended, that just happened because no one knew what the others were doing.' (Interview 5)*

Fragmentation becomes the problem to be solved and as a result, the child's problems are no longer central to the meeting. Moreover, the inspectors expected that coordinating the child's problems in a coherent whole would give professionals options to handle the situation. We present a summary of the narrative of Khadija's journey, which is on the partnership's website, to elaborate on this:

> *'Khadija lives with her father, mother and younger brother. When she is 11, her father tells her school teacher that he is having problems with his daughter's behavior and does not know what to do. The teacher agrees that Khadija is displaying negative behavior. Together the teacher and school counselor draw up an action plan. Despite Khadija's high level of intelligence, she is advised to go to a school for vocational education. The primary school shares its concerns about Khadija's behavior with the secondary school.*

> *In secondary school, Khadija's behavior remains problematic. In her fourth year, the school reports a serious escalation. Khadija is so unmanageable that she is excluded from class almost every day. She is a frequent truant and often fights with other pupils. In this phase, Khadija calls the police to say that her father beats her regularly and she does not know what to do. When the police visit her home both her parents and Khadija promise to do the best they can to improve the situation and Khadija decides not to press charges. After graduation, Khadija enrolls at a school for senior secondary vocational education. However, in the first three weeks other students complain about Khadija's intimidating behavior. In consultation with Khadija and her parents, the school decides to send her to a smaller, more cohesive school. Soon, however, Khadija stops turning up at school altogether. Shortly thereafter, Khadija again seeks help at the police station. Things at home have worsened; there has been a quarrel involving physical violence. The police contact the Youth Care Agency and repeat Khadija's allegations that her father has abused her for four years.' (JIY 2013)*

This narrative presents at least three problems: Khadija's disruptive, aggressive behavior, her truancy and the physical abuse by her father. The problems are distributed in various places. At school, Khadija is a badly behaving pupil who plays truant, whereas at the police station Khadija is a daughter abused by her father. According to the inspectors, the problems are related and the professionals should have tackled them jointly. They state in their report:

> *'In this case, it is noteworthy that not one professional, or any professionals together, analyzed the problems that underpin the behavior of Khadija and her parents. [. . .] The problem is not that professionals don't act. They do, but mostly on their own in their own sector.' (ISYA 2007)*

Moreover, the inspectors expect the professionals to do a joint analysis and come to a shared understanding of what the problem is and how it could be solved (criterion 2 of the inspectors' assessment criteria, see Table 4.1). In other words, professionals are supposed to coordinate the multiple versions of a problem to establish a hierarchy and define one single problem that describes the child's situation. The omission of the shared-problem analysis has, according to the inspectors' report, negative consequences for Khadija:

> *'The professionals try to find solutions for Khadija's problems in their own sector. For instance, the school focuses on learning outcomes (advising the child to enroll in a lower level of education despite the child's high intelligence, and transferring*

> *her to a smaller school, encouraging her to graduate). The police come to an agreement with Khadija and her parents to stop the abuse continuing [. . .]. As a result, the actual problems do not get tackled.' (ISYA 2007)*

Although the inspectors emphasized the need for a shared problem, they were vague about how they would define Khadija's 'actual problems'. The meeting with professionals did not lead to a shared understanding of Khadija's problems, besides addressing the problem of fragmented services. None of the other meetings led to a shared understanding of the child's problems either. In all of the 24 journeys, the inspectors stated in their judgments that the professionals missed a shared-problem analysis. In none of the 24 journeys had the inspectors defined the child's problems explicitly themselves. Although professionals should, according to inspectors' criteria, reach consensus on what the problem is and how it could be solved, there were no shared-problem definitions.

To sum up our argument so far, inspectors coordinate the information they collect by constructing a chain of events in a timeline and establishing a network in a meeting with professionals. The timeline and meeting result in one specific problem, namely fragmentation. This limits the scope of their assessment and the solution they present to professionals, namely cooperation to come to a shared understanding of the problem. According to the inspectors, the definition of a shared problem will give professionals better options to deal with the situation. However, such a coherent definition of the child's situation had not been made in any of the children's journeys; neither in the inspectors' own assessments, nor by the professionals.

Allowing multiplicity by composing a patchwork

What would happen to the judgments, the timeline and the conversations with the children, parents and professionals if we introduced 'patchwork' to the inspectors' practice? We conducted a secondary analysis of the documents of the inspectors to gain insight in the answer to this question. Let us list the problems of Anouk to elaborate on this. As we explained earlier, a list assembles diverse elements without necessarily turning them into a single object (Law & Mol 2002). The inspectors met Anouk at the age of 6, during a joint inspection of care for children with linguistic and developmental disorders (JIY 2013). Based on the documents of the inspectors we constructed the following narrative:

> *Anouk and her mother participated in a play-and-learn program to develop Anouk's linguistic skills and improve the interaction between parents and child. As they were worried about the child, the program's professional and the teacher asked the school's care and advice team to review Anouk's situation. The team members*

discussed how Anouk was often absent from school, looked neglected and wet herself regularly and how the police had called several times at her home because of complaints about noise. The care and advice team decided to refer Anouk to the Youth Care Agency so that she would get access to specialized services. Although the parents were consulted in this decision, they repeatedly cancelled the appointments at the Youth Care Agency. As a result, the specialized services did not get going. One reason given for cancelling appointments was that Anouk's parents had marital problems and were splitting up. Anouk's father threatened her mother, so Anouk and her mother ended up in various refuges for their safety. However, when she was staying in these refuges, Anouk could not attend her own school. Although the police reported their concerns about Anouk's well-being several times to the Advice and Reporting Centre for Child Abuse and Neglect, a center that can take compulsory measures if parents do not accept help, this center did not start an investigation.

Anouk's situation contains multiple problems. In a list:

- Anouk's linguistic skills are behind her age level, according to the Youth Health Care.
- Anouk is often absent from school.
- According to her teacher, Anouk looks neglected and she wets herself regularly.
- When the teacher pays a home visit, the house smells of cannabis.
- The mother says that Anouk is often ill and unable to go to school.
- Anouk's mother says that she herself has psychological issues because she was abused as a child. Dealing with these issues is central in meetings with the school social worker.
- According to the police, neighbors often complain about noise.
- According to the Youth and Family Centre, Anouk's parents need help with parenting.
- The mother calls the police several times because Anouk's father and his new girlfriend have threatened her. Because of the threats, Anouk and her mother do not feel safe in their home and end up in various refuges.
- The teacher finds out that Anouk suffered a head injury during a fight between her parents.
- Anouk lives alternately with her mother, father, and grandparents. When she lives with her mother, she attends another school than when she lives with her father or grandparents.
- Anouk's mother has major debts.

This list contains 12 concurrent problems. They all relate to Anouk's situation, but at the same time they are diverse. The problem to be tackled is a composite object, rather than a single problem (Mol 2002). Defining one problem is complicated as it

is difficult to demarcate Anouk's situation and distinguish between her situation and that of the people around her. For instance, would Anouk's situation include or exclude her father's new girlfriend? Is abuse of Anouk's mother when she was a child part of Anouk's problem or not? Anouk's situation may stretch to the professionals that provide help to Anouk, or even to the inspectors that look into her situation. Establishing a hierarchy is also problematic. Anouk's mother has multiple problems (psychological issues, debts etc.). In meetings with the school social worker, these problems win. Yet, Anouk's neglected appearance and incontinence are also urgent and not necessarily lower in the hierarchy. Putting Anouk's problems on top of the hierarchy, without taking into account her parents' situation, would not lead to workable solutions either. For instance, the rift between Anouk's parents has serious consequences for how the parenting problems can be dealt with. In other words, defining one coherent problem for Anouk's situation is problematic and does not allow for the multiplicity of the situation.

Introducing patchwork coordination that allows discrepancies makes it no longer necessary to define one problem statement for Anouk's situation. Including the various elements of Anouk's situation means that diverse options to handle the situation can be explored. For inspectors, introducing patchwork to their practice would enable them to evaluate whether and how professionals create options to improve children's situations. As Anouk's journey shows, the professionals offered only one option to handle the parenting problems; namely the Youth Care Agency. However, this agency's services did not get off the ground as the parents failed to turn up for appointments. The inspectors could have discussed with professionals what alternatives could have helped Anouk. Looking after Anouk's safety and simultaneously ensuring her education is not automatic as Anouk cannot attend her own school when she stays in refuges. Her education has to be organized in other ways. Inspectors could have asked the professionals what could have helped Anouk to develop adequately at school and yet be in a safe home? These questions create opportunities for inspectors to reflect on how professionals handle diverging problems. In the next section, we discuss the implications of introducing patchwork, and the ontological gestalt that goes with it, into inspection practices.

DISCUSSION AND CONCLUSION

Inspectorates are encouraged to put the child's journey through the organizations at the heart of the inspection system and to concentrate on outcomes for children (Munro 2011). A partnership of five Dutch inspectorates has developed a journey tool to reconstruct and assess children's travels through all the organizations providing

care. In this paper, we argued that how inspectors reconstruct and assess children's journeys and how this provides input to improve outcomes for children, limits their assessment to fragmentation and cooperation.

To reconstruct children's journeys, the inspectors create a chain of events that brings the professional's activities together on a timeline. The timeline coordinates the various problems in the life of a child into one problem. This process also brings together all the professionals providing services in a network. In other words, in their practice, inspectors create a common object; one problem definition that is treated as the starting point for all professional activities to improve the child's situation. The chain design leads to unilateral judgments: professionals do not conduct a shared-problem analysis and thus provide fragmented services. In the inspectors' practice, improving outcomes for children becomes identical to improving cooperation between professionals. However, our analysis reveals that the journey tool never culminated in one coherent problem definition of the child's situation. Rather, children's problems remained multiple. Our study suggests that to assess complex care practices, inspectors should look for alternatives that acknowledge multiplicity. The ontological gestalt offers the inspectors such an alternative and a new repertoire. It facilitates inspectors in the evaluation of children's journeys by putting the specific situation of the child and the results for children center stage.

The introduction of this ontological gestalt has at least three implications for the inspectors' work. In the practice of the partnership, inspecting means assessing whether professionals and organizations meet a set of criteria and encouraging them to improve cooperation to contribute to better outcomes for children. In the ontological gestalt, what good care entails is not universal, but bound to a specific situation. Good and bad may be intertwined and what good care is in one situation may not be so in another (Mol et al. 2010). Thus firstly, introducing the ontological viewpoint would mean that inspectors would look more thoroughly into the specificities and diversity of practices and discuss what good care entails in given situations. Inspection work would change from making judgments to reflecting on the situation in a dialogue with professionals, parents and children.

The second implication places emphasis on how a problem is dealt with and, in turn, facilitates action (Timmermans & Haas 2008). Instead of focusing on whether or not fragmented services are provided, it places the diversity of options to handle a situation central. Evaluating how and what variants of a problem are coordinated (or stay separate) creates opportunities for inspectors to find out how a problem in a specific time and place opens up possibilities for professionals to act and closes other possibilities. In addition, it creates opportunities for inspectors to find out how professionals handle changing situations and collect a diversity of options for improvement.

The third implication involves the meaning of place. In the ontological gestalt, place is no longer universal. Whereas generic criteria can be easily transported to various places (Singleton 2010), the ontological evaluation of a child's journey is bound to the location of a particular care practice. By evaluating the journeys of individual children, the inspectors aim to improve the outcome for groups of children suffering the same problem, transporting their assessments to other places. However, in the ontological gestalt, it is impossible to define improvements that would be widely adaptable throughout all complex care practices. Yet, the ontological gestalt offers a repertoire for unraveling care practices that can be applied in various places. It can stimulate inspectors and professionals to reflect on care practices and make improvements that would fit their professional practices. Using these reflections, inspectors can also address important developments to policymakers on a national level, bringing care practices to policy practices and presenting the complexities of care practices (WRR 2013).

In conclusion, the Dutch partnership of inspectorates has been looking for ways to improve the journey tool to stimulate professionals and organizations to create better childcare outcomes. We argue that in order to do so, it is necessary that inspectors broaden the scope of their assessments. We suggest that the patchwork design of the journey tool adds a new repertoire as it facilitates inspectors to look into the multiplicities and diversity of complex care practices and to reflect on the results for children. This paper provides a strong analytical framework to enhance reflexivity and acknowledge multiplicity, which is indispensable in the evaluation of complex care practices.

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5

Enhancing responsiveness and consistency

Comparing the collective use of discretion and discretionary room at inspectorates in England and The Netherlands

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INTRODUCTION

Traditionally, inspectorates of services such as health and social care are positioned in-between central governments and the organizations carrying out public tasks. In this mediating role, regulatory bureaucracies are expected to exercise control over the quality of care, take action in cases of poor quality, and protect vulnerable people from harm (OECD 2014). The consequences of inspectors' judgments may be far-reaching for the services they inspect and the people using the services. Therefore, it is important that inspectors do not make arbitrary judgments and that their judgments are fair. To do this, inspectors need to act consistently on the one hand (May & Wood 2003; Tuijn et al. 2014; OECD 2014), and be responsive to the specific case on the other (Bardach & Kagan 2002).

One strategy that inspectorates adopt to promote consistency is standardization of inspections, for instance, using an inspection framework with predefined criteria to reach judgments about compliance. However, a standard inspection framework cannot contain comprehensive criteria to cover the full range of situations that inspectors encounter. Not all judgments can be scripted beforehand. Overstandardization may lead to inspectors 'ticking the boxes' and becoming less responsive to unknown or unexpected risks, which may have a negative impact on what they aim to achieve (Bardach & Kagan 2002; Walshe & Phipps 2013; Perez 2014). Reflexivity is put forward as one strategy to enhance responsiveness. Reflexive inspections are characterized by consensus with judgments based on experimental and participatory processes (Huising & Silbey 2011; Sabel & Zeitlin 2012; Perez 2014). Reflexivity stimulates flexibility and adjustment to specific circumstances, but may make the work of inspectors opaque and inconsistent (Perez 2014). It is generally agreed that inspectors need discretion to act responsively and come to balanced judgments (Sparrow 2000; Mascini 2013).

Discretion is often considered a feature of the individual professional worker, who interprets, balances, or deviates from generic rules to make a decision. A particularly influential perspective in this literature is Lipsky's (2010) work on the use of discretion by public officials responsible for delivering policy on the front line (see also Evans 2011; Hupe & Buffat 2014). Lipsky introduced the term 'street-level bureaucrats' for these workers. The traditional literature describes how discretion raises concerns and needs constraining because its use is associated with variation between workers, which potentially has negative consequences on consistency and fairness. More recently, a growing literature suggests that discretion can be used to benefit both workers and the organization, as it increases responsiveness and flexibility to advance organizational purposes (Piore 2011; Silbey 2011). Workers' uses of discretion are significantly affected by collective and organizational dynamics, which create constraints and incentives to follow possible courses of action.

In the literature, discretion often figures as a broad term with multiple meanings. Hupe (2013) distinguishes between discretion and discretionary room. In this paper, we adopt that distinction. We use 'discretion' to refer to the behavior of the individual worker interpreting, balancing, and deviating from rules. We use 'discretionary room' to refer to the organized space that allows workers the freedom to make a choice among various courses of action (Hupe 2013).

Our paper aims to contribute to the understanding of how inspectors, who need to act consistently and responsively at the same time, use discretion and discretionary room in the regulatory bureaucracies in which they operate. We focus on how inspectors involve others to make their judgments in the context of their organization. We compared the work of inspectors assessing the provision of care at two inspectorates with different organizational forms: the Care Quality Commission (CQC) in England and the Joint Inspectorate for Youth in the Netherlands (JIY; *Samenwerkend Toezicht Jeugd*). While CQC inspections might be considered standardized and, at the time of our research, conducted primarily by individual inspectors, JIY inspections used reflexive processes carried out by teams. Thus, there were considerable differences in the individual and cooperative work inspectors performed to reach their judgments and use their discretion. Based on a comparison of the two inspectorates, we argue that inspectors create collectives to use their discretion effectively. This entails engaging other people – inspectors, managers, experts, and stakeholders – and incorporating their skills, knowledge, and authority. The way discretion is used depends on the inspectorates' organizational form. Whereas at the CQC, engaging others was mainly left to the inspectors' own initiative, at the JIY, teams of inspectors are granted collective discretionary room. Although discretionary room is often referred to as freedom granted to an individual, we argue that collective discretionary room addresses concern about inconsistency in the judgments of individual inspectors as it places limits on individual variation, while allowing enough room to make fair judgments that respond to the specific case.

The next section of this paper elaborates on the individual and collective features of discretion and discretionary room. We then describe our methodology and the context of both inspectorates. Our comparative analysis of how inspectors create and use discretion is at the heart of the paper. Finally, we discuss our findings and draw conclusions.

INDIVIDUAL AND COLLECTIVE ASPECTS OF DISCRETION AND DISCRETIONARY ROOM

Inspectors have been described as 'street-level bureaucrats,' performing their jobs outside the purview of their managers in interaction with non-voluntary clients, and using discretion in their work (May & Wood 2003; Mascini & Van Wijk 2009; Walshe & Phipps 2013). Inspectors use discretion when they apply generic rules and regulations to specific situations that are often too complex to be reduced to scripted formats. They are compelled to interpret and balance rules, for instance, to take account of the consequences of their actions for providers and people using the services (Bardach & Kagan 2002; Mascini & Van Wijk 2009).

Discretion is an important concept in understanding the work of street-level bureaucrats, and is taken to mean choice or judgment within recognized boundaries (Durose 2011). A classic formulation of discretion from Davis (1969, p.4; used e.g. in Hupe & Hill 2007; Evans 2011; Tummers & Bekkers 2014) is *'whenever the effective limits on his [the public official's] power leave him free to make a choice among possible courses of action or inaction.'* This definition suggests that it is a feature of the individual. The use of individual discretion, however, may have a negative impact on fairness. When workers follow their personal 'logic of appropriateness,' they make judgments that lead to variation and hamper equal treatment (March & Olsen 2004). There is considerable literature on the factors that influence judgments. Rice (2013) describes characteristics of street-level bureaucrats, such as their moral values, training, and personal experiences, and the characteristics of the person they are regulating, such as demography, behavior, and knowledge of rules and laws. These may tip the balance for or against 'big-hearted' or 'mingy' judgments (Rice 2013).

While discretion is ubiquitous in the workplace and nearly all rules embody matters of interpretation (Hupe & Hill 2007; Canales 2011), the negative impact on fairness has led to 'fear of discretion' (Pires 2011). In the traditional literature on street-level bureaucracy, the emphasis is on how to constrain discretionary room (Maynard-Moody & Musheno 2012) by formulating more rules or hierarchical control by managers (Piore 2011). The use of discretion occurs in a context of conflict between the organization and individual worker. While managers seek to limit their staff's use of discretion to encourage workers to act consistently and 'go by the book' (Bardach & Kagan 2002), street-level bureaucrats oppose this control as they feel the need to be responsive to the specific case (Lipsky 2010; Durose 2011; Evans 2011). Such tensions put individual workers under pressure and cause stress (Bardach & Kagan 2002; Lipsky 2010).

Although discretion is a feature associated with individual decisions and actions, workers do involve others in their decision making. The use of discretion is increasingly considered to be embedded in, and the result of, relations with workers of other

organizations, rather than an accomplishment of the individual (e.g. Ellis 2011; Evans 2011; Huising & Silbey 2011; Piore 2011; Pires 2011; Silbey 2011; Sabel & Zeitlin 2012; Hupe & Buffat 2014). In this regard, literature on the sociological citizen is relevant (Silbey et al. 2009). Sociological citizenship applies to workers who understand themselves and their work as links in a complex web of interactions (Canales 2011; Coslovsky 2011; Haines 2011; Pires 2011; Silbey 2011). They are pragmatic, experimental, and adaptive, going beyond and outside the prescribed rules and processes, involving all kinds of relevant others to achieve the ostensible organizational purposes (Coslovsky 2011). Huising and Silbey (2011) have named this practice of workers in regulatory bureaucracies 'relational regulation.' Although interaction with others is necessary to make relational regulation work, the involvement of others is realized at the workers' own initiative.

This emphasis on individual initiative in relational regulation does not consider teamwork, when workers reach their judgments together. We lack the concepts to understand how judgments are made by teams or networks and the tension felt by teams to act both consistently and responsively. We introduce the notion of experimentalist governance in teams to explore whether a collective view on discretion is relevant. The policy strategy of 'experimentalist governance' is employed to tackle volatile and complex problems. Through experimenting in interdisciplinary teams, and monitoring and reflecting on progress and disruptions, workers cooperate to develop new methods and innovative solutions to advance organizational purposes. Rules are not a given; teams are allowed to transform and improve on them (Piore 2011; Pires 2011; Sabel & Zeitlin 2012; Perez 2014). Experimentalist governance departs from the organizational features that gave rise to ad hoc deviation from rules by the solitary street-level bureaucrat (Sabel & Zeitlin 2012). The focus is on interdisciplinary teams that have been granted discretionary room as a resource strategy to advance organizational purposes.

The three bodies of literature described here have differing views on consistency and responsiveness. In the traditional literature on street-level bureaucrats, organizational purpose is associated with applying rules to stimulate consistency and equal treatment, relegating responsiveness to the background. Consistency is not considered in the literature on experimentalist governance, where acting responsively by transforming rules is prominent. Consistency and responsiveness are both included in the literature on relational regulation. Sociological citizens are considered a distinct group of people, who work alongside another group of strict rule enforcers in rule governed organizations. While sociological citizens take a pragmatic approach to act responsively, strict rule enforcers strive for consistency (Canales 2011; Coslovsky 2011; Silbey 2011). We acknowledge the importance for inspectorates to be able to act both consistently and responsively in this article, taking into account the literature on street-level

bureaucrats and sociological citizens. In addition, in accordance with the literature on experimentalist governance, we recognize that inspections are not always performed individually, but are also carried out in teams. In these instances, discretionary room is granted to teams. To discriminate between situations when discretion is formally granted to individual workers – individual discretionary room – and situations when discretion is granted to teams, we introduce the notion of collective discretionary room (see Table 5.1). We use this label for teams of inspectors granted collective discretionary room to reach judgments together, dealing jointly with the tension between rule compliance (consistency) and specific circumstances (responsiveness). We also distinguish between individual and collective use of discretion. We apply the notion of individual discretion to the ways individual inspectors use their own 'logic of appropriateness,' interpreting, balancing, and deviating from rules to reach judgments and take action (March & Olsen 2004). In many organizations, individual workers use discretion on their own initiative as social citizens in cooperating with colleagues and people from other organizations (Hupe & Hill 2007; Huising & Silbey 2011; Noordegraaf 2011; Silbey 2011; Rice 2013). We use the notion of 'collective discretion' to refer to how individual inspectors pragmatically involve others at their own initiative to interpret, balance, and deviate from rules to reach judgments and take action.

Table 5.1 *The distinction between individual and collective work combined with the distinction of discretion and discretionary room, applied to the regulatory context*

	Discretion	**Discretionary room**
	Interpreting, balancing, and deviating from rules to make a judgment and take action	Organized space which allows the freedom to make a judgment and take action
Individual	Individual discretion – individual behavior of an inspector interpreting, balancing, and deviating from rules to reach judgments and take action	Individual discretionary room – degree of freedom formally granted to individual inspectors to reach judgments and take action
Collective	Collective discretion – ways in which individual inspectors pragmatically involve others on their own initiative to interpret, balance, and deviate from rules to reach judgments and take action	Collective discretionary room – degree of freedom formally granted to regulatory teams to reach judgments and take action

In this article, we compare the individual and cooperative work inspectors do to use discretion and to benefit from the discretionary room granted to them in two contrasting organizational forms; one in which discretionary room is individual and the other in which it is collective. The next section describes how we conducted this comparative research.

METHODS

This paper reports on part of a research project that conducted an international comparative analysis to understand the role of inspectors in the specific context of an inspectorate. The two inspectorates included in our study differ considerably. While CQC inspections in England are standardized and, at the time of research, were often carried out individually, JIY inspections in the Netherlands were reflexive and conducted in teams. We selected these inspectorates, with maximal variation, to gain a deeper understanding of the particularities of the specific contexts and shared patterns of inspectors' roles (Stake 1994). The literature describes a decentered, comparative approach as a context-sensitive method that acknowledges variations and brings together a team of researchers from various geographical locations. The locations are chosen because they have significant variability (Wrede et al. 2006; Bourgeault et al. 2009). The researchers shape the research questions via interaction, interpret the data together, and develop analytical concepts that have meaning across geographical boundaries (Wrede et al. 2006).

Our team consisted of four researchers from various disciplinary backgrounds at two geographical locations. Therefore, we could draw on the knowledge and expertise of the specific context of two countries. To compare the two cases, we combined interviews with inspectors with document analysis. CQC inspectors (n = 11) and JIY inspectors (n = 17) were interviewed for between 45 minutes to two hours. The inspectors varied with respect to professional background, experience as an inspector, age, and gender. We used a semi-structured interview format to ask participants to describe their daily work in three situations they encountered in practice: one where the inspector was able to make a difference, one where things did not go to plan, and a third that the inspector considered routine. We also collected documents relevant to the role of inspectors, the inspectorates, and the broader organizational context. All interviews were audio-recorded, transcribed verbatim, and read closely several times. In addition, we held two meetings with inspectors (one each at the CQC and the JIY) to discuss results. Notes on the conversations were included in the analysis.

Analysis was performed iteratively, with multiple shifts between data and literature. In line with decentered comparative research, we held meetings to analyze and

interpret the data and the two inspection contexts. At these meetings, we compared differences and similarities and shared information through storytelling. We specified our research question and decided to focus on discretionary room and how inspectors use discretion. We also developed the notions of individual and collective discretionary room and individual and collective discretion as analytical concepts.

The first and second authors are inspectors at the JIY and the CQC, respectively. In their dual roles of inspector and researcher, they had access to data, as well as tacit knowledge about the work of inspectors in the social and political context of their country. A disadvantage of this dual role is that it raises the issue of methodological distance (Alvesson 2009; Rutz et al. 2013). Tensions in the dual roles were managed in two ways. First, the research team meetings formed an important part of the analysis, with researchers questioning each other's interpretations. These discussions stimulated self-reflection and challenged locally situated assumptions. Secondly, we discussed the analysis with representatives of health and social care inspectorates from various countries (members of the European Partnership of Supervisory Organizations of services for health care and social work), representatives of various regulatory agencies inspecting services in other sectors in the Netherlands (e.g. Inspectorate for Education, Human Environment and Transport Inspectorate, Inspectorate for Social Affairs and Employment) and in meetings with other researchers. These audiences recognized our findings and provided us with examples of the collective work to use discretion and discretionary room at other inspectorates in various countries, which helped us to elaborate on and to enhance the reliability and validity of our analysis.

CONTEXT

This section describes the two contexts in which the studied inspectors did their work.

The Care Quality Commission

The CQC was set up in 2009 and brought together the inspectorates for health care, social care and the Mental Health Act Commission. The Health and Social Care Act (2008) outlined the CQC's role to register services and inspect whether they were meeting the standards set out in the regulations. The CQC regulates a broad range of health and social care services, such as hospitals, care homes, home care, general practitioners, dentists, and community health services. During inspections, inspectors collected evidence using a variety of methods including observation, interviews with the users of services and staff, examining records, and reviewing policies and procedures, in addition to considering data about performance, and information gathered from

stakeholders. They examined the evidence to assess whether the provider met the predefined standards.

At the time of the data collection (January–May 2014), inspectors at CQC conducted inspections of small social care services, independent health services, and dentists on their own. Inspections of larger organizations and all hospital inspections were conducted in small teams. The majority of services were inspected annually. Over 30,000 locations were inspected in 2013/14 (Care Quality Commission 2014). In about 85 percent of the inspections, services were judged to have met the expected standards. When the predefined standards were not met, a judgment framework was used to decide whether to ask the service to report how they would improve or to take enforcement action. Enforcement actions ranged from warning notices through civil penalties to placing conditions on registration and suspension or cancellation of registration. CQC inspectors are part of a robust United Kingdom tradition of neutrality and objectivity in public services, within which the principle of equal treatment of the public is very strong (Vandenabeele et al. 2006). However, the framework explicitly recognized that judgments must consider the particular circumstances of the service provider. The CQC's model of responsive regulation reflected the pyramid of enforcement responses, considering the individual situation, the impact of non-compliance on service users, and assessing the ability of the provider to improve (Ayres & Braithwaite 1992).

Recently, CQC has undergone considerable change in response to criticism of a lack of consistency in inspectors' judgments and for using inspection methods that did not differentiate between care sectors (The Parliamentary Public Accounts Committee 2012). Since April 2014, CQC has had three inspection directorates (hospitals, primary medical services, and adult social care). There is sector-specific training for inspectors in those directorates and inspection methods that differentiate between sectors have been developed. Another prominent change is that inspections are often conducted by more than one inspector, possibly accompanied by one or more specialist advisers. Teams of 35 or more, for example, inspect large general hospitals. In addition to CQC inspectors, there are external specialist advisers with current or recent experience of working in health services, such as nurses, medical consultants and managers, and 'experts by experience' who have received healthcare (Iacobucci 2014). To meet the challenge of ensuring consistent judgments, inspection methods are scripted and a quality assurance approach culminates in scrutiny by a national panel, to minimize variation.

The Joint Inspectorate for Youth

Since 2003, five government inspectorates have cooperated in the JIY: the Health Care Inspectorate, Inspectorate of Education, Inspectorate for Youth Care, Inspectorate for Safety and Justice, and Inspectorate of Social Affairs and Employment. Based on the Convention on the Rights of the Child, the focus is on the child. The partnership's

inspections are mainly theme-based, focusing on public problems concerning young people that cannot be solved by one organization or sector, but require synchronized contributions from many sectors.[9] Examples are child abuse, obesity, youth offenses, addiction, and poverty. The partnership's intention is to contribute to solving problems at the local level (Integrated Supervision of Youth Affairs 2009). To achieve this, inspectors inspect a broad range of local services in all sectors providing services to children, including health, youth care, education, police, and social affairs.

Multidisciplinary teams of three to eight inspectors conduct inspections to reach collective judgments. Joint inspections include reflexive methods focused on involving all stakeholders, for instance, brainstorming and consensus-building sessions with professionals, managers of providers, and young people, to create solutions that match young people's needs. Inspectors use a regulatory framework for their assessments, based on eight criteria (Rutz et al. 2014). The framework and methods can be adjusted to specific circumstances or the theme under scrutiny. If providers are found to be non-compliant, they are encouraged to improve cooperation and take concrete steps to create better outcomes for children and their families (Integrated Supervision of Youth Affairs 2009). Although the partnership lacks official enforcement powers, the inspection teams use their authority to convince providers to make the necessary changes. Individual inspectorates in the partnership can take enforcement measures if they are needed to stimulate compliance and improvement of services.

The Youth Act that came into force in January 2015 gave the inspectorates in the partnership the task of assessing local care systems for young people (VWS 2014). A new framework for this task has been developed. In addition, the five inspectorates cooperating in the JIY have developed a joint inspection program, which synchronizes regular inspections of services for young people.

CQC and JIY inspections and the organizational forms of the two inspectorates differ considerably. Table 5.2 highlights the key characteristics of the inspectorates. Despite the differences, both CQC and JIY inspect quality of care, with inspectors using relatively open criteria for interpretation to arrive at a judgment. Consequently, inspectors at both organizations use a great deal of discretion in their work.

9 Inspectors also investigate critical incidents involving children.

Table 5.2 *Key characteristics of the Care Quality Commission and the Joint Inspectorate for Youth*

	Care Quality Commission	**Joint Inspectorate for Youth**
Country	England	Netherlands
Year established	2009	2003
Number of staff	2,148 (2013)	22 (2014)
Inspectors	Inspectors work from home. They have various professional backgrounds (e.g. social work, nursing, care work, research, governance)	Inspectors work in teams. They have various professional backgrounds (e.g. social work, teaching, legal, youth care, criminology, epidemiology)
Inspections	Assessing against standards to support enforcement	Measuring performance to stimulate improvement
Regulatory focus	Legislation-led regulator	Mission-led regulator

Adapted from Rutz et al. 2013; Walshe & Phipps 2013; CQC 2014.

RESULTS

Making a difference

Inspectors at both CQC and JIY were determined to make a difference to people using services, especially vulnerable people. In common with other public officials, they expressed altruistic motives, going beyond individual or organizational interests to address public interest (Vandenabeele et al. 2006; Lipsky 2010). Inspectors emphasized that they could make a difference because of their authority as an inspector. In the interviews, inspectors illustrated this by referring to the relatively limited scope they had in previous jobs to take action. To quote a CQC inspector who used to work in the commissioning team of a local authority:

> *'[I] started to tire of it a bit, mainly because of the lack of any authority really in terms of trying to get providers to do any actions or anything like that. So that's why I joined the CQC, to try and have a bit more clout and try and improve things.'*

Because inspectors are in the position to make an impact, it is important that they do not follow their personal 'logic of appropriateness' (May & Wood 2003; March & Olsen 2004; Tuijn et al. 2014). Both inspectorates had set rules to stimulate consistency. At

the CQC, standards were set out in regulations and the judgment framework promoted neutrality and equal treatment. The JIY stimulated consistency through deliberative discussions among inspectors and between inspectors and managers, as part of the reflexive processes. The JIY also had protocols on whom to involve in each phase of the inspection. For instance, before distribution to others, an inspection report first needed the approval of the team manager, managing director, chair, and one of the chief inspectors in the program committee. Inspectors considered it important to follow these procedures. When a colleague inspector sent a report to an inspected service before the team manager and managing director had approved it, one JIY inspector commented:

> *'That is against how we want to work and against our procedures. An inspector cannot do this on his own without involving others.'*

The action had serious consequences. The inspection was terminated and the inspector concerned was no longer allowed to work at the partnership.

The use of discretion in two inspectorates

Organizational rules in the form of CQC regulations and JIY protocols held the promise that judgments would not depend on an inspector's own logic. The rules embodied a standard decision making process. Yet in many situations, inspectors could not rely on following rules, as illustrated by a CQC inspector who commented that '*every inspector has something that does not fit in the box*.' In these situations, inspectors needed to find other ways to reach judgments and used their discretion to consider specific circumstances.

Organizational dynamics and form may significantly affect the use of discretion. CQC inspection work often involved inspectors going out on their own, taking responsibility for their own judgments. Even when they went out in small teams – for instance, to inspect a hospital – one inspector primarily made the judgment. An inspector explained:

> *'I wasn't leading the inspection so I didn't need to make a judgment, I just needed to feed back what I found. So I left it to [name] to make the judgment. I just said my evidence suggests this, but you need to make the judgment across everything that we've looked at.'*

It was part of the organizational routines to make judgments alone. Discretionary room was granted to individual inspectors. This differed significantly from the JIY inspections, in which cooperation and deliberation were key characteristics. One JIY inspector described his input in developing an inspection framework as contributing to a dialog with others:

> *Interviewer: 'Do you think that you were able to contribute to the development of the framework? Because that took a lot of deliberation, didn't it?'*
>
> *Inspector: 'Yes, yeah, of course it was developed in a dialog with the others. My contribution came about through the discussion. So I can't tell you which part of the inspection framework is based on my input.'*

Here, it was part of the organizational routine to make judgments together. The JIY teams were free to develop inspection plans that matched the circumstances of the problem under scrutiny and to develop new methods or tools to conduct the inspections. Discretionary room was granted to collectives and individual input was no longer discernible.

The cooperative work of making judgments

Although CQC inspections might be considered mostly individual and the JIY's teamwork, we found that both regulatory bureaucracies' inspectors engaged others and created collectives to use discretion. Rather than using discretion individually, which might have a negative impact on fairness and consistency and make the individual inspector vulnerable to criticism (as shown in the example of a JIY inspector no longer allowed to work at the partnership), creating collectives gave inspectors additional skills and knowledge, and a broader mandate and repertoire. In this section, we describe the three kinds of collectives we found in the contexts of the two inspectorates.

Involving colleagues to create support

The first collective that the inspectors created concerned the involvement of colleagues in their discretionary judgment. The literature considers that professional workers should be granted discretionary room or trusted to use discretion because of their specialist theoretical knowledge, practical skills, defined codes of conduct, and commitment to professional values and norms (e.g. Abbott 1988; Freidson 2001; Hupe & Hill 2007; Durose 2011; Evans 2011). CQC and JIY inspectors not only used their own skills and knowledge, but also needed the skills and knowledge of others to use their discretion successfully.

CQC inspectors, working mainly on their own, emphasized how much onus there was on the individual inspector in reaching judgments. An experienced inspector, describing taking action to confront poor practice, characterized this as follows:

> *'It was actually having the confidence in my own judgments and my own ability to stand up to them [the owners of a non-compliant service]. And I've got that,*

because I've got my background in regulation, I've got the legal frameworks, and I've got the expertise and knowledge.'

To limit isolation and create opportunities for deliberation, some inspectors had informal arrangements. One inspector explained that she and a colleague rang each other daily; it might be a quick 'hello' or a discussion about a tricky inspection. This inspector and her colleagues also arranged regular peer-support meetings to share learning, and weekly catch-ups by telephone conference to exchange views.
Because inspectors mainly worked individually, they needed to decide for themselves when to involve others in inspections:

'I think that the bottom line with that is that you will be faced with situations which are difficult, and I think it's knowing when to make a decision yourself, and when you need other people to help you make that decision.'

CQC inspectors involved colleagues when they wanted support and advice, when they wanted an impartial view, needed additional evidence, or if they felt they lacked specific or state-of-the-art knowledge. In the latter situation, inspectors involved colleagues who had specific knowledge because of their background or experience. One inspector explained that colleagues consulted her on questions about mental health issues because of her experience and, in turn, she consulted colleagues on other matters, for instance, infection control. CQC inspectors asked for information from advisers with specialist knowledge or expertise or invited them to join them on inspection visits.
JIY inspectors also included the skills, knowledge, and expertise of others, combining them in the inspection teams. One inspector characterized inspections as a concerted effort:

'You are part of a project group. So you don't need all the skills yourself. I think that not everyone has to be able to analyze information, not everybody needs writing skills, and not everyone needs to be able to develop an inspection framework. But with your colleagues you are in a team and together you make sure the job is done.'

The literature describes involving colleagues in judgments as a way for workers to deal with work pressure and find gratification, and for managers, as an instrument for quality control (Bardach & Kagan 2002; Lipsky 2010; Hupe & Buffat 2014). In addition, we found that engaging colleagues and including others' knowledge and skills could benefit inspectors as it enabled them to act responsively while sharing responsibility for the judgment.

Including managers for mandate

The second collective that the inspectors created concerned the involvement of managers to gain a mandate for their actions.

At the CQC, the majority of the services were judged to meet standards. If inspectors felt that standards were not met, they were granted discretionary room to consider the most appropriate action within the bounds of the inspectorate's judgment framework. If they decided compliance actions were appropriate (the most common response), they needed only their manager to confirm the decision. Inspectors and their managers used their discretion to consider the impact of both failure to meet standards and the service providers' motivation on service users. These aspects were crucial in deciding what action to take. In situations where the stakes of their judgments were high, such as when there was a risk of moderate or major impact on service users or when there was persistent failure to meet standards, CQC inspectors involved their managers and others in a formal discussion. Inspectors organized a review meeting with their manager, which often included members of the legal team. Inspectors presented information and set out the regulatory options, based on evidence on the service, and their view of the service's ability to improve. However, deciding what action to take on non-compliance was not always straightforward. An inspector compared this to balancing on a tightrope:

> *'It was quite difficult at the time to decide well should I make compliance actions, bearing in mind this home has never had compliance actions before, or should I issue a warning notice which is quite a harsh action to take, bearing in mind that people [service users] generally told us their needs were being met. And it's a tightrope to decide whether the right action has been taken.'*

In this case, the manager decided to take the stronger action and constrained the inspector's use of discretion in favor of his own. The inspector suggested this was because CQC had decided to be seen as tougher than previously because of external criticism. Managers tended to take into account additional considerations to those of the inspector.

Similarly, managers at the JIY took into account aspects that the team of inspectors would not do on its own, such as political aspects, the perspective of the media, and whether the five participating inspectorates would approve. Inspectors at the JIY also needed to involve their manager in situations where there were high stakes, for instance, when the team of inspectors made major changes to the inspection plan or when they decided to make major adjustments to the inspection framework. Inspectors considered this flexibility to be an important virtue. This is illustrated by a situation where inspectors felt they needed to adjust the inspection framework for

the care of vulnerable families with multiple problems. According to the inspection criteria, professionals providing support were expected to involve the families' social networks. However, during inspections, the team discovered that some people in the social network had a negative influence on the young people (e.g. relatives with a criminal history or other serious problems whose advice was detrimental to progress). Therefore, the inspectors adjusted the inspection criteria and involved the manager and one of the chief inspectors in confirming these. In this example, the inspectors engaged managers in their discretionary room to improve the rules and apply these new rules to other situations. In this regard, the JIY's approach showed similarities with experimentalist governance, which gives teams broad discretionary room and uses their experience to improve their approach (Sabel & Zeitlin 2012).

Engaging stakeholders to create extra options

The third collective that the inspectors created concerned engaging stakeholders to extend their abilities to take action or to prevent harm.

For the CQC, local authorities and commissioners of care for people are vital stakeholders. A CQC inspector said that she looked for an alternative to cancelling the registration of a care home as there was no similar service in the area. This inspector involved the head office of the service and contacted the commissioners to persuade them to put extra pressure on the service to improve their quality of care. As the inspector used to work for the local authority, she found it easy to cooperate with the commissioners:

> *'And from there we've worked closely with the provider, with the local authority [..] But because I'd worked [there] at a more senior level, I knew the assistant director for contracting so I had those relationships in place. [. . .] The fact I knew processes and I understood safeguarding and the collective care process [of the area] meant that I was able to work with others and move that forward.'*

The inspector's cooperation with the commissioners led the care home to make the necessary changes. At the JIY, inspectors also asked stakeholders to use their authority. For instance, they asked local authorities to impose conditions for care quality in contracts for services. Moreover, the JIY added the authority and abilities of individual inspectors to the team's repertoire. One inspector explained that when she expected to meet resistance in a healthcare service, she introduced herself as a healthcare inspector rather than a JIY inspector. In these situations, she used the authority of her home inspectorate to convince people to cooperate. She used the metaphor of a lion to describe this authority:

> *'So in a lot of situations we encounter at JIY, you don't need the lion, because generally people are willing to cooperate and share information. But on some occasions [. . .] you do need the lion. It doesn't occur often, but it happens sometimes. [..] Mostly the advantage [of using formal authority] is that people agree to cooperate. It results in people giving you information you otherwise wouldn't have obtained.'*

This inspector used her discretion to increase the options available to her in particular instances. This also increased the available options for the team, which usually relied on using persuasive arguments. Other team members asked this inspector to use her authority when they met resistance to cooperation in healthcare services:

> *'At the moment one midwifery service seems uncooperative. [. . .] So [name of a colleague] said to them: 'An inspector from your own inspectorate will call you.' I am fine with that, let me call and persuade them.'*

The authority and ability of this inspector, related to her home inspectorate, were incorporated in the discretionary room of the team.

In summary, at CQC, discretionary room was individual, and acting responsively was the responsibility of individual inspectors. Individual discretionary room was granted to decide whether services complied with the standards, and in situations of non-compliance to consider the impact of failure to meet standards on service users. CQC inspectors created collectives to engage others in their judgments, on their own initiative and outside prescribed rules. As sociological citizens, they drew on their informal relations and used their discretion collectively.

At the JIY, discretionary room was collective and acting responsively was a shared responsibility of the team. Collective discretionary room was granted to develop inspection plans, methods, and tools, to stimulate scrutinized services to improve, and to adjust and improve rules. This did not mean that JIY inspectors did not use discretion individually; we found that inspectors did act on their own at times. However, using individual discretion made inspectors vulnerable to criticism. The relations inspectors drew on and the collectives they created provided them with a broader repertoire of roles, tactics, and options. A CQC inspector could call on the knowledge of a specialist advisor to consider a judgment, engage a manager in the discretionary room to decide which action to take against non-compliance, and use the authority of local commissioners to prevent harm to service users. JIY inspectors could use the skills of colleagues to collect information from various perspectives, using discretionary room to improve inspection frameworks, or the powers of 'the lion' to persuade services to cooperate. This broader repertoire helped inspectors to act responsively and consistently at the same time.

DISCUSSION AND CONCLUSION

In this paper, we compared two different inspectorates to analyze the individual and cooperative work inspectors, using their discretion and the discretionary room granted to them, employed to act responsively to specific situations. Our analysis reveals that inspectors create collectives to use discretion effectively. They engage colleagues, managers, and stakeholders to include other perspectives and knowledge, and to gain mandate and broaden their repertoire. The organizational context shapes the collectives and how inspectors are enabled to use their discretion and discretionary room. The JIY formalized collective work, granting teams of inspectors collective discretionary room. At the time of our research, CQC granted inspectors individual discretionary room, but as sociological citizens, individuals took the initiative to engage others and use discretion collectively. As described above, CQC had recently changed the set-up of its inspections, now often conducted by teams, which created the opportunity for collective discussion of the evidence. However, scripted inspections may limit the team's repertoire to respond to issues not included in the inspection framework. The quality assurance process promotes consistency, but may be less responsive to the circumstances of individual providers. This change in organizational context highlights the challenges for regulators in finding a balance between collective and individual discretionary room and being consistent and responsive at the same time.

In the literature, individual discretion and discretionary room have been described as individual resources for street-level bureaucrats to act responsively (Bardach & Kagan 2002; Hupe & Buffat 2014). We found that discretion is used collectively. As social citizens, inspectors pragmatically involve others on their own initiative to interpret, balance, and deviate from rules to reach judgments and take action. In the literature, sociological citizens conducting relational regulation are described as a faction of workers working alongside strict rule enforcers (Huising & Silbey 2011). Some scholars characterize sociological citizens as operating covertly in a regulatory bureaucracy that claims to be consistent, creating a more responsive organization but not openly (Coslovsky 2011). Here, responsiveness and consistency are considered opposites. However, collective discretionary room – organizing others' involvement and a shared space to act flexibly – allows for responsiveness and consistency at the same time.

Collective discretionary room enhances responsiveness in two ways. First, it includes various perspectives and principles in reaching a balanced judgment. The involvement of other inspectors, managers, and stakeholders adds knowledge and skills and multiplies the number of angles from which to view the subject under scrutiny. This facilitates the ability to make complex decisions, balancing rules, context, interests, and understanding of the subject (Bardach & Kagan 2002; Thiele 2006; Pires 2011).

Second, the broader repertoire available to inspectors may enhance responsiveness. If inspectors lack the tools to do what they consider necessary in a particular case, the inclusion of other stakeholders may open up alternatives to stimulate compliance and improvement of the organizations under scrutiny. This broader repertoire is available not only to inspectors who may be viewed as sociological citizens with good relations at other organizations, but other inspectors may also draw on these relations and gain access to these alternatives.

Collective discretionary room may enhance consistency in two ways. First, by working collectively, inspectors develop a shared perspective, and share knowledge and experience in reaching judgments and stimulating compliance and improvement. Other scholars have pointed out that discussion and reaching consensus can increase the consistency of judgments (Pires 2011; Tuijn et al. 2014). Second, cooperative work performed within collective discretionary room opens up the possibility of adjusting and redefining goals, strategies, and tools, making them more practicable and effective. Therefore, collective discretionary room may not only reduce variance, but also enhance learning and the development of more effective ways of working (Pires 2011).

Collective discretionary room also has limitations. The work of engaging others, weighing various perspectives, and reaching consensus is time-consuming. Collectives also constrain the flexibility of individual inspectors and the inclusion of others in the judgment does not always result in the judgment individual inspectors had hoped for.

Our findings have implications for the practice of regulatory bureaucracies and for research into discretion. Rather than controlling and constraining the use of discretion, it is important for regulatory bureaucracies to strengthen and organize collective processes to obtain benefit from discretion. They should not leave the inclusion of others solely to the inspectors' initiative, but should organize processes for interaction between inspectors and their colleagues, and for engaging others outside the organization. In arguing for strengthening collective discretionary room, we do not suggest minimizing the importance of individual discretionary room or defining and adhering to rules. We have shown that collective discretionary room has limitations. In straightforward situations, individual inspectors can make judgments themselves (based on rules) and involving others would delay the process. In situations that need a swift response, individual discretion may prove invaluable in promoting the compliance or improvement of services under scrutiny. The combination of individual use of discretion, cooperative work at the inspector's own initiative to use discretion collectively, discretion granted to individuals, discretion granted to teams, and a set of rules gives inspectors a broad repertoire to act in the wide variety of situations they encounter.

Based on our findings, we propose broadening the view on the use of discretion and discretionary room in two ways. First, to study inspectors and other street-level

bureaucrats, it is important to look broadly at the collectives they create and the teams and networks to which they belong. The argument of contemporary scholars reflects this broader view of discretion; workers should be studied in context, including horizontal and vertical relations and institutional and systemic environments (Silbey et al. 2009; Huising & Silbey 2011; Pires 2011; Rice 2013; Hupe & Buffat 2014). The ways in which discretion is granted influences the way discretion is used (Hupe 2013). In our study, we showed that discretion may be granted to both collectives and individuals and that it may be used both individually and collectively. How discretionary room is arranged and how discretion is used varies between regulatory bureaucracies and both are affected by organizational conditions. Although regulators from various countries recognized our findings when we discussed our analysis, our exploratory study was limited to two organizational contexts. Future research should focus on the variety of ways discretionary room is organized and how its organizational form affects the collective and individual use of discretion.

Second, rather than viewing rules as the creators of consistency, and discretionary room and the use of discretion as stimulating responsiveness, it is important to reconsider how consistency and responsiveness are related. Whereas literature on street-level bureaucrats presents consistency and responsiveness as two opposite ends of a continuum, and literature on relational regulation labels two distinct groups of inspectors, we found that consistency and responsiveness can be combined by organizing discretionary room collectively. We have mentioned that our study was limited in extent. As it is vital for regulatory bureaucracies to act both consistently and responsively, this topic deserves further study.

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6

Discussion and conclusion

INTRODUCTION

Reflexive regulation is presented as an answer to two challenges that inspectorates face in our society. First, regulating social problems poses a serious challenge for inspectorates because these problems are often cloaked in cognitive and normative uncertainty (WRR 2008; IRGC 2015). Second, inspectorates cannot control or manage the quality of services on their own because of the multiplicity of institutional contexts (Heimer 2011; WRR 2013; Overdevest & Zeitlin 2014; IRGC 2015). Although regulation by command and control works well when criteria and regulated services are well defined, the approach becomes challenging when inspectors are confronted with cognitively and normatively uncertain situations involving multiple actors. For these complex situations, reflexive regulation is offered as alternative (Perez 2011; Gunningham 2012).
In this thesis, I analyzed what reflexive regulation entails in practice. The central question that guided the research was:

How do inspectors practice reflexive regulation in the context of their inspectorate?

The three sub-questions were:
- How do inspectors deal with uncertainty?
- How do inspectors act in multi-actor contexts?
- How do inspectors learn and generate options for improvement?

To answer these questions, I studied the case of the Joint Inspectorate for Youth (JIY), a partnership of five government inspectorates in the Netherlands that is considered to have a reflexive approach. The partnership conducts themed inspections focused on social problems concerning young people in municipalities. Data collection took place between 2009 and 2012 and covers the work of the inspectors from 2003 to 2012. Since the foundation of the JIY in 2003, the partnership inspectors have constantly worked to develop their methods. In consequence their approach changed considerably over the time interval examined in this research.
The regulatory context has also changed over the years covered in this study. In January 2015 the Youth Act (Jeugdwet) came into force. It has given the JIY inspectorates the task of assessing local systems of services for young people. During this time period, care and assistance for adults was also decentralized from central government to municipalities. As part of these changes, the JIY's scope was broadened: inspectors now assess care and support systems not only for young people but also for adults. In 2017, the name of the partnership changed to '*Joint Inspectorate Social Domain/Joint Inspectorate for Youth*' (STJ/TSD 2015). To illustrate the changes in the JIY's approach and in the regulatory context, some examples used in this concluding chapter are more recent, and were not

mentioned in the preceding chapters. I am able to add these recent examples because, as an insider researcher, I have had prolonged access to the case under study.
In this concluding chapter, I first answer the research sub-questions and the central question, then I reflect on my role as an insider researcher. The chapter ends with suggestions for future studies of reflexive regulation and recommendations for reflexive regulation in practice.

DEALING WITH UNCERTAINTY

I found that inspectors deal with uncertainty in two ways. First, they collect all kinds of knowledge and diverse opinions, studying relevant literature and involving a variety of stakeholders. In Chapter 2, for instance, I describe how the inspectors started the inspection with a dialogue with adolescents and parents living in poverty about how they defined poverty and what they felt needed improvement in the services to poor people. In addition, the inspectors set up meetings to discuss what poverty is about and to conceive improvement options with two different groups of stakeholders, 1) professionals, service workers and volunteers, and 2) managers, policymakers and elected members of the local governments. By doing this, inspectors gained insight into a whole range of interpretations and diverse actions for improvement. In other words: they created a knowledge base that shows where knowledge or interpretations differ or are consistent.
In the literature on risk governance creating a knowledge base is widely acknowledged as a strategy to deal with uncertainty (Renn 2004; Van Asselt & Renn 2011), yet various authors argue that the high expectations of this strategy need to be moderated. The knowledge base is likely to show that social problems are multi-causal, interactive effects cannot be identified, and many interpretations of the data exist. Consequently, creating more knowledge may lead to more uncertainty – and fewer options for control (Beck 1994; Perez 2011). This places a heavy burden on the inspectors, who need control to make a difference (Chapter 5) and tackle these social problems.
It is for these reasons that – and this is the second strategy – inspectors reframed social problems as problems of 'fragmented services for children' (Chapter 2). The inspectors developed a claim that improving cooperation between services for children reduces fragmented care and is a necessary precondition to tackling the social problem (Chapter 4), thus tapping into the general consensus on the need to improve cooperation and remove fragmentation from children's services (Van Eijk 2004; Charles & Horwath 2009; Munro 2011). The inspectors thus created a reduction in which they break down the social problem into separate pieces and then reduce it further to one piece about which there is consensus.

It is important to look at what this process of reduction does (Mol 2002; Voss et al. 2006). In the case of JIY inspectors the reduction diminishes uncertainty, which facilitates their assessment and options for control. It creates opportunities for them to formulate and use assessment criteria and make a strong claim for action. However, the reduction of the problem to 'fragmented services for children' rules out addressing other aspects of the social problem. In Chapter 4, for instance, I described Anouk's situation. As a girl with linguistic and developmental disorders, she did not have just one, but twelve problems. In Chapter 4 I showed that when fragmentation becomes the only problem to be solved, the child's problems are no longer central. Consequently, options for improvement only relate to solving the problem of fragmented services and render other options for improvement invisible.
Reduction therefore not only diminishes many aspects of the social problem, it also reduces the range of options for improvement. As a consequence, various scholars claim that it is important not to reduce a problem to a single topic. They state that it is better to create a set of reductions and to experiment with the variety of options for improvement related to these reductions (IRGC 2005; Voss et al. 2006; Sabel & Zeitlin 2008).

ACTING IN MULTI-ACTOR CONTEXTS

JIY inspectors involve all kinds of actors in their work, creating a network that can be the starting point for cooperation between stakeholders to make improvements for youth (Chapter 4). Inspectors not only involve the service providers they regulate, but also bring in other actors who provide care and assistance for children and their families, including volunteers, as described in Chapter 2. By assembling this range of stakeholders, the inspectors bring together diverse skills, knowledge bases and capacities for action. This diversity enables the inspectors and the stakeholders to find a wider range of options for improvement (Renn 2004; Engeström, 2008; Hagel III et al. 2010; Van Asselt & Renn 2011).
Inspectors leave the network they have initiated as soon as they have made their assessments. When the inspectors step back from the network, a notable change takes place in the role and position of both the inspectors and the municipality – which is one of the actors in the initial network. To mark this change in the role and position of these actors, the distinction between horizontal and vertical relations is relevant. In the initial network that the inspectors construct (Figure 6.1), all relevant stakeholders are first connected horizontally. In Figure 6.1 the inspectorate has connections with all the other stakeholders (white lines). The dark grey lines in the figure indicate the network that the stakeholders form. To illustrate the diversity of the stakeholders, they

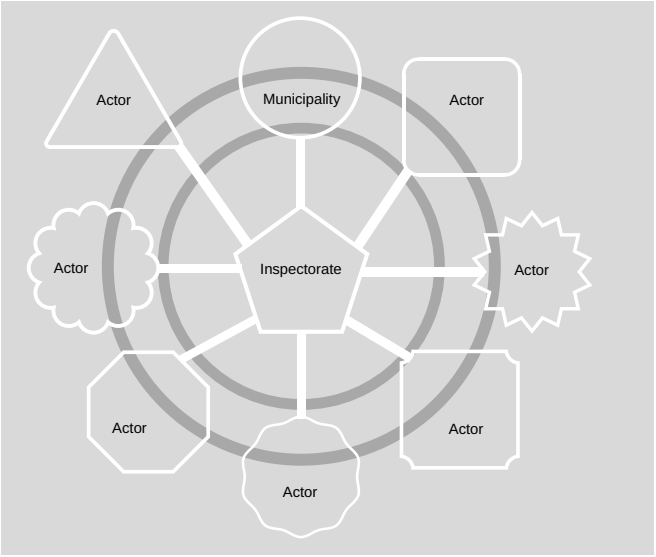

Figure 6.1 *The network of inspectorate, municipality and actors connected horizontally during the initial inspection phase*

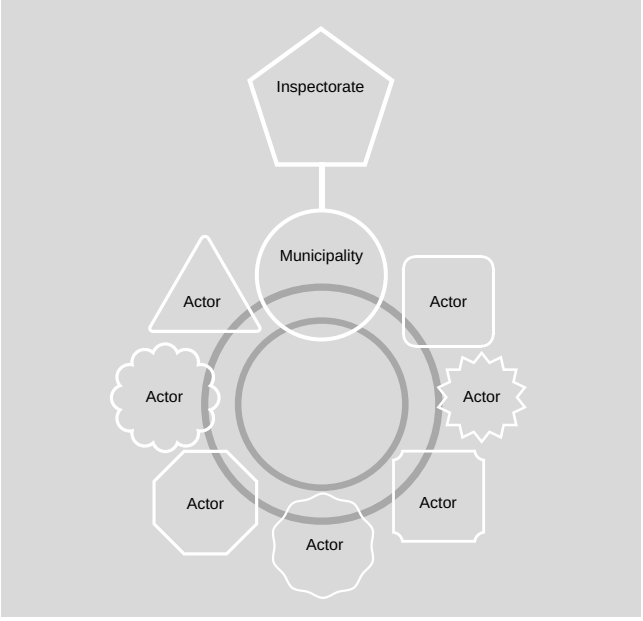

Figure 6.2 *The inspectorate, municipality and actors connected vertically in the later phases of the inspection*

have been given different shapes. When the inspectors have stepped back from the network (Figure 6.2), they are no longer connected with all stakeholders; their only connection is the municipality (white line).
Inspectors expect the municipality to take the lead in making improvements in services for children. The inspectors not only assume that municipalities can coordinate local action and encourage the other stakeholders to make improvements, inspectors also address their actions to municipalities because it is the municipalities legal duty to coordinate services for young people on the local level (VWS 2013). The inspectors expect the municipality to maintain relations with the other stakeholders and to take care of the network (dark grey lines). They hold the municipality accountable for whether the network achieves improvements. Hence, inspectors start to assess whether the municipality – rather than the network – achieves improvements. In Chapter 2, I described how this way of working had consequences for the inspectors' relation to the municipalities. The municipalities used the inspectors' recommendations in a technocratic manner. They interpreted the recommendations as a package of measures that had to be implemented to meet the inspectors' demands. In other words, a vertical relationship is created between the inspectors and the municipalities. The advantage of the vertical relation is that inspectors can hold one central stakeholder accountable for initiating and carrying out improvements. The disadvantage is that the municipalities focused on the inspectors and only marginally involved the other stakeholders. The vertical relation reduces the stakeholders' own potential to take the initiative. So their goal is reduced to meeting the inspectors' demands rather than creating learning opportunities to deal with the social problem at hand.

LEARNING AND GENERATING OPTIONS FOR IMPROVEMENT

At the JIY learning forms an important part of inspectors' work. In Chapter 5, I have shown how JIY inspectors work in multidisciplinary teams with collective discretionary room, which differs from other inspectorates (such as the Care Quality Commission) in which inspectors' discretionary room is individual. The JIY inspectors use this collective discretionary room to decide which methods, tools and assessment criteria to use in an inspection. They may decide to adjust these (based on previous experience or the need to adapt to the inspection theme) or to develop new working methods (Chapter 5). The inspectors thus use their collective discretionary room to learn to adapt and develop new tools, methods and criteria. This study also contributed to learning, for instance in the development of the journey tool. Based upon Chapter 4 in which the conclusion was drawn that inspectors created just one problem definition (fragmented services), the inspectors decided to adjust the tool. The adjusted journey

tool no longer holds one problem central, but includes the problems and services of all family members. Similarly, based on my study on the role of adolescents in inspections in which I found that inspectors did not let adolescents influence their own assessments because the adolescents' perspective conflicted with the inspectors' assessment criteria (Chapter 3), inspectors decided to involve service users (and other stakeholders) in the development of inspection criteria. They now, for example, engage people with learning disabilities to define inspection criteria for this target group and have involved service users in the development of a new inspection framework via online discussions.

One observation of note is that the learning of inspectors described here does not focus on learning how to generate options for improvement of the social problems that are central in the inspection. The explanation for this relates to the finding described in the previous section: inspectors expect municipalities to take the lead in making improvements. In other words, they expect the network of municipalities and relevant stakeholders to learn how to tackle the problem. However, in one inspection in 2013/2014, the inspectors did not reduce the social problem that was central in the inspection to fragmented services and did not step back from the network. This case concerned an inspection into services for young people who were chronic truants from school. During this inspection, the inspectors looked for local practices among professionals that had been successful in bringing these young truants back to school. Based on the successful local practices, JIY inspectors developed a website for professionals. The inspectors then brought various stakeholders together to generate attention for the website. With these stakeholders, the inspectors developed webinars for parents, young people, professionals and policymakers. The stakeholders and an inspector remained involved over a period of three years. This example demonstrates that the inspectors can be involved in the work to tackle the social problem.

In sum, JIY inspectors have developed their reflexive regulatory approach, and their main focus is on the methods, tools and inspection framework. However, more recently, inspectors have started to learn how to generate options for improvement of the social problems they address.

PRACTICING REFLEXIVE REGULATION

Based upon the answers to the three sub-questions, I can now answer the overall research question of this thesis: '*How do inspectors practice reflexive regulation in the context of their inspectorate?*' In this study I have shown that inspectors practice reflexive regulation by collecting a diverse range of knowledge, experience and opinions. They are open to multiple problem definitions and build a broad knowledge base. However,

they also narrow the problem they assess down to one aspect – in this case fragmented services, and make their assessment based upon this reduced definition of the problem. Similarly, inspectors initially build a network with a broad variety of stakeholders. During their inspection, however, they leave the network they have initiated to create a vertical one-to-one relationship with one stakeholder. In this way, inspectors distance themselves from the stakeholders who need to make improvements to deal with the social problems that the inspectors placed on their agenda.

The translation of a broad knowledge base into a specific problem definition, combined with the switch from multiple horizontal relations to one vertical relation, can be interpreted as a switch from reflexive regulation to command and control. In fact, various reflexive regulatory theories – responsive regulation and smart regulation in particular – combine both approaches. Smart regulation is based on a mix of instruments, which may include both reflexive and command and control tools (Gunningham & Grabosky 1998). Responsive regulation is based on the general idea that inspectors can switch between persuasive methods (open and cooperative, based on horizontal relations, linked to reflexive regulation) and punitive methods (based on vertical relations, related to command and control) (Ayres & Braithwaite 1992; Mascini & Van Wijk 2009; Braithwaite 2011). Reflexive regulation is thus distinct but not separated from command and control, and inspectors who practice reflexive regulation do not distance themselves from the underlying principles of command and control.

The reflexive regulatory theories stress one particular advantage of the switch between a reflexive approach and a command and control approach, namely that it broadens the inspectors' repertoire. This study examined the switches between reflexive regulation and command and control in more detail, showing the differences and conflicts between the two approaches. First, command and control requires inspectors to reduce uncertainties and reframe the problems they address in one direction. Second, inspectors using command and control need to distance themselves from the stakeholders with whom they need to explore the options for improvement and learn. Consequently, the switch from reflexive regulation to command and control relegates social problems to the background and prevents crucial learning about how to tackle the social problem at hand. Other scholars concluded that the combination of reflexive regulation and command and control is difficult to bring into practice because it is unclear for inspectors when to make the switch from persuasive to punitive methods (Mascini & Van Wijk 2009). As my study shows, the switch is not only a practical difficulty; the repertoire of command and control is not appropriate when it comes to tackling uncertain problems in multi-actor contexts. The example of the inspection project on chronic truancy discussed above shows that it is possible to stick with a reflexive approach, to focus on the process of 'muddling through and tinkering', and to

learn what helps best in handling the problem. Below I offer some suggestions on how to implement this approach in the future.

My study focused on one particular inspectorate: the JIY. This is an exceptional case as the JIY is a partnership of inspectorates that has developed an approach that crosses organizations and sectors, an approach which was new at the time the JIY was founded. Moreover, as my study shows, their methods for reflexive regulation are still in development. However, I can provide – based upon my study – three reasons why the findings of this study are also relevant for other inspectorates.

First, the observation that reflexive regulation is distinct but not separated from command and control will hold for other inspectorates, because many inspectorates use the theory of responsive regulation (Braithwaite 2011; Mascini 2013; Parker 2013), which combines both approaches. Second, many inspectorates across various domains are being urged to shift their focus from compliance with laws to tackling social problems (IRGC 2015, van Montfoort 2010). This makes it more likely that they will be confronted with uncertain situations in which the laws, rules, tasks and roles are unclear, while at the same time they are urged to act strictly. This is connected to the third reason which is that command and control is regarded as the prototype regulation. The notion of regulation is framed as a vertical relationship between the inspector and the regulated services, and the assessments are based on well-defined criteria with straightforward options for improvement, such that command and control will shape any alternative method for inspection. It fits current ideas of state governance in which inspectorates act as intermediaries between central governments and the organizations carrying out public tasks. In this mediating role, inspectorates are expected to exercise control and take action to protect the public from harm (OECD 2014). Moreover, inspectorates in various countries and sectors have been criticized for intervening too late, and this criticism has had an important impact on public confidence and on the accountability and legitimacy of inspectorates (Adams et al. 2013; Perez 2014; Bouwman et al. 2015; Ottow 2015). Consequently, inspectorates are expected to act firmly by strictly enforcing rules and regulations. This regulatory context triggers every inspectorate to hide uncertainty and focus on internal learning (not having to be open to outsiders about why learning is needed; which is the uncertainty about how to deal with the problem). While the regulatory context may change in the future, at present it pushes inspectorates away from reflexive regulation towards command and control.

PRACTICING INSIDER RESEARCH

Reflexivity seems to have a boomerang effect; whoever scrutinizes the reflexivity of others has their own reflexivity scrutinized in return. Inspectors practicing reflexive regulation are asked to reflect on their inspection work and researchers studying reflexivity need to reflect on their research too (Lynch 2000). As I both practice and study reflexive regulation, this urges reflexivity upon me.

As explained in Chapter 1, I conducted insider research. Traditionally, insider research is seen as problematic because the researcher is native to the situation and may be too close to conduct valid research (Van Heugten 2004; Brannick & Coghlan 2007; Alvesson 2009). Therefore, I made additional efforts to deal with the issue of methodological distance (see Chapter 1). Various authors also argue that insider researchers not only need to create distance, they also need to remain close to the object of study. These authors relate closeness to prolonged access to the organization (enhancing data gathering), enriched interpretation of findings (using lived experience in developing theory) and increased impact of the research (being able to provide meaningful suggestions for improvement) (Van Heugten 2004; Brannick & Coghlan 2007; Alvesson 2009; Dobson 2009). In addition to an influence on validity, closeness may have other limitations. The position of insiders may block access to certain parts of the organization, lived experiences may block innovative interpretations and an insider's suggestions for improvement may be ignored more easily than those of an outsider (especially when the organization is not committed to self-learning) (Brannick & Coghlan 2007). Clearly, the key to insider research is to balance closeness and distance.

Based on my experience, I would add 'topic selection' as an important aspect related to closeness. Being an insider helped me to select topics for the research because I knew the difficult situations that inspectors encountered based on my lived experience and insider knowledge. The chapter topics reflect issues that often led to discussions among inspectors on how to do their work and how to carry out inspections. For instance, since the foundation of JIY, inspectors have been discussing whether its primary focus is fragmentation of services or tackling a social problem, as well as how fragmentation and the social problem relate to each other. Chapters 2 and 4 have developed an understanding of this issue. Indeed, I selected controversial topics when I felt that the scientific literature could offer a new perspective to the discussion and new options for improvement. My selection of topics also led to criticism. While I aimed to contribute to the development of the JIY's learning processes, various chapters were perceived as critical towards the JIY approach.

The literature reports on the dilemmas insider researchers face such as that of identification and how they find themselves caught by tug of loyalty (Coy 2006; Brannick & Coghlan 2007). While scholars focus on dilemmas insiders face inside

their organization, I found the dual role of researcher and inspector more difficult to combine when I acted outside the inspectorate. In Chapter 2, I mentioned the informal conversations I had with professionals and policymakers in the municipalities in my role as a researcher, which they interpreted as if they had to justify their decisions to an inspector. Thus, when I acted as an inspector, carrying out inspections, I eased the tension by conforming to the mores of the team and following the team's agreed-upon procedures.

Brannick and Coghlan (2007) argue that, in order to increase the impact of insider research and achieve actual improvement, both the researcher and the organization need to commit to self-learning. The JIY is open to learning as learning is an important part of its approach. During the research, I found that the best way to contribute to the JIY's learning and development was by being closely involved. As an inspector, I was a member of the teams that carried out thematic inspections and pilot projects. I learned to make a fruitful contribution by offering practical suggestions in the teams without referring to scholars or relating my contribution to science in any other way, thus positioning myself as an inspector and not as a researcher. Yet, I have to be modest about my input. In the JIY's team discussions, individual input is not clearly discernible (Chapter 5).

IMPLICATIONS FOR FURTHER STUDY

I have concluded above that, in practice, reflexive regulation does not distance itself from the underlying principles of the prototype regulation 'command and control'. From my viewpoint, it is important to specifically think through what reflexive judgments should entail. In many cases scholars consider inspection processes to contain three main activities: 1) setting standards and criteria, 2) collecting information to assess whether the service complies with the criteria, and 3) taking action to meet the criteria and make improvements (Hood et al. 1999; Bundred 2006; Perryman 2006; Nutley et al. 2012; Koop & Lodge 2015). While collecting information for assessment is one of the three main activities in the inspection process, in reflexive regulation, due to uncertainty, standards and criteria cannot be specifically defined and may need to be formulated more loosely and be more open to adaptation. Collecting information is not only necessary to assess whether services comply, but also to generate options for improvement and uncover new aspects that could turn out to be important. Moreover, while the command and control approach often entails a binary assessment – whether or not a service complies – such binary assessments do not offer enough options for handling the situation in the uncertain circumstances and multi-actor contexts that reflexive regulation needs to address. Yet, when information collection does not lead

to a binary assessment, it raises the questions of what information is needed and what reflexive judgments should entail in order to offer inspectors the best options for dealing with the problem. I suggest this as a subject for further study.

To go one step further, although I used the three parts of the inspection processes in this thesis, my findings lead me to argue that it is important to carefully reconsider whether these three main activities do indeed help researchers understand reflexive regulation processes and, at the same time, help the inspectors practicing reflexive regulation to structure their work. I would therefore provisionally suggest that three other activities need to be highlighted in reflexive regulation: 1) putting a social problem on stakeholders' agenda, 2) building a network of relevant stakeholders, and 3) creating circumstances for experiments and learning to deal with the social problem. In highlighting these three new activities, I do not want to imply that we should drop setting standards, collecting information and making assessments, and taking action as activities. They may still be part of the inspection process, but in a less prominent way. In further studies, it would be worthwhile to theorize on the process of reflexive inspection and develop an understanding of the key activities in reflexive regulation.

In addition, I suggest that future studies could strive to gain new insight into the work of the stakeholders in the multi-actor context of inspectorates. As the day-to-day work of inspectors practicing reflexive regulation has not been studied in any depth before, I started in the middle of the action and zoomed in on the inspectors' work (Nicolini 2009). However the reflexive regulation approach influences the work of all kinds of other stakeholders, for instance the policymakers of municipalities. Therefore, it is important to zoom out (Nicolini 2009) to learn about what these stakeholders do during inspections. More understanding of this subject may help in the development of new scenarios for inspectors to cooperate with stakeholders in dealing with social problems.

IMPLICATIONS FOR PRACTICE AND POLICY

For practicing reflexive regulation, it is necessary to enable inspectors to experiment with a variety of strategies to deal with social problems. As explained above, there are no 'best solutions' for the problems the inspectors want to address. Improving requires adaptive learning. The inspectors should create a variety of problem definitions that result in a list of potential strategies to experiment with (Van Gunsteren 1994; Voss et al. 2006; Sabel & Zeitlin 2012). As the success of a strategy cannot be predicted in advance, strategies that turn out irrelevant may quickly be abandoned and replaced by new options (Sparrow 2000).

As members of the network of stakeholders, inspectors have an important role to

play in these experiments. Hence, rather than building and subsequently leaving the network, inspectors should stay in it, contributing their knowledge and experience and using the knowledge and experience of others to learn together with the other stakeholders (Sparrow 2000; Engeström 2008; Hagel III et al. 2010).

It takes persistence to make these two suggestions work (Braithwaite 2011). It takes time to build and maintain networks. It also takes time to experiment with diverse strategies and learn how to deal with the social problem. Therefore, I suggest putting social problems – inspection themes – on the inspectorate's agenda for a longer period. In recent years the JIY has started giving prolonged attention to inspection themes. For instance, the inspection into care for vulnerable families with multiple problems has been on the JIY's agenda since 2012 (STJ/TSD 2015). This has offered opportunities to focus on diverse aspects of care for these families; to develop and adapt tools, methods and inspection criteria; and to involve all kinds of stakeholders.

It is also essential to communicate to stakeholders that the reflexive approach is unlike their standard idea of inspections. This gives inspectors the opportunity to explain the differences and tell the stakeholders involved that their knowledge and experience are needed to develop new strategies. For the JIY, the distinction recent policy documents draw between command and control and the reflexive approach (BZK 2015) underlines this difference and may support openness.

These suggestions relate to the practice of inspectors and inspectorates whose practice, I have shown, is influenced by a societal context that pushes inspectorates away from reflexive regulation towards command and control. To maintain a reflexive approach, politicians and policies have to be willing to give the inspectors, inspectorates and other stakeholders the room to maneuver that will allow them to deal with uncertainty, build networks and learn.

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Summary

This thesis is about how inspectors practice reflexive regulation. Reflexive regulation was introduced to meet two current challenges for inspectorates in our society. First, inspectorates are urged to tackle social problems that are often surrounded by uncertainty. For inspectors, this means that they are confronted with uncertainty about what is best to do. Second, because of the multiplicity of the regulatory system, inspectorates cannot control or manage the quality of services on their own. For inspectors, this means that they must work with a diversity of regulators and regulatory instruments.

The problem analysis that led to the quest for reflexive regulation points to the limitations of traditional regulation employing 'command and control'. The command and control regulatory approach is characterized by criteria that legally define the desired standards and conduct on the one hand, and the coercive powers and a firm sanctioning regime to enforce compliance with these criteria on the other. Inspections take place in a vertical one-to-one relationship between the inspectorate and the regulated service. One strength of the command and control regulation is that it can use force of law to immediately impose standards and criteria, taking a firm stand to protect the public from harm. Regulation by command and control works well when the criteria and regulated services are clear and well-defined. It becomes challenging when laws, rules, tasks and roles are unclear and inspecting does not occur in a one-to-one relationship, but other actors are involved too. In these situations, reflexive regulation offers an alternative.

Reflexive regulation typically has three characteristics:

- Dealing with uncertainty: reflexive regulation explores and develops regulatory methods and tools that take into account that knowledge is unavailable or contested.
- Acting in multi-actor contexts: reflexive regulation is sensitive to the limits of state regulation and acknowledges the role of multiple actors in advancing regulatory aims by engaging citizens, experts and other relevant public and private stakeholders in participatory processes.
- Learning: reflexive regulation is characterized by learning, by applying a continuous process of self-observation and self-critique in order to generate options for improvement. Learning of inspectors is seen as essential, both in view of the absence of knowledge and as a measure against taken-for-granted routines.

Reflexive regulation includes a variety of theories. Prominent theories include meta-regulation, responsive regulation, problem-centered regulation and experimentalist governance. These theories vary considerably in their design and in how they acknowledge uncertainty, facilitate interaction with multiple actors and open up learning opportunities. In the literature on regulation, reflexive regulation is often set against command and control. Yet, in practice, the approaches may not necessarily be opposites.

Reflexive regulation theories often connect reflexivity to organizational levels. In many instances, it is unclear what the theories mean for the day-to-day work of inspectors, what benefits and problems they encounter while applying the theories and how they deal with these. In this thesis, I aim to advance understanding of what inspectors do when they conduct reflexive regulation. Therefore, the central question that guided the research was:

How do inspectors practice reflexive regulation in the context of their inspectorate?

I formulated three sub-questions that follow the three characteristics of reflexive regulation:

- How do inspectors deal with uncertainty?
- How do inspectors act in multi-actor contexts?
- How do inspectors learn and generate options for improvement?

To gain insight into these questions, I studied the case of the Joint Inspectorate for Youth (JIY; *Samenwerkend Toezicht Jeugd*), a partnership of five government inspectorates in the Netherlands. The partnership was founded in 2003. Instead of assessing the quality of services of a specific organization in a specific sector, which inspectorates do traditionally, the partnership developed an approach that crosses the borders of organizations and sectors. Social problems concerning children that require input from organizations in different sectors were chosen as inspection themes. Examples are child abuse, obesity, youth offences, high school dropout, and growing up poor. Theme-based inspections are carried out in municipalities. The partnership's aim is to help find solutions to social problems that respond to local circumstances. Multidisciplinary teams of three to eight inspectors conduct the inspections jointly and inspect a broad range of local services in various sectors that provide services to children, including health, youth care, education, police, and social affairs. In addition to theme-based inspections, since 2012 inspectors have also been investigating complex critical incidents. These are outside the scope of this thesis.

To study how inspectors practice reflexive regulation, I followed a thematic inspection process through a combination of participant observation, informal interviews and document analysis. This helped to gain an understanding of inspectors' activities, their interactions with one another and with others, and their capacity and competence to conduct inspections. Also, I conducted semi-structured interviews with inspectors who described their work in the partnership. In addition, based on the assumption that inspection methods steer the work of inspectors, I studied two inspection methods. The first was youth participation, studied through document analysis and a meeting with inspectors. The second considered the journey tool, which reconstructs

children's journey through the organizations providing services, studied again through document analysis and analysis of the semi-structured interviews. The inspectors' working practices in the JIY were compared in a decentered comparative analysis of the practices of inspectors working in a vastly different inspectorate; the Care Quality Commission (CQC) in England. This analysis was based on semi-structured interviews, document analysis and meetings with inspectors.

During this study I had a dual role of inspector and researcher, and as such conducted insider research. As familiarity with the research subject may create bias, I made an extra effort to gain methodological distance. I managed any tensions in the dual role of inspector and researcher by working with a theoretical framework and also involved and cooperated closely with researchers who were outsiders to the partnership. In addition, writing memos assisted self-reflection, challenging taken-for-granted forms of understanding and following up surprises. Although these strategies were meant to create distance, I also took care to stay close to the practice of the inspectors. For instance, I relied on the closeness to select topics for the research and to offer meaningful suggestions for improving the inspectors' working practices.

Using the literature on risk regulation, specifically the characterization and governance of risks, Chapter 2 focuses on how inspectors deal with uncertainty when they conduct a thematic inspection which has as its central theme a social problem surrounded by uncertainty. This chapter reports on a thematic inspection into care and assistance for children growing up poor. It reveals that at first, inspectors tolerate uncertainty. For instance, they collect information and a range of options for improvement from all kinds of stakeholders. However, to reach an assessment, the inspectors reduce and reframe the problem into the problem of fragmented services for children. Moreover, instead of involving all kinds of stakeholders, they start to focus on one stakeholder, the municipality, in particular. An explanation for the reduced focus can be found in the regulatory context. Inspectorates are expected to have a strict regulatory role, acting firmly and making a strong claim for action. Reducing the scope to 'fragmented services' creates the possibility for inspectors to make a strong claim for action.

Chapter 3 focuses on the inclusion of one stakeholder, namely young service users. The rationale for involving them in inspections is that their distinct perspective offers new options to improve the quality of services and deal with the social problem. This distinct perspective may conflict with organizational rules and conventions, and professional or societal standards. The chapter combines the literature on regulation with the literature on user participation. It uses data on the thematic inspection of care and assistance for children growing up poor to compare the views of both adolescent service users and inspectors on good care and to seek to understand what the differences and similarities mean to incorporating the views of these adolescents in inspections. The chapter shows that inspectors and adolescents agree on the importance of timely care,

creating opportunities for personal development, and a respectful relationship. The views on quality of care differ with regard to sharing information, creating solutions, and the right moment to offer help. Inspectors deal with the differences in three ways. They prioritize their own standards, pass the problem onto others to solve, and separate the differing perspectives. With similar viewpoints, inspectors use the adolescents' views to substantiate and illustrate their view. When viewpoints conflict, information from adolescents does not influence the inspectors' decisions. The literature generally offers two explanation for problems with involving service users; difficulties are mainly related to participants and the organization where participation takes place. The chapter offers the external context as a third explanation. A fundamental tenet of Dutch youth policy is that it is better to prevent than to solve problems. In this case, the value of prevention is so dominant that any input from adolescents that goes against this value is put aside. The external context cannot be disregarded easily and limits the inspectors' room to let the voice of adolescents influence their decisions. Hence, in the regulatory context, conflicts between the views of adolescent service users and inspectors are not easily overcome.

Effective learning processes are considered essential in reflexive regulation. Chapter 4 focuses on the journey tool, an inspection instrument that aims to enhance learning to improve outcomes of services for children. When they work with the tool, inspectors reconstruct and assess children's journeys through the service-providing organizations and create a network of the organizations involved. Using an ontological theoretical framework, the chapter shows that with the reconstruction the inspectors define one central problem by creating a hierarchy and placing other problems lower in the hierarchy. The inspectors created the problem of fragmented services for children. This problem definition resulted in one set of options for improvement, related to fragmented services. However, in the complex care practices the inspectors have to assess, children have multiple and often incompatible problems so it is impossible to make one coherent problem definition. Therefore, the chapter explores what patchwork – an alternative that allows for multiple problem definitions – would mean for the inspectors' assessment and the options for improvement. It argues that patchwork offers more diverse options for improvement, by emphasizing the variety of options to handle a situation.

Chapter 5 focuses on how inspectors involve other stakeholders and create learning when they use their discretionary room. It draws on a comparative analysis between the working practices of JIY and the CQC, that inspects health and social services in England, and based on the literature on street-level bureaucrats, relational regulation and experimentalist governance, it develops the notions of collective discretionary room and collective discretion. Collective discretionary room is used to refer to the space granted to teams of inspectors in which they reach their judgments together. The

label 'collective discretion' refers to individual inspectors who pragmatically involve others on their own initiative. In both inspectorates, inspectors engage with colleagues, managers and stakeholders when they use their discretion. At the CQC, inspectors use their discretion collectively; they involve others on their own initiative to include other perspectives, gain mandate and broaden their repertoire. At JIY, teamwork is central and collective discretionary room is organized for these teams. Based on the findings, the chapter argues that while collective discretion offers individual inspectors the opportunity to be responsive to specific cases, collective discretionary room offers this opportunity to groups of inspectors and the inspectorate. Collective discretionary room allows inspectors to use the broad and varied repertoire of roles, tactics and options of the various members of the group. Moreover, it enhances learning processes as in the collective discretionary room inspectors develop responsive and consistent ways of working.

Chapter 6 discusses the findings of the previous chapters, draws conclusions and provides recommendations for future research and practice. With regard to dealing with uncertainty (the first research question) this study found that inspectors initially open up to uncertainty and collect diverse knowledge, experience and opinions. During the inspection process, they close down and reduce the problem to fragmented services, which allows them to use clear criteria and make an assessment. With regard to behavior in a multi-actor context (the second research question), inspectors initially engage all kinds of stakeholders to create a network of actors. During their inspection, they leave the network and create a one-to-one relationship with one stakeholder, namely the municipality. With regard to learning (the third research question), the inspectors' learning processes focus on methods, tools and the inspection framework. Less emphasis is placed on learning with other stakeholders how to deal with the social problems that are the themes of the inspections.

Although the inspection process is initially very open to all aspects of the social problem as well as to all kinds of stakeholders, during the process, the inspectors reduce the issues to one well-defined risk (e.g., fragmented care), and switch from horizontal relations to a one-to-one vertical relation with one stakeholder (the municipality), two aspects related to command and control regulation. Hence, during the inspection process, the inspectors switch approaches from reflexive to command and control. Reflexive regulation is thus distinct but not separated from command and control. Inspectors who practice reflexive regulation do not distance themselves from the underlying principles of command and control. This blocks opportunities for learning how to deal with the social problem as it is no longer central in the inspection. Although command and control is considered the prototype regulation, the repertoire of command and control is not appropriate when it comes to tackling uncertain problems in multi-actor contexts.

For further study, I suggest elaborating on reflexive inspection processes as distinct from command and control by reconsidering what a reflexive judgment needs to entail, theorizing on the process of reflexive inspections and developing understanding of its key activities. I also suggest that further research should focus on the work stakeholders (not being inspectors) do during inspections in order to develop an understanding of how inspectors can cooperate with these stakeholders on the social problems that are on the inspectorates' agendas.

Although this study does not provide easy options for reflexive regulatory practices, it offers various suggestions for practice and policy that are related to learning. It is important to arrange learning processes in which inspectors – with other stakeholders – can experiment with a variety of strategies to deal with social problems. As it takes time to experiment with various strategies and build stakeholder networks, it would be advisable to put social problems on the inspectorate's agenda for a longer period of time. In addition, it is essential to be open about reflexive regulation and communicate to stakeholders that the reflexive regulation approach is unlike their standard idea of inspections and thus asks for a different roles and activities. In order to maintain a reflexive regulatory approach, policies (and the politicians who establish it) have to give the inspectors, inspectorates and other stakeholders the room for maneuver to deal with uncertainty, build networks and learn.

Samenvatting

Dit proefschrift gaat over de praktijk van reflexief toezicht voor inspecteurs. Reflexief toezicht is geïntroduceerd als mogelijkheid voor inspecties om in te spelen op twee belangrijke ontwikkelingen. Ten eerste worden inspecties steeds vaker uitgedaagd om maatschappelijke problemen aan te pakken. Deze problemen zijn vaak omgeven door onzekerheid, waardoor het voor inspecteurs onduidelijk is wat de beste aanpak is. Ten tweede zijn in het speelveld van inspecties andere toezichthouders met overlappende taken actief. Hierdoor kunnen inspecties de kwaliteit van de organisaties die onder hun toezicht staan niet alleen bepalen en moeten inspecteurs samenwerken met diverse inspecteurs.

Reflexief toezicht komt voort uit beperkingen van traditioneel toezicht, waarin naleving centraal staat. Bij nalevingstoezicht zijn er duidelijke criteria die het gewenste gedrag van ondertoezichtstaanden beschrijven op basis van wet- en regelgeving. Daarnaast kan de toezichthouder maatregelen nemen om af te dwingen dat de criteria worden nageleefd. Toezicht vindt plaats in een verticale een-op-een-relatie tussen de inspectie en ondertoezichtstaande. De kracht van nalevingstoezicht is dat inspecteurs op basis van de wet criteria kunnen opleggen en zo de bevolking kunnen beschermen tegen schadelijk gedrag. Nalevingstoezicht werkt goed op het moment dat duidelijk en onomstreden is wat de criteria zijn en wie de ondertoezichtstaanden zijn. Nalevingstoezicht wordt een uitdaging wanneer wetten, regels, taken en rollen niet goed te definiëren zijn en er niet langer sprake is van een een-op-een-relatie, maar ook andere partijen in het spel zijn. In deze situaties vormt reflexief toezicht een alternatief voor nalevingstoezicht.

Drie eigenschappen zijn kenmerkend voor reflexief toezicht:

- Omgaan met onzekerheid: reflexief toezicht verkent en ontwikkelt toezichtmethoden die rekening houden met het ontbreken of ter discussie staan van kennis.
- Actief in een context met verschillende partijen: reflexief toezicht houdt rekening met de beperkingen van toezicht en regelgeving vanuit de staat en doet een beroep op andere partijen om beoogde doelen te bereiken. Via participatieve methoden worden burgers, experts en andere relevante publieke en private organisaties betrokken.
- Leren: in reflexief toezicht staat leren centraal. In een continu proces van zelfobservatie en zelfkritiek worden mogelijkheden voor verbetering gecreëerd. Dat inspecteurs leren wordt essentieel gevonden, omdat kennis over hoe te handelen ontbreekt en te bewerkstelligen dat inspecteurs hun gebruikelijke routines doorbreken.

Verschillende theorieën worden gerekend tot reflexief toezicht. Bekende voorbeelden zijn systeemtoezicht (*meta-regulation*), responsief toezicht, probleemgericht toezicht en experimentele sturing (*experimentalist governance*). Deze theorieën variëren aan-

zienlijk in de wijze waarop ze omgaan met onzekerheid, interactie tussen verschillende actoren faciliteren en mogelijkheden scheppen om te leren. Hoewel de toezichtliteratuur reflexief toezicht en nalevingstoezicht vaak tegenover elkaar plaatst, hoeven de benaderingen in de praktijk niet per definitie tegengesteld te zijn aan elkaar.
In de theorieën over reflexief toezicht is reflexiviteit vaak gekoppeld aan organisaties. Over het algemeen is het onduidelijk welke betekenis de theorieën hebben in het dagelijks werk van inspecteurs, welke voor- en nadelen ze met zich meebrengen en hoe inspecteurs daar in de praktijk mee omgaan. Dit proefschrift beoogt meer inzicht te krijgen in wat inspecteurs doen als ze reflexief toezicht uitvoeren. De centrale vraag van mijn onderzoek is dan ook:

Hoe houden inspecteurs reflexief toezicht in de context van hun inspectie?

Ik heb subvragen geformuleerd rondom de drie eigenschappen van reflexief toezicht:
- Hoe gaan inspecteurs om met onzekerheid?
- Hoe handelen inspecteurs in een context met verschillende partijen?
- Hoe leren inspecteurs en creëren ze mogelijkheden voor verbetering?

Om inzicht te krijgen in deze onderwerpen onderzocht ik het Samenwerkend Toezicht Jeugd (STJ, sinds 2017 Toezicht Sociaal Domein/Samenwerkend Toezicht Jeugd), een samenwerkingsverband van vijf Nederlandse rijksinspecties. Dit samenwerkingsverband is opgericht in 2003. Terwijl inspecties traditioneel toezien op de kwaliteit van specifieke organisaties binnen een bepaalde sector heeft het samenwerkingsverband een aanpak ontwikkeld om toezicht te houden over sectoren heen. Het betreft thematisch toezicht waarin maatschappelijke problemen rondom kinderen en jongeren centraal staan die niet kunnen worden aangepakt binnen een sector, maar inzet vragen van verschillende organisaties en sectoren. Voorbeelden van deze problemen zijn kindermishandeling, overgewicht, jeugdcriminaliteit, voortijdig schoolverlaten en opgroeien in armoede. Het thematisch toezicht wordt uitgevoerd in gemeenten. Het samenwerkingsverband wil hiermee bijdragen aan het vinden van oplossingen voor de maatschappelijke problemen die passen bij de lokale situatie.
Multidisciplinaire teams van drie tot acht inspecteurs voeren het toezicht gezamenlijk uit. Ze inspecteren organisaties uit verschillende sectoren die zorg en ondersteuning bieden aan kinderen en jongeren, waaronder gezondheidszorg, jeugdzorg, onderwijs, politie en sociale zaken en werkgelegenheid. Sinds 2012 voeren de inspecteurs niet alleen thematisch toezicht uit, maar doen ze ook inspecties naar aanleiding van complexe calamiteiten. Calamiteitentoezicht is in het kader van dit proefschrift echter niet onderzocht.
Om de dagelijkse praktijk van reflexief toezicht te onderzoeken heb ik een thematisch

toezicht gevolgd aan de hand van participatieve observaties, informele interviews en een documentanalyse. Dit bood inzicht in de activiteiten van inspecteurs, hun interacties met elkaar en met anderen en hun vaardigheden en competenties om inspecties uit te voeren. Daarnaast vroeg ik inspecteurs in semi-gestructureerde interviews om hun werk te typeren. Ook onderzocht ik twee inspectiemethoden, vanuit de veronderstelling dat die het werk van inspecteurs sturen. De eerste inspectiemethode betrof jongerenparticipatie, die ik onderzocht door middel van een documentenanalyse en een bijeenkomst met inspecteurs. De tweede betrof het levensloopinstrument, dat een reconstructie maakt van de zorg en ondersteuning aan een kind of jongere. Dit instrument onderzocht ik aan de hand van een documentenanalyse en een analyse van de semi-gestructureerde interviews. Tot slot werd een vergelijking gemaakt van het werk van inspecteurs in het samenwerkingsverband met het werk van inspecteurs in een geheel andersoortige inspectie, namelijk de Engelse Care Quality Commission (CQC). Het betrof een decentrale vergelijkende analyse gebaseerd op semi-gestructureerde interviews, documenten en bijeenkomsten met inspecteurs.

Tijdens het onderzoek vervulde ik een dubbele rol; ik was zowel onderzoeker als inspecteur en deed het onderzoek dus als ingewijde (*insider research*). Wanneer onderzoekers zo dicht bij een onderzoeksobject staan, kan dit leiden tot een vertekend beeld. Ik gebruikte verschillende strategieën om methodologische afstand te scheppen en beter te kunnen omgaan met de spanningen tussen beide rollen. Zo gebruikte ik een theoretisch kader en werkte ik intensief samen met andere onderzoekers niet werkzaam binnen het samenwerkingsverband. Ook schreef ik notities waarin ik reflecteerde op zowel mijn rol als mijn aannames en waarin ik uitkomsten die ik vooraf niet had verwacht beschreef en verder uitwerkte. Hoewel ik deze strategieën gebruikte om afstand te scheppen, zorgde ik er ook voor dat ik dichtbij de inspectiepraktijk kon blijven. Zo gebruikte ik mijn directe betrokkenheid om onderzoeksonderwerpen te selecteren en passende verbetersuggesties te doen.

In hoofdstuk 2 wordt de literatuur over omgaan met risico's - en dan specifiek de literatuur over type risico's - gebruikt om te duiden hoe inspecteurs tijdens een thematisch toezicht over een maatschappelijk probleem omgaan met onzekerheid. Het hoofdstuk gaat in op het thematisch toezicht over zorg en ondersteuning aan kinderen die opgroeien in armoede, een onderwerp dat is omgeven door onzekerheid. Het laat zien dat inspecteurs de onzekerheid eerst tolereren. Ze betrekken bijvoorbeeld allerlei partijen om informatie te verzamelen over het onderwerp en zicht te krijgen op verbetermogelijkheden. Echter, om tot een oordeel te kunnen komen, reduceren de inspecteurs het probleem en ze herdefiniëren het tot samenwerkingsprobleem waarin partijen geen samenhangende zorg en ondersteuning bieden. Daarnaast richten inspecteurs zich tijdens het toezicht steeds meer op een specifieke partij, namelijk de gemeente. Een verklaring hiervoor ligt in de externe context van toezicht. Inspecteurs worden geacht

duidelijk te oordelen, verbeteracties te benoemen en hard op te treden. Het reduceren van het toezichtonderwerp tot te weinig samenhangende zorg en ondersteuning maakt het voor inspecteurs mogelijk dit te doen.
In hoofdstuk 3 staat het betrekken van jongeren in het toezicht centraal. Het gaat om jongeren die vanuit hun ervaring met zorg en ondersteuning nieuwe mogelijkheden kunnen inbrengen voor verbetering van de kwaliteit van organisaties en het aanpakken van een maatschappelijk probleem. Het perspectief van ervaringsdeskundigen kan echter conflicteren met regels en gebruiken van toezichthouders en met professionele of maatschappelijke standaarden. Dit hoofdstuk combineert toezichtliteratuur met literatuur over participatie van patiënten en cliënten in zorg en ondersteuning. De gegevens uit het thematisch toezicht over opgroeien in armoede zijn gebruikt om te vergelijken wat jongeren verstaan onder goede kwaliteit van zorg en ondersteuning met wat inspecteurs daarin belangrijk vinden. Daarnaast werd geanalyseerd wat deze verschillen en overeenkomsten betekenen voor het gebruik van de informatie van jongeren in de inspecties. Het hoofdstuk laat zien dat zowel inspecteurs als jongeren tijdige hulp, het creëren van mogelijkheden voor jongeren om te kunnen meedoen in de samenleving en een respectvolle relatie belangrijke elementen van goede zorg en ondersteuning vinden. Ze verschillen echter van elkaar waar het gaat om informatieuitwisseling, het vinden van passende oplossingen en het juiste moment om hulp te bieden. Inspecteurs gaan op drie manieren met deze verschillen om. Ze geven prioriteit aan hun eigen normen, schuiven het verschil door naar anderen die het moeten oplossen en houden hun eigen perspectief apart van dat van jongeren. Wanneer de perspectieven van jongeren en inspecteurs overeenkomen, gebruiken inspecteurs de inbreng van jongeren om hun oordeel te onderbouwen en te illustreren. Wanneer jongeren een ander perspectief hebben, beïnvloedt dit het oordeel van inspecteurs niet. Over het algemeen zijn hiervoor in de literatuur twee soorten verklaringen te vinden die te maken hebben met ofwel eigenschappen van de participanten ofwel met de organisatie waar de participatie plaatsvindt. Dit hoofdstuk voegt een derde verklaring toe die is gerelateerd aan de externe context van het toezicht. Het Nederlandse jeugdbeleid is gebaseerd op de visie dat het beter is om problemen te voorkomen dan om ze in een later stadium te moeten oplossen. Het idee van preventie is zo dominant dat de inbreng van jongeren, die in tegenspraak is met preventie, opzij wordt geschoven. Inspecteurs kunnen deze externe context niet eenvoudig veranderen of naast zich neerleggen. Dit beperkt de mogelijkheden voor inspecteurs om de inbreng van jongeren hun oordeel te laten beïnvloeden. Als gevolg hiervan kunnen conflicten tussen het perspectief van jongeren en het perspectief van inspecteurs niet zomaar worden verholpen.
Leren wordt als essentieel onderdeel van reflexief toezicht beschouwd. Hoofdstuk 4 heeft betrekking op het levensloopinstrument, dat erop is gericht om leren mogelijk te maken en resultaten van zorg en ondersteuning te verbeteren. Wanneer inspec-

teurs werken met het levensloopinstrument reconstrueren en beoordelen ze de zorg en ondersteuning die een kind of jongere heeft gekregen. Vervolgens brengen ze alle betrokken organisaties bij elkaar en initiëren zo een netwerk. Dit hoofdstuk gebruikt een ontologisch theoretisch kader om te laten zien dat inspecteurs bij het maken van de levensloop het gebrek aan samenhang in de zorg en ondersteuning als prioritair probleem definiëren. Ze creëren daarmee een hiërarchie en plaatsen andere problemen op een lager plan. Het definiëren van het probleem van onsamenhangende hulp bepaalt de opties voor verbetering die inspecteurs identificeren; deze zijn allemaal gericht op het verbeteren van samenhang. Echter, in de complexe zorgpraktijken die de inspecteurs beoordelen heeft een kind of jongere vaak meerdere, elkaar tegensprekende problemen, waardoor een hiërarchie lastig is aan te brengen en een coherente probleemdefinitie moeilijk te maken is. Het hoofdstuk verkent wat patchwork , een alternatieve manier van het definiëren van problemen waarbij problemen naast elkaar mogen bestaan, zou betekenen voor het oordeel van inspecteurs en de mogelijke verbeteropties. Het hoofdstuk betoogt dat doordat patchwork een meervoudige probleemdefinitie toestaat, inspecteurs komen tot verbeteropties die meer divers zijn.
Hoofdstuk 5 heeft betrekking op de wijze waarop inspecteurs andere partijen betrekken en mogelijkheden creëren om te leren wanneer ze hun discretionaire ruimte gebruiken. Dit hoofdstuk maakt een vergelijking tussen het werk van inspecteurs in het samenwerkingsverband en de CQC, die toezicht houdt op zorg en maatschappelijke ondersteuning in Engeland. Het hoofdstuk ontwikkelt de concepten 'collectieve discretionaire ruimte' en 'collectieve discretie', op basis van de literatuur over ambtenaren die beleid uitvoeren in direct contact met burgers (*street-level bureaucrats*), toezichthouders die hun relaties met anderen inzetten om organisatiedoelen te bereiken (*relational regulation*) en experimentele sturing (*experimentalist governance*). Collectieve discretionaire ruimte verwijst naar de ruimte die teams van inspecteurs hebben gekregen en waarin ze samenwerken om te komen tot een oordeel. Collectieve discretie verwijst naar individuele inspecteurs die op hun eigen initiatief anderen betrekken om tot een oordeel te komen. Zowel binnen STJ als in de CQC betrekken inspecteurs collega's, managers en andere partijen wanneer ze hun discretie gebruiken. In de CQC is sprake van collectieve discretie; inspecteurs betrekken anderen uit zichzelf om nieuwe kennis en ervaring te kunnen aanboren, mandaat te verkrijgen en hun repertoire te verbreden. Bij STJ werken inspecteurs samen in teams; collectieve discretionaire ruimte is voor hen georganiseerd. Aan de hand van de resultaten wordt in dit hoofdstuk beargumenteerd dat hoewel collectieve discretie individuele inspecteurs mogelijkheden biedt om in specifieke gevallen responsief te kunnen handelen, andere inspecteurs en de inspectie als geheel hiervan niet kunnen profiteren. Collectieve discretionaire ruimte maakt dit wel mogelijk. Het biedt groepen inspecteurs een breed en gevarieerd repertoire aan rollen, tactieken en mogelijkheden. Bovendien stimuleert collectieve discretio-

naire ruimte leerprocessen, doordat inspecteurs samenwerken aan responsiviteit en consistente manieren van werken kunnen opbouwen.
Hoofdstuk 6 behandelt en bediscussieert de resultaten van de voorgaande hoofdstukken, trekt conclusies en doet aanbevelingen voor toekomstig onderzoek en de praktijk. Met betrekking tot omgaan met onzekerheid (de eerste onderzoeksvraag) constateerde ik in dit onderzoek dat inspecteurs onzekerheid in eerste instantie toestaan. Ze verzamelen allerlei kennis, meningen en ervaringen. Gedurende het toezichtproces vermindert dit en reduceren ze het probleem tot onsamenhangende hulp. Dit biedt inspecteurs de mogelijkheid duidelijke criteria te hanteren en tot een oordeel te komen. Wat betreft acteren in een context met andere partijen (de tweede onderzoeksvraag), betrekken inspecteurs in eerste instantie allerlei partijen, waardoor ze een netwerk opbouwen. Gedurende het toezichtproces verlaten de inspecteurs het netwerk en richten ze zich op een van de partijen, namelijk de gemeente waarmee een verticale relatie ontstaat. Met betrekking tot leren (de derde onderzoeksvraag) zijn de leerprocessen van inspecteurs sterk gericht op het verder ontwikkelen van methoden, instrumenten en het toezichtkader. Minder nadruk ligt op het leren hoe ze samen met andere partijen de maatschappelijke problemen die centraal staan in het toezicht beter kunnen aanpakken.
Hoewel inspecteurs aan het begin van het toezichtproces allerlei aspecten van het maatschappelijk probleem meenemen en allerlei partijen betrekken, verandert dit gedurende het toezicht. De focus komt te liggen op een afgebakend risico (onsamenhangende hulp) en een verticale relatie met een ondertoezichtstaande (de gemeente). Afgebakende risico's en verticale een-op-een relaties zijn gerelateerd aan nalevingstoezicht. Gedurende het toezicht verruilen inspecteurs dus een reflexieve benadering voor nalevingstoezicht. Reflexief toezicht en nalevingstoezicht zijn twee aparte methoden, maar in de praktijk niet gescheiden van elkaar. De praktijk van het reflexief toezicht doet geen afstand van de onderliggende principes van nalevingstoezicht. Dit beperkt de mogelijkheden om te leren omgaan met het maatschappelijk probleem. Hoewel nalevingstoezicht wordt gezien als het prototype, past het repertoire van nalevingstoezicht niet bij het aanpakken van maatschappelijke problemen in situaties met meerdere actoren.
Een aanbeveling voor toekomstig onderzoek is om reflexieve inspectieprocessen apart van nalevingstoezicht onder de loep te nemen en dan specifiek te onderzoeken waar een reflexief oordeel uit zou moeten bestaan en te achterhalen welke activiteiten essentieel zijn in reflexieve toezichtprocessen. Een tweede aanbeveling is verder onderzoek te richten op werk dat andere partijen (niet zijnde inspecteurs) gedurende inspecties verrichten om meer zicht te krijgen op hoe inspecteurs met deze andere partijen kunnen samenwerken aan de maatschappelijke problemen die de inspecties willen aanpakken.

De resultaten en conclusies van dit onderzoek leiden niet tot eenvoudige verbeteropties voor de praktijk van reflexief toezicht. Toch kunnen op basis van de resultaten verschillende verbetersuggesties worden gedaan. Deze suggesties hebben vooral te maken met leren. Het is belangrijk dat inspecteurs samen met andere relevante partijen experimenteren met het aanpakken van maatschappelijke problemen. Daarbij is het vooral van belang dat diverse strategieën worden uitgeprobeerd. Omdat het tijd vergt te experimenteren en netwerken van relevante partijen op te bouwen wordt geadviseerd om maatschappelijke problemen langere tijd op de agenda van de inspecties te houden. Bovendien is het essentieel om open kaart te spelen richting betrokken partijen dat reflexief toezicht afwijkt van het standaard idee van toezicht en dus ook een andere rolinvulling en andere activiteiten vraagt van de betrokken partijen. Tot slot: om reflexief toezicht tot zijn recht te laten komen is het belangrijk dat beleidsmakers en politici bereid zijn om inspecteurs, inspecties en andere partijen ruimte te geven om open om te gaan met onzekerheid, samen te werken met relevante partijen en te leren.

Dankwoord

Het begon rond de zomer van 2009 op een maandagmorgen in het kantoor van Simone bij TNO in Leiden. Op de tafel stonden de chocolaatjes die Simone dat weekend op de markt had gehaald. Esther Deursen en ik spraken met Simone over het Samenwerkend Toezicht Jeugd en de instrumenten die we daarvoor gebruikten en verder ontwikkelden. Simone merkte terloops op dat dit een promotieonderzoek waard zou zijn. Esther keek haar enthousiast aan en samen keken ze naar mij. Ik had al vaker overwogen om een promotieonderzoek te starten, maar concrete ideeën had ik niet. Nu dacht ik: ik hou van analyseren, lezen en schrijven, dus waarom niet?
We betrokken Antoinette erbij vanwege haar kennis over het doen van onderzoek in organisaties en Paul vanwege zijn kennis over het onderzoek naar toezicht. De plannen werden snel concreet. In oktober 2009 startte ik echt.
Met veel plezier heb ik de afgelopen acht jaar aan het promotieonderzoek gewerkt. Dat het nu klaar is, heb ik te danken aan velen:
Antoinette, je hebt me wegwijs gemaakt in de wereld van het onderzoek en het handwerk van het doen van onderzoek bijgebracht. Jouw creatieve geest en vaardigheid in het vormen van theorie hielpen mij om mijn onderzoeksobject - mijn dagelijkse praktijk - met een frisse blik te bekijken. Hoewel ik weet dat mijn promotieonderzoek slechts een van jouw vele activiteiten is, maakte je altijd tijd om stukken te bekijken, mee te denken over het oplossen van problemen en na te denken over vervolgstappen. En bovenal kwam ik vol ideeën en goede moed uit onze overleggen.
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Esther, het vergt lef om je organisatie te laten onderzoeken. De resultaten kunnen anders zijn dan gehoopt op momenten dat het niet uitkomt. Jouw overtuiging dat het promotieonderzoek kon worden gebruikt om onze inspectiepraktijk te verbeteren

heeft mij het vertrouwen gegeven dat resultaten ook zinvol waren als ze anders waren dan gehoopt. Jij hebt de resultaten met open armen ontvangen. Daarnaast heb je ervoor gezorgd dat ik een deel van mijn werktijd mocht besteden aan dit promotieonderzoek. Bovendien ben ik je dankbaar dat je me steeds kansen geeft om me te ontwikkelen; te verdiepen in nieuwe onderwerpen en nieuwe aanpakken en methoden uit te proberen. Dat ik met dit promotieonderzoek kon beginnen is ook te danken aan Hans ter Steege en Joke de Vries. Joke, jij was destijds voorzitter van de Stuurgroep STJ en zag de meerwaarde van een promotieonderzoek voor STJ. Hans, jij was destijds mijn leidinggevende en hebt het eerste contact met Paul gelegd om het promotieonderzoek onder te brengen bij zijn leerstoel. Ik ben jullie zeer dankbaar voor deze goede start.

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Dinah, although we had to work very hard to make progress during your short stays in Utrecht, we had great fun. We were surprised to discover so many commonalities in working as an inspector at the Care Quality Commission and the Joint Inspectorate for

Youth. I have warm memories of the supper you cooked for Antoinette and me in your Bed & Breakfast and the evenings in Dublin and London.
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PhD Portfolio

Courses	
Ted X talks	2017
Project leadership	2017, 2016, 2012
Masterclass Philosophy of policy, practice and research in health, University Maastricht	2013
Academic Writing in English, Erasmus University	2011
Problem oriented education, Erasmus University	2011
Document analysis	2011
Intensive English Language Training, Regina Coehli	2010
Interviewing children and adolescents, Universiteit Utrecht	2010
Qualitative data analysis, Kwalon	2010
Atlas-ti for beginners, Kwalon	2010

Teaching activities	
Workgroups Qualitative Research Methods, small group instructor	2011, 2012, 2014

Presentations at conferences, seminars and symposia	
International Sociological Association (ISA), Milaan	2015
Toezicht en Wetenschap, Rotterdam	2015
The state of citizen participation, Maastricht	2015
European Partnership of Supervisory Organizations in health services and social care (EPSO), Dublin	2014
Academisch Netwerk Toezicht, Utrecht	2014
Council for European Studies (CES) Conference, Washington	2014
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ABOUT THE AUTHOR

Suzanne Rutz was born in Purmerend, The Netherlands, on July 16, 1977. She studied Human Nutrition and Health at Wageningen University, concentrating on health promotion and epidemiology (1995-1999), and graduated with honor. After her graduation, she worked as a researcher at the National Institute for Public Health and the Environment (2000-2002) and as a policy advisor at the Ministry of Public Health, Welfare and Sports (2002-2006). In 2006, she started working at the Health Care Inspectorate as an inspector of public health. From that position, she was seconded to a partnership of five inspectorates known as Joint Inspectorate for Youth (JIY; now called: Toezicht Sociaal Domein/Samenwerkend Toezicht Jeugd).
During her work as an inspector, Suzanne grew interested in the research done on the issues inspectors encounter in their daily practice. Consequently, in 2009 she began studying for a PhD degree at the Institute of Health Policy and Management (iBMG), conducting research into how reflexive regulation is carried out. Since then, she has taken on the dual role of researcher and inspector; studying, publishing and presenting on the work of inspectors and leading regulatory projects concerned with thematic inspections, inspections after complex critical incidents, and developing regulatory frameworks.
Suzanne currently lives in Ede with her husband Erik and her two children Thirza and Lennard.

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Reflexive regulation has been developed to provide inspectors with strategies to deal with uncertain situations in which rules and roles are unclear, inspecting involves multiple actors and learning how to deal with the situation is crucial. In many instances, it is unclear what reflexive regulation entails in practice. Based on insider research, this thesis provides in-depth insights into the work of inspectors practicing reflexive regulation and offers suggestions for further research, and the improvement of regulatory practice and policy.