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# How does an ageing policy translate into professional practices? An analysis of kitchen table conversations in the Netherlands

## Hoe wordt een verouderingsbeleid vertaalt in de praktijk van professionals? Een analyse van keukentafelgesprekken in Nederland

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### ABSTRACT

In the context of the transformation of welfare states into participatory societies, care and welfare professionals are assigned new roles. In the Netherlands, they are tasked with activating and empowering older adults, as well as negotiating customised care. For this purpose, policymakers introduced the kitchen table conversation as a social technology to assess needs and abilities in an informal setting, at home or in public places. The notion of a kitchen table refers to the idea that an informal sphere may increase the professionals' ability to attune to the needs and abilities of citizens. This paper discusses findings of a qualitative study, in which ethnographic methods were used to examine kitchen table conversations with older adults in practice. Our study demonstrates that, although the tool aims to increase attunement between professionals and citizens, it actually creates tensions between policy, professionals and citizens. Professionals struggle with the issue of how other policy expectations – such as cutting the costs of care – resonate in the conversations, a phenomenon which becomes even more awkward in the private domain of older adults. In practice, however, rather than mediating participative citizens, kitchen table conversations mainly generate ambiguity in relationships between professionals and citizens.

### SAMENVATTING

In de context van de transformatie van verzorgingsstaten naar participatiesamenlevingen krijgen zorg- en welzijnsprofessionals nieuwe rollen toebedeeld. In Nederland hebben zij de taak gekregen om ouderen te activeren en te 'empoweren', terwijl zij tegelijkertijd zorg-opmaat onderhandelen. Om dit doel te kunnen bereiken introduceerden

### KEYWORDS

Ageing-in-place; older people; social policy; participation/citizenship

### TREFWOORDEN

ageing-in-place; ouderen; social beleid; participatie/burgerschap

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beleidsmakers het keukentafelgesprek als een sociale technologie, om daarmee behoeften en mogelijkheden in een informele omgeving te kunnen toetsen, bijvoorbeeld bij burgers thuis of op een publiek (toegankelijke) plaats. Het begrip keukentafel refereert aan het idee dat een informele sfeer de mogelijkheden van de professional vergroot om op de behoeften en mogelijkheden van burgers af te kunnen stemmen. Dit paper bediscussieert bevindingen uit een kwalitatieve studie waarin we etnografische methoden gebruikten om keukentafelgespreken met ouderen in de praktijk te onderzoeken. Hoewel het doel van het instrument is om de afstemming tussen professionals en burgers te vergroten, laat onze studie zien dat het instrument in werkelijkheid spanningen creëert tussen beleid, professionals en burgers. Professionals worstelen met hoe andere beleidsverwachtingen – zoals het terugbrengen van de zorgkosten – resoneren in de gesprekken. Dit wordt nog ongemakkelijker op het moment dat de gesprekken in het privédoelgebied van ouderen plaatsvinden. In de praktijk zien we dat keukentafelgesprekken niet zozeer participatieve burgers mediëren, maar vooral ambiguïteit creëren in de relaties tussen professionals en burgers.

## Introduction

Enabling opportunities to remain living independently for longer is the key element of current ageing policies. The World Health Organization (WHO) advises governments to develop age-friendly environments for active, healthy ageing (2017). These WHO-policy concepts fit in a broader activation development to confront challenges induced by an ageing population and increasing healthcare expenditures in Western welfare states (Liebenberg, Ungar, & Ikeda, 2015; Newman & Tonkens, 2011). Different studies about activation regimes demonstrate an emphasis on prevention, personalisation, responsabilisation and active citizenship that is widely spread across Europe, such as for instance in Italy (Muehlebach, 2012), Scandinavian countries (Matthies & Uggerhøj, 2014) and the UK (Manthorpe et al., 2010; Newman & Tonkens, 2011).

To enable active citizen participation, the Dutch government has decentralised many responsibilities to organise healthcare and welfare services towards municipalities. The Dutch government expects all citizens to remain as active and independent as possible while organising care within citizens' own informal networks should take priority over the use of formal care. In 2012, the government's coalition agreement stated: 'the decentralisation of many assignments to municipalities enables a more tailor-made [policy] and an increased citizen involvement'. However, this decentralisation-process also has to help municipalities 'to do more with less money', which is deemed necessary given a shortage of professionals and financial means to fulfil all current and future care needs.

Discourses of citizen participation, including aims to encourage independence and individual responsibility, also create new challenges for professionals. Studies on changes in social work demonstrate how governmental aims of activation rely on professionals' abilities to mediate the activation ideal (Ellis, 2014; Liebenberg et al., 2015; McDonalds & Chenoweth, 2009). This implies, professionals have agency in shaping the eventual outcomes of activation policies. Until recently, provision of care and welfare services in the Netherlands was based on legal entitlements. Requests for help were examined by special indication officers who were guided by criteria in policy documents. For long-term care needs, individuals could appeal to the 'Exceptional Medical Expenses Act' (Algemene Wet Bijzondere Ziektekosten, ABWZ), for welfare services (e.g. domestic help, a mobility scooter, adjustments to the home) the 'Social Support Act' (Wet Maatschappelijke Ondersteuning, Wmo) was applied. Basically, policy documents acted as decision-making tools to assess individuals' eligibility for care and welfare (cf. Høybye-Mortensen, 2015). When eligible, an individual received an

indication that was an official approval for the specific service or provision requested. The complete verification procedure often took place behind a desk, relying on information that was provided in the individual's request.

Since 2015, instead of verifying an individual's entitlement to at-home care or welfare services, municipalities verify whether they must compensate individuals for their 'participation abilities and wishes'. Therefore, municipalities make arrangements when individuals are 'actually and continuously lacking' informal solutions in their immediate environments (Dutch Social Support Act, 2015). While care and welfare professionals formerly provided care when it was requested, they must now control their urge to help, as the new ageing policy encourages them to help people to take care of themselves. Professionals have to stimulate people to search for help in their informal circle and facilitate them in remaining self-sufficient.

To facilitate the new, empowering role of care and welfare professionals, Dutch policymakers introduced the kitchen table conversation. Kitchen table conversations are expected to enable negotiations that result in customised, yet fair and comparable, care arrangements. Professionals have to use a generalist approach to explore the participation abilities and wishes of the people they visit. In their recent work on de-professionalisation in the Netherlands, Trappenburg and van Beek (2017) warn about this new policy and state it is a cause for concern. Although the generalist approach that is being promoted, is appreciated by professionals themselves, the de-professionalisation implies informal caregivers are expected to take over. This means professionals' opportunities to signal problems will decrease, as their interaction with citizens becomes less frequently. In addition, de-professionalisation might also lead to a devaluation of the professional identity. In her work on social workers' professional identity, Beddoe (2013) describes how social workers lack a distinctive space that helps them distinguish their value, while a similar space, based on the acknowledgment of expertise and knowledge, is undisputed in medical professions. Professional identity is important as an acknowledgment of professionals' value.

In this paper, we explore the kitchen table conversation as a tool and how it is used in professional practices involving older people (from age 70). The aim of our study is not to evaluate this tool in terms of its effectiveness, nor to evaluate professional behaviour. Instead, we aim to investigate how the kitchen table conversation, that was introduced to mediate a participatory society, works out in practice. Specifically, we are interested in how kitchen table conversations affect conversations and enable professionals and older citizens to attune to each other while negotiating needs and abilities. Thereby, we explore how the new professional role is constructed by using this technology as a mediator of the participatory society, and we reflect on meanings of the kitchen as a place for professional practice.

To understand the underlying ideal of the kitchen table conversation, we will first explain how the kitchen table conversation was introduced as a participatory technology for professionals, and describe the theoretical background related to expectations of the kitchen as a place to enable in-depth dialogues. Next, we describe the design of the study. After presenting four in-depth descriptions of kitchen table conversations, we conclude by reflecting on what this tool entails for ageing policies that aim to stimulate participation and ageing-in-place. We reflect on meanings of the kitchen (table) as a participatory technology, by unfolding how it works as a mediating place and affects the professional-citizen relationship.

## **The kitchen table conversation as a participatory technology**

In September 2008, the Dutch State Secretary for Health, Welfare and Sport wrote a letter to introduce 'the initiative of the so-called with citizens, by which the situation is explored using an integrated approach and an inventory is made of the extent to which citizens can still contribute themselves'. A guideline of the Association of Netherlands Municipalities (2010) added that kitchen table conversations represent 'a careful investigation, an adequate analysis, the application of a wider perspective, a collective search for solutions. It requires abandoning a claim culture and taking one's own strength and responsibility as point of departure'. As many municipalities felt that further regulation was

desired, they introduced additional technologies to structure the kitchen table conversations. These technologies include intake and consent forms, questionnaires and the self-sufficiency matrix, a tool that is used to measure and monitor an individual's self-sufficiency.

Drawing on insights from Science and Technology Studies (STS), we understand the kitchen table conversation as a social technology. Derksen and Beaulieu (2011) characterised social technologies as technologies that consist of human actions or depend on social interactions while being designed with expected and prescribed behaviour in mind; a machine does not work without human intervention, a social technology such as a questionnaire cannot be completed without any human intervention either. Mol, Moser, and Pols (2010, p. 174) argue that technologies do not fail or work on their own: 'Devices get their particular shape, value and functions in the practice in which they are used, and users creatively negotiate the scripts that technologies carry'. In other words, technologies are designed to serve a specific purpose, but do not achieve this purpose in isolation. Following this line of argumentation, technologies must interact with humans to be 'activated', to become social technologies, and to work in practice. In practice, however, technologies may have a different impact than the designer originally intended. A questionnaire can become a checklist instead of a helpful tool to collect information.

From this perspective, technologies introduced to facilitate professional work may not automatically be effective at achieving their intent. Broadhurst et al. (2010) show how the use of an assessment system at the front-door of children's services was introduced to decrease flaws in initial assessments but did not prevent errors from occurring. The standardised format combined with performance targets and a culture where individuals were held accountable for errors induced a selective use of the instrument and reduced situational awareness. They argue a tool needs to be tailored to the specific practice it is used for to actually work. However, no consensus exists about what is needed for a tool to work in practice. Høybye-Mortensen's (2015) conclusions in her study on decision-making tools imply that the more a tool is descriptive, the more the professional will be a performer of the tool, limited in space for own initiatives. She argues that tools that require a great deal of interpretation have less impact on a professional's discretionary space than tools that are more predefined. Using a tool analytically, during an assessment to guide and mediate a decision, means that the tool basically defines the professional's space. Conversely, considering it as a documentation-tool to structure the advice afterwards, means that the space is defined during the conversation. Yet, Evans (2011) makes the claim that the elaborateness of a procedure creates a greater need for discretion from the professional because it is impossible to follow many different guidelines simultaneously. Professionals thus have to negotiate their own framework by choosing which guidelines they want to follow. To make their assignment workable, they choose between different technologies while tinkering to ensure applicability (Mol et al., 2010).

The kitchen table conversation in our study has been devised as a social technology that is expected to enable professionals to empower citizens, as part of their mediating assignment which is considered crucial in aiming for a participatory society. Professionals have to mediate between policy ideals and the ideals of older adults, as they have to assess and negotiate the needs and participation abilities of older people in order to legitimise care provision if necessary. Before analysing the use of this tool in practice, we provide some background on the kitchen table as an enabling place.

### **The kitchen table as an enabling place for a new professionalism**

The use of kitchens and kitchen tables as mediating places is not new. In a variety of fields, including human geography, social and healthcare, history, feminist studies and political science, scholars have identified different meanings that people attribute to the kitchen as a place to enable social interactions (Abram, 2007; Bennett, 2006; Kohl & McCutcheon, 2015; Sarkissian, Shore, Vajda, & Wilkinson, 2012; Smith, 1989). Many emphasise how the kitchen acts as a safe space for interactions (Bennett, 2006; Kohl & McCutcheon, 2015; Smith, 1989) and for informal and in-depth conversations (on self-

reflexivity for instance). Kohl and McCutcheon (2015) even argue a kitchen enables a dialogue where no consensus needs to be reached. Sarkissian et al. (2012, p. 7) explain the kitchen table is used as a metaphor, it represents 'the place where we have casual but important conversations, we share meals and where people, even in a busy world, frequently come together. (...) a place where many feel comfortable to speak openly about their real perspectives, ideas and concerns'. In general, it is presented as a place that invites people to share ideals, ideas, fears and dreams. By introducing the kitchen table as part of an ageing and activation policy, policymakers expect that these characteristics of the kitchen table will help translate their policy into practice. However, some scholars also mentioned how the kitchen articulates patriarchal and unequal power relations (as the work-place of servants, for instance), which empowers people in the kitchen who 'control' the food, and offers opportunities to create a community of care, to communicate and to organise actions (such as the development of feminist activities).

Following a social-constructivist approach in a four-year-long study of an ageing-in-place policy helped us to understand that places are not only constructed by the different meanings that people attach to them, but instead, that places also construct new meanings and social interactions (van Hees, Horstman, Jansen, & Ruwaard, 2018). As we focus on the kitchen table as a place of care, we recognise a parallel with Ferguson's (2010) study of the car as a place of care. Ferguson demonstrates how characteristics of the car can work therapeutically for clients. The car not only offers the professional a mobile office and a safe space for reflections, it can also symbolise a transitional phase in care (moving a child from one place to another) or enable a dialogue (not having to look at each other, providing opportunities to relieve tension in difficult conversations).

According to Norlander and McSteen (2000, p. 532), who studied conversations on end-of-life issues, kitchen tables symbolise 'the familiar and comfortable setting of the home'. They argue this should help mediate possibly 'the most important' but also 'one of the most difficult conversations'. In addition, Truglio-Londrigan (2013) explains how home-visits enable professionals in such shared-decision-making conversations to spend more time talking about a person's needs and desires, than during a formal office-visit. Besides, relatives and friends can attend more easily, while personal issues can be discussed outside the context of acute care. Both studies further underline how more space for dialogue also requires professionals who are able to 'forge their own path'. While institutions offer formal structures to be followed, such as time-limits and care procedures, the at-home-setting requires and enables professionals to respond to the specific personal setting.

That kitchens can provide safe places for dialogue also relates to ideas of relation-based practice within social work. The notion of relation-based practice is based on the idea that a sustained professional relationship between a professional and the client is conditional for more effective social work (Ruch, 2005; Trevithick, 2003), as this professional relationship mediates opportunities for situational awareness of the professional. Based on the relationship help or interventions can be offered. Ruch (2005) argues time and space for reflective practice is needed for professional work. Technologies or frameworks (such as procedures) are claimed to be 'insufficient to meet the challenges and demands of social work' (Ruch, 2005, p. 112). Following this insight, reflective practice provides an opportunity for professionals to understand and cope with the situatedness (or uniqueness) of each individual's circumstances. This is necessary in order to create a personalised plan.

Based on the literature described, we conclude that introducing the kitchen table as a place where care is being negotiated, changes the relationship between professionals and (older) people. In our case this means that instead of entering the home solely as a care provider, professionals now enter the private domain at an earlier stage to discuss the need for care. As a result, the home also starts to play a role in deciding whether care is necessary and, if so, what kind. Several scholars studying relationships between care and place, demonstrated how healthcare, social work and nursing practices change when they take place outside formal care institutions (e.g. Andrews, 2003; Ferguson, 2010; Kearns, 1993; Poland, Lehoux, Holmes, & Andrews, 2005). According to Dahlin-Ivanoff, Haak, Fänge, and Iwarsson (2007), who studied meanings of ageing-in-place, the home changes at the moment that a professional enters, becoming a place of care in addition to being a home.

Because of this 'complex relationship between power, technology, culture, and place', Poland et al. (2005) state there should be more attention to place-sensitivity, to explore the way that the uniqueness of a place affects professional work. In short, the kitchen table is described as a place that enables professionals to have more personalised conversations, but also requires professionals to adjust to all these different kitchen tables. By unfolding kitchen table conversations as social technologies, we aim to demonstrate how the introduction of a mediating tool works out in practice and how it affects the professional-citizen relationship.

## Methodology

Our study took place in Parkstad, an area in the Southern part of the Netherlands. We studied kitchen table conversations, that were introduced in this area as part of an ageing-in-place policy. Our observations are part of a larger qualitative study that we conducted between 2011 and 2015, using ethnographic methods to explore how this ageing-in-place policy was developed and worked out in practice. The kitchen table conversation has been formally included in Parkstad's regular procedures since 2014, but in preceding years, professionals already experimented with the tool. Kitchen table conversations take place at people's own home, but also at other places, such as a community centre. During intake and follow-up meetings professionals (appointed as case managers) often use intake forms or questionnaires to describe a person and the reason for the visit. In a social neighbourhood team, professionals can reflect on their cases and appointments can be made with other professionals who need to be involved. If a case manager lacks specific expertise, for instance, a back-up option is organised within this team.

In this paper, we follow a social-constructivist approach in which we explore the use of these kitchen table conversations. Therefore, we draw on observations of fifteen kitchen table conversations that took place in 2012 and 2014. These conversations were employed by a neighbourhood nurse, an advisor of older adults, two social workers, a care manager, and three Social Support Act servants (executors of the Dutch Social Support Act, regulating the delivery of welfare services, such as a domestic help). Eleven observations took place at people's homes in two neighbourhoods (one urban, one rural), three at a community centre and one at a consultation room in a Town Hall. To organise these observations, the first author explained the study during formal meetings of professionals and asked for consent to observe professionals while 'doing' kitchen table conversations. Further agreements were made in-person with professionals who agreed to be observed during one or several conversations. Although no formal ethical approval was required, we did follow the ethical guidelines in ethnographical and anthropological research that included informed consent and agreements about the anonymity of all participants. Sometimes only one conversation was observed, in other cases, multiple (maximal three). At the beginning of conversations, professionals asked individuals for their consent to be observed by the first author. It was explained to both the professional and the older adult that their anonymity would be preserved at all times. After consent was given, the actual kitchen table conversation commenced. All professionals participated in different pilots with kitchen table conversation designs and were familiar with this method of activation. To share information and to include other professionals in the procedure related to a kitchen table conversation, professionals have to ask the citizen for a specific signed informed consent. The citizen can withdraw this consent at any time.

During the conversations, professionals had to collect as much information as possible about the citizen before writing an advice about a customised arrangement. Intake-forms and questionnaires were introduced to facilitate professionals in doing kitchen table conversations, partly as a reply to a request of some professionals for more guidance, partly because they are deemed necessary to guarantee comparable kitchen table conversations. These questionnaires covered a variety of topics such as daily activities, social activities, physical condition, and informal care providers. Questions could be: 'how do you usually spend your days?', 'how do you manage your household?', and

'what activities do you enjoy?' but also ask how people organise their personal care; whether they have children, and if so, if they live nearby and how they provide assistance.

Field notes were taken during all observations and were then elaborated on extensively and promptly. In this paper, we highlight some observations that are exemplary for the huge variety of conversations between professionals and older people in practice. To preserve their anonymity, all names of professionals mentioned in our observations are pseudonyms to maintain their anonymity and the anonymity of individuals visited during these observations.

## Professional kitchen table practices

### *Negotiating a predefined need*

Most professional home visits are scheduled when people ask for help. If a request is submitted, a professional is appointed to 'do' a kitchen table conversation during a home visit. In some of these cases, individuals already have a valid indication for help based on the previous policy. Because it is a transitory phase, the municipality decided that these indications remain valid until their expiration dates. However, during a home visit, professionals are still expected to negotiate activation opportunities.

Jenny visits an older woman who received an indication for a mobility scooter some years ago, but soon after returned the device. Now, the woman wants 'to get her mobility scooter back'. Before entering the home, Jenny introduces herself and me [first author]. She explains how things have changed 'in our policy as you might have heard already' and that she wants to talk about the life of the woman in a more extensive way than she might have been used to: 'Just to be able to help you towards our best abilities, so let us talk about your life in general'. The woman agrees, and we join her and her daughter-in-law in her living room. Jenny puts a questionnaire on the table. She says they will discuss the request for a mobility scooter, but that she first wants to know more about the woman's daily and social life. The woman says, 'that's okay'. However, when Jenny formulates her first question, she replies by elaborating on why she really does need 'her mobility scooter'. Jenny states she understands that the woman wants to talk about the mobility scooter, but that she really must know some other things in advance.

Although the woman indicates that she understands this, she continues to respond to Jenny's questions that 'she really does need her mobility scooter'. She talks about her physical constraints, her medication, why she would like to use the mobility scooter, and a misunderstanding that led her to return her scooter a few years ago. She searches for medical information to prove that her claims about her physical condition are justified. After leaving the house, Jenny bursts out: 'This is not how it is supposed to go' and that she feels like she has failed, because she was not able to have a conversation or complete the questionnaire. In addition, she experiences mixed feelings because she would have responded differently to this claim in the past: 'She has obtained a formal indication, which I would just renew (...) her claim is still legitimate'.

In this case, a professional is expected to have a kitchen table conversation that is consistent with the ideals of a negotiation of activation opportunities. In the woman's home, the professional wants to assess needs and abilities and organises the conversation by following her questionnaire. While this questionnaire covers many domains of life, the woman only wants to prove the legitimacy of her request. The professional struggles with her assignment to negotiate activation while knowing there is a valid legitimisation for the request. Eventually, the professional experiences a feeling of failure because she was unable to complete the list, as the woman was not willing to give up her agency in her own living room, seeking to ensure that her needs would be heard.

### *Negotiating a need proactively*

Within some neighbourhoods, it is common practice that when inhabitants turn eighty years old, they receive a home visit. During these visits, a professional must 'do' a typical kitchen table conversation, although there is no formal request to assess. The idea is that conversations can be preventive, detecting problems at an early stage, while simultaneously helping to activate people, for instance to become volunteers.

Sitting on the couch in the living room of an older couple, Annette explains that she is here today to determine if the man needs any support now that he has turned eighty. Immediately, the couple replies they do not need anything at all, as they are both perfectly healthy. Nevertheless, they answer all of Annette's questions during the next hour. Annette apologises several times for the length of her questionnaire (the same list Jenny used), but the couple repeats: 'it does not matter at all'. For instance, Annette asks them about their physical constraints, as well as how they spend their days. Only when she asks them about their financial situation, they refuse to answer: 'this information is private'. Annette takes notes about all of the details that are shared during the conversation, including intimate information concerning the relationship with their son and daughter-in-law. Afterwards, Annette explains to me that, although these conversations are time consuming, they are also important to 'stay in touch with the everyday feelings of regular older people'.

In this case, there is no request for help. The assignment is to find out whether there are problems or activation opportunities. There are no restrictions to which professionals should shape their conversations, although they are expected to use a questionnaire. Professionals expect their questions are legitimate as they are part of their form. The couple in this fragment is cooperative, allowing a professional to enter their home and to ask many questions. According to the professional, the conversation does not reveal any problems, but she considers the conversation useful as a means to '*stay in touch*' with older inhabitants.

### ***Negotiating an undefined need***

As part of a pilot project to increase professional space, a professional visits an older couple. She visits people after receiving a request for help, but she has no further instructions or guidelines. There are no time limits nor questionnaires that she needs to complete. If she considers it necessary, she can immediately organise specific care. However, a kitchen table conversation is needed to provide the municipality with a recommendation. The older woman whom we are visiting has a husband suffering from Parkinson's disease. A care manager involved with this man has asked to verify whether his wife is eligible to receive any extra help now her husband's care demands are increasing rapidly. The woman is coping with infirmities that occur with old age.

The woman invites us in her home, while apologising for her husband's current absence. She assures he will join us later, although it is difficult for him to stay in one room and to remain focussed. The woman says that she is nervous because she is afraid that she will not get any help. In the past, a physician has 'interrogated' them, [as part of the verification procedure for an indication] and rejected their care claim. Laura reassures that it will be all right and that she understands that the situation is different now. She adds that she is aware that the couple has to cope with a great deal at the moment and that it is probably difficult for them to understand everything at once, but that she will do what she can to help them. When asked to tell something about their physical abilities, the woman retrieves some documents that contain both their medical histories and reads the information out loud (which dates back to the 1970s). Sometimes, Laura looks for explanations regarding medication or medical conditions on her tablet and makes notes on her form. She asks whether the woman could show us their house, as this will help to understand how they live and what kind of help might be suitable. During the tour, the woman explains specific adjustments which they made for her husband, including a special chair in the kitchen that enables him to get around, handles beside the toilet and an additional balustrade next to the stairs, adding that they can move a bed to the living room when necessary. Laura interrupts the woman occasionally to ask for additional details, such as how they get out of bed in the morning or how they deal with a higher threshold in one of the rooms. Back in the living room, Laura explains that she intends to advise the municipality at least to adjudge a domestic help to the couple and that she can also organise some extra support if desired, although she understands this visit can be a bit overwhelming.

In this case, there is an unspecified request for help. It is up to the professional to find out what the request actually entails, why it is made and how the couple can be facilitated. Although the professional is able to structure the conversation in the way she thinks is appropriate, it follows a similar structure to conversations in which questionnaires are used. The professional already anticipates the advice which she has to write and which has to meet a certain structure, but she also tries to provide reassurance to the couple.

### ***Negotiating a need for support***

Some activation practices take place outside the home, during consultations in public places, such as a neighbourhood community centre. Everyone can walk in to discuss whatever they choose during a

short conversation of fifteen minutes. These consultation hours are introduced to enable people who do not know what to do or where to get professional help. At times, there are no visitors, at other times there are plenty. Professionals 'do' these conversations as kitchen table conversations. While professionals mostly do not know anything about visitors in advance, they need to collect specific information for accountability reasons.

An older woman enters the room. Anne knows she must encourage a dialogue about actual needs of visitors. She asks the woman for her name, while she points to a form and explains that she wants to write it down. The woman hesitates, trying instead to talk about a letter she received from the municipality. However, Anne says she cannot discuss this letter when she does not have her name. During the following minutes, Anne repeats her argument that she needs a signature to make her time accountable, while the woman replies that she feels disrespected and that she has only 'a small question for which no registration is needed'. Eventually, the woman becomes angry and walks away. Anne tells me that she feels confused. While she only wants to help people, they must understand that receiving their consent is part of her job.

During another observation at this community centre, another professional first held a conversation about the wishes of a visitor, after which the professional explains some additional information is needed to be able to help, for which a follow-up meeting would be the best opportunity. Beforehand, a sign informed consent is needed: 'Why don't you just fill in this form, while I check my calendar to schedule a follow-up consultation?' The woman in this conversation writes down her details and signs the form. The professional afterwards explains that 'getting a signature' is just part of the activation assignment. Signatures can even be a way 'to make visitors a participant in the conversation by giving them a specific task'.

These two conversations differ from most kitchen table conversations because they do not take place at home. This gives citizens an opportunity to meet professionals in a more anonymised way. But if they want actual help, they must reveal their identities. Professionals have some flexibility in the ways that they do the conversation, but they are bound by time limits and administration rules that oblige them to obtain written informed consents. They also have to activate visitors to look for solutions in their own social networks. Although both professionals use the kitchen table conversation technology, the conversations work out differently. The first conversation is a discussion about unveiling one's identity, while in the second conversation, identity is used as an activation strategy.

## Discussion and conclusion

In this paper, we explored how the kitchen table conversation works out in and affects practice, following the introduction as a new participatory technology to facilitate care and welfare professionals in fulfilling their assignment to encourage ageing-in-place. We conclude, that overall, the kitchen table conversation fails as a participatory technology. This is demonstrated by unfolding conversations in which the kitchen acts as a place for dialogues and constructs a new relationship between professional and citizen. Policy expectations concerning this technology describe a kitchen table as a symbolic place for informal, open, and in-depth dialogues. Whereas such a dialogue implies an equal power balance in which consensus does not have to be reached (Kohl & McCutcheon, 2015), in fact one of the kitchen table conversation's underlying policy aims was to mediate the activation of older people in an unequal professional/citizen relationship. While citizens do not exactly know what they stand to gain or lose in these conversations, they are usually aware that professionals also have an assignment to cut costs, and that it is not only about being eligible for help.

When professionals enter a home as representatives of the government, the home becomes a place where publicly provided care is negotiated. Kitchen table conversations illuminate tensions between policy (a withdrawing government) and practice (professionals invading the privacy of the home). The home changes from a safe and private place into a place where care and independence are discussed (cf. Dahlin-Ivanoff et al., 2007), affecting the role of professionals and turning them into gatekeepers and care negotiators. Where they would previously enter a private space as care providers, they now enter before any care arrangements are made. The home now can be used to demonstrate one's needs, but professionals' decisions are also affected by the home-setting. The home as a context can empower the inhabitant to endeavour in determining the

agenda, but can also emphasise his or her vulnerability, as he or she feels obliged to share private information and to reveal personal stories, while the personal living situation is being exposed. In addition, the home-setting might also make it more difficult to end the conversation by walking away. Professionals can incorporate the home-setting in helping to decide what care is possible and needed, but can also experience that it complicates their professional authority.

In general, studies on the kitchen (table) as a place to mediate dialogues confirm recent policy expectations. Places construct different relationships. In his work on the car as a place of care, Ferguson (2010) emphasises, how a place (the car) can facilitate relationship-based practice. A similar effect is expected from the kitchen. Ferguson (2010) made a critical note, stating that professionals could feel unsafe when they are being enclosed in a small space with a client. While the examples provided by Ferguson (2010) demonstrate how the car often mediates deeper interactions and warm care, a similar depth seems to be lacking in the kitchen table conversations we observed. As a place, the home not necessarily facilitates warm, in-depth dialogues, but creates distance. Individuals can feel dependent on the goodwill of the professional or aim to act according to what they think is expected of them to get what they want. However, professionals depend on citizens too, as the cooperation of the citizen is needed to fulfil their assignment and be accountable. Some professionals tinker with the technologies available, softening them by making them less prominent, for instance by embedding the informed consent.

Our study demonstrates that professionals who are having kitchen table conversations, struggle to find a balance between their ideals of good care and their interpretation of current policy expectations. Completing a form or a questionnaire becomes a goal in itself, though such tools – clearly visible as policy-instruments – impede an open dialogue based on equality. Among others, Broadhurst et al. (2010) and Høybye-Mortensen (2015) state that to actually work as mediators in practice, social technologies have to be designed with space for situational awareness, for which reflective practice is conditional (Ruch, 2005; Trevithick, 2003). As each context is different, a smart, adaptable design is needed. In practice, the kitchen table conversation design limits opportunities for reflexivity. Policy expectations, accountability and the expectation to use questionnaires or forms decrease space for a dialogue and relationship-building. Where relationship-based practice ideas draw on an idea that all ‘stories’ should be respected, while the relationship is being built in a collaboration (O’Leary, Tsui & Ruch, 2013), policy ideals on kitchen table conversations seem to oversee that this relationship cannot spontaneously commence, especially when it is bound by contrasting expectations.

Ideally, the professional and the citizen reach consensus on a customised care arrangement. In the current policy context, the dependence of older people on the professional’s verdict precludes an equal relationship. The cases that we analysed illustrate that kitchen table conversations articulate different kinds of tensions between policy and practice, demonstrating the ambiguity of the ‘new professional’ role in participatory regimes and of a social technology introduced to mediate ageing-in-place. The expected role of professionals in helping to cut back on care costs adds to the tensions which professionals experience in practice. Though professionals are formally expected to come to a good care arrangement with citizens, their assignment is combined with a message that less formal care is preferred, as policymakers strive to increase older citizens’ independence in this manner. While the government increasingly withdraws from society by shifting responsibilities to individuals, it paradoxically expects professionals to activate these individuals by entering their private sphere (home).

Within STS, Mol et al. (2010) demonstrated that although social technologies that are used in caring practices contain an inscribed purpose, they acquire their eventual meaning in use. Our analysis indicates that the social technology of the kitchen table conversation not only affects professionals’ activities and space in interactions with individuals, but also their definitions of good care, and of what is public or private. Studies on social technologies that elaborate on how practice oftentimes deviates from its scripts support our findings, which suggest that kitchen table conversations lack the standardising and predictable characteristics anticipated on in policy. Rather than

facilitating professionals and their assignment in practice, professionals are required to be creative to use the technology, as the technology in and of itself does not enable or mediate (Derksen & Beaulieu, 2011). Despite a small sample, our analysis shows that new participatory regimes create new and complicated assignments for professionals.

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