

# Mental health care reforms: evaluation research of 'therapeutic projects' - first intermediate report

*KCE reports 103C*

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**Mental health care reforms:  
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'therapeutic projects' - first  
intermediate report**

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*KCE reports 103C*

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## Executive summary

### BACKGROUND AND LIMITATIONS

This report is an atypical KCE-report, in the sense that it is not aiming at developing final conclusions or any policy recommendations, yet. This is a first intermediate report on the evaluation research of the “therapeutic projects” (TP) in mental health care. The overall research process lasts for at least three years and a lot of data-collection and data-analysis is still ongoing. Final conclusions and recommendations can only be made at the end of the entire research trajectory

### THERAPEUTIC PROJECTS IN MENTAL HEALTH CARE

In 2006 a policy program on therapeutic projects in mental health care was launched by the federal government. The government program intends to develop practical experiences with new organisational modes in mental health care. TP should aim at “complex and chronic” patients with psychiatric disorders, within a clearly identified age group (namely children and youth, adults, elderly, addiction or forensic psychiatry). The individual projects are intended to develop experiences in the *organisational* approach offering effective support for different mental illness target groups.

The government program describes a general framework without putting forward precise criteria to assess the success of therapeutic projects. The framework is set as an invitation to obtain proposals from the sector in a ‘bottom-up’ way in order to develop organisational reforms in Belgian mental health care. Therapeutic projects are intended to implement an ‘integrated health services model’ in clearly defined catchment areas, providing services adapted to the needs of the patient and promoting his/her rehabilitation in the society and guaranteeing the continuity of care.

A working group of NIHDI selected eighty-two TPs.

### SCOPE OF THE STUDY

The KCE was asked by the federal Minister of Health to perform a scientific evaluation study on the government program. The scientific analysis has to contribute insights supporting (further) organisational reforms of mental health care. The formal demand of the Minister was to assess to what extent the organisation models proposed by the sector contribute to develop needs-based care and reach the aim of continuity of care in a less residential oriented approach. The demand of the Minister is not to focus on the clinical content of the TP. The research is a typical “health services approach”, as it mainly focuses on organisational issues. In this research the focus is mainly on collaboration issues between different care providers and organisations. It is mainly a process-evaluation focussing on barriers and facilitators in the development of collaboration.

The evaluation research is embedded in a long term approach of at least 3 years of TP activities. Different sources of information will be used: document analysis, interviews, patient data from a prospective patient monitoring.

A separate research performed by another academic research consortium focuses on the issue of patient participation and patient and family-members related issues.

## SCOPE OF THIS REPORT

This is a report with preliminary descriptive findings of interviews with representatives of 44 of the initially approved 82 TPs (14 group children and adolescents, 26 group adults, 4 group elderly), using a qualitative data-analysis methodology.

On the content level the report focuses at: the initial plan of each project (aims at patient level and level of partners), describing and classifying types of coordination and collaboration; understanding the functioning of the collaboration and the nature of the relation between partners (and the patient); understanding barriers and facilitating factors of the collaboration within the TP.

## RESULTS

### COMMENTS ON THE GOVERNMENT PROGRAM

In general projects react positively in the development of a government program trying to stimulate organisational reforms in mental health care. Projects state that the TP framework offers an opportunity to experiment with models of organisational and professional collaboration. For some projects the TP enables funding an existing practice of collaboration between partners.

### OBJECTIVES AND BACKGROUND OF THE TP-PROPOSALS

Some TP refer to the local context and the local health care provision as a motivation to submit and develop a TP. Other motives are: to inform other providers (in healthcare and other sectors) about their activities and working practices, or strategic reasons (“we want to part of the movement”).

Continuity of care) is often cited as a motivation to elaborate the TP. (Many projects aim at continuity between hospital and ambulatory care, sometimes within health care often between health care and other sectors. A number of projects aim at the discharge from hospital towards home care. Part of the arguments related to continuity of care holds the issue of ‘consistency’ or coherence in services provided.

Quite a number of projects have developed a proposal embedded in longer lasting collaboration between a number of partners. For only a limited number of projects the governments program on TP triggered for the first time the idea for collaboration. Previous collaboration can be formal or informal, and can both be institutional or at the level of individual professionals.

In some area’s the preparation of the proposal has been coached or sometimes even directed by the mental health care consultation platforms. For many projects plans are developed in rather general ways, and –logically—mainly to address the administrative requirements of the call. The plans are in most cases not conceived as practical guiding tools for the implementation of the TP.

Generally, interviewees are not very specific on particular objectives. It is particularly interesting to observe that projects have difficulties in defining the issue of “chronic and complex’ patients, although for many projects ‘complexity’ is defined as an issue of a combination of needs in different life-spheres (requiring support from different professionals) rather than the severity of the psychiatric disorder as such.

Indications are found that the target group influences the importance paid to include patients and family (e.g. for projects on children and elderly persons the target group seems to influence the perspective on patient and family participation).

## DIFFERENT COLLABORATION MODELS

An important observation is that the “therapeutic projects” develop different models of collaboration. The bottom-up strategy to collect TP proposals, induced a lot of variation in the underlying organisational approaches of the TP. The coordination or management of the partnerships varies from rather formalised procedural and layered modes of coordination (with different types of meetings) to smaller scale and informally organised network or collaboration models. The allocation of tasks to the coordinators and the division of labour between persons (coordinators) differs between projects. The frequency, time, participants, tools and content of different coordination activities varies between the projects. At this stage of the research it is too early to detect any patterns controlling for project or contextual issues. Part of the differences between TPs is not only to be explained by contextual issues or the structural configuration, but also by the ‘vision’ or the meaning given by the actors involved to develop a TP.

The preliminary results give indications that the TP have to manage a collaboration model on two main axes: on the one hand the particularities of managing the partnership, on the other the management of patients. We have indications from the interviews that TPs do not always have an evenly developed vision or approach on the handling of the two main axes simultaneously. Projects seem mainly to be concerned with the management and collaboration of individual patient activities.

## A LEARNING EXPERIENCE

The current experiences of the interviewed projects show that the development of a TP is a learning experience requiring time of all participants. The adoption of an organisational change both requires changes in the minds of people as well as in the structures and ways of working. Theoretical plans have to be translated into practice. The development of an organisational network or collaboration is not solely an issue of developing structures. It is also a cultural issue of shared values, interorganisational norms, expectations, common understanding and strategic interests of partners. Moreover, strategic interests play an important role.

For some TP a kind of ‘knowledge gap’ exists between the people having reflected conceptually and the ones who putting the project in practice. Sometimes visions between the persons who conceptualised the TP and the ones who have to implement them are not compatible.

Part of the learning experience of the projects is developing ‘feasible’ and ‘workable’ practice for all actors involved; projects are adapting their working practices, in order to attain a feasibility and workability level for all actors.

This collaboration process has to be supported by rather important efforts to inform and promote all actors involved. Part of the difficulties of the TPs is disseminating (a sufficient level) of ) information to the participants, mainly those involved in direct patient care. Part of these promotion activities seems to consist of building trust relationships between actors (often) from very different backgrounds with their proper professional values, norms, working experiences and opinions on professional practice.

Some projects or partners within projects have withdrawn because of difficulties to respond to the conditions set by the government program. Some projects are sometimes struggling with the vast number of parallel “experimental” projects and initiatives (in different health care sectors) taken by different provincial, regional and federal authorities, without any streamlining of these activities. Many partners of the TP are sometimes also participating in other organisational initiatives outside the TP, but seem to be confronted with the lack of an overarching common policy framework.

## FUTURE RESEARCH STEPS

This report summarises preliminary descriptive results of a selected number of TP's. It is only in an intermediate phase of data-collection and –analysis. The next step is to continue the first round of interviews with the projects and continue an in-depth data-analysis of the first interview round. Findings of the Belgian TPs need to be confronted with existing research on international mental health care reforms and with theoretical insights too. The triangulation with insights from scientific literature will enable to develop statements on the underlying models of collaboration and networking in the future steps of research. Moreover, other data-sources such as written documents need to be explored further. The second interim report will explore the theoretical issues, and make a final analysis of the first round of interviews with all projects. The report will not be limited to descriptions but also use all collected data and theories to draw more substantiated conclusions.

The final report-- in which the second round of interviews with the TP's will be analysed and in which data of the patient monitoring will be integrated -- will draw final conclusions and recommendations with regard to the implementation of the TP government programme. It is hoped for that a parallel research process coordinated by another research consortium on patient participation can shed additional light on the issue of patient participation, as part of these organisational reforms in mental health care.

## Scientific summary

Table of contents

<b>ABBREVIATIONS</b> .....	<b>5</b>
<b>1 INTRODUCTION</b> .....	<b>6</b>
1.1 SCOPE OF THIS RESEARCH.....	6
1.2 LIMITATIONS OF THIS REPORT .....	7
<b>2 CONTEXT AND AIMS OF THE TP</b> .....	<b>8</b>
2.1 A BRIEF OVERVIEW OF POLICY INITIATIVES ON ORGANISATIONAL CHANGES IN MENTAL HEALTH CARE.....	8
2.1.1 Initiatives to stimulate organisational innovations.....	8
2.1.2 Therapeutic projects (TP) and transversal consultations .....	9
<b>3 METHODOLOGY</b> .....	<b>12</b>
3.1 INTRODUCTION.....	12
3.2 AIMS OF THE EVALUATION RESEARCH.....	13
3.3 LIMITATIONS OF OUR APPROACH.....	14
3.4 RESEARCH METHODS.....	14
3.5 PLAN EVALUATION OF TPS.....	15
3.5.1 Data-sources .....	15
3.6 PATIENT LEVEL: PATIENT MONITORING.....	17
<b>4 INTRODUCTION TO RESULTS</b> .....	<b>20</b>
<b>5 HISTORY OF TP</b> .....	<b>21</b>
5.1 PREVIOUS COLLABORATIONS BETWEEN PARTNERS .....	21
5.1.1 Informal collaboration between partners .....	21
5.1.2 Formal collaborations between partners .....	22
5.2 THE PREPARATION OF THE TP PLAN .....	23
5.2.1 Mental health care consultation platforms.....	23
5.2.2 The elaboration of the proposal .....	23
5.2.3 The selection of the partners .....	25
<b>6 OBJECTIVES OF THE TPS</b> .....	<b>28</b>
6.1 INTRODUCTION.....	28
6.2 COLLABORATION OBJECTIVES.....	28
6.2.1 Patient level .....	28
6.2.2 Partners level.....	28
6.3 SERVICE DELIVERY OBJECTIVES .....	30
6.3.1 The transition between organisations.....	30
6.3.2 Simultaneous health care services delivery.....	30
6.3.3 Accessibility of care .....	30
6.3.4 A better use of care.....	31
6.3.5 Family support.....	32
6.4 OUTCOME OBJECTIVES.....	32
6.4.1 Patient level .....	32
6.4.2 Professional level.....	32
6.5 MOTIVATIONS TO COLLABORATE .....	34
6.5.1 Experimental network collaboration .....	34
6.5.2 The formalisation of collaboration between professionals .....	34
6.5.3 The local context .....	34
6.5.4 The improvement of service delivery .....	35
6.5.5 The consistency of the provided services.....	35
6.5.6 Other motives.....	36
<b>7 SELECTION OF THE TARGET POPULATION</b> .....	<b>37</b>
7.1 MOTIVATION FOR SELECTION OF PATIENT GROUP.....	37
7.1.1 Difficulties in service delivery for a specific patient group .....	37

7.1.2	Availability of expertise for a specific patient group.....	37
7.2	INCLUSION AND EXCLUSION CRITERIA.....	37
7.2.1	Inclusion criteria.....	37
7.2.2	Exclusion criteria.....	39
7.3	CHRONIC AND COMPLEX.....	39
7.3.1	Comments.....	40
<b>8</b>	<b>SELECTION OF THE PARTNERS.....</b>	<b>41</b>
8.1	FORMAL PARTNERS.....	41
8.1.1	Type and number of the formal partners.....	41
8.1.2	The choice of the formal partners.....	41
8.1.3	The role of the formal partners.....	42
8.2	INFORMAL PARTNERS.....	42
8.2.1	Type and number of informal partners.....	42
8.2.2	Role of informal partners.....	43
8.2.3	The choice of the informal partners.....	43
8.3	FAMILY AND PATIENT ORGANISATIONS.....	43
<b>9</b>	<b>GEOGRAPHICAL AREA OF ACTIVITY.....</b>	<b>44</b>
9.1	SIZE OF THE CATCHMENT AREA.....	44
9.2	MOTIVATION.....	44
<b>10</b>	<b>COORDINATION OF TP.....</b>	<b>45</b>
10.1	INTRODUCTION.....	45
10.2	COORDINATION OF ACTIVITIES AT PROJECT LEVEL: MEETINGS.....	46
10.2.1	Steering committee.....	48
10.2.2	Other meetings with partners of TP.....	50
10.2.3	Informal bilateral communication.....	50
10.2.4	Promotion of the TP.....	51
10.3	COORDINATION OF PATIENT RELATED ACTIVITIES.....	51
10.3.1	The process of inclusion.....	53
10.4	TOOLS.....	58
10.4.1	Tools used to coordinate the management of partners.....	59
10.4.2	Tools used to coordinate patient related activities.....	60
10.4.3	Tools used to coordinate the follow-up of the patient.....	61
<b>11</b>	<b>THE COORDINATOR.....</b>	<b>64</b>
11.1	INTRODUCTION.....	64
11.2	OVERALL COORDINATOR.....	64
11.3	PROJECT COORDINATOR.....	65
11.3.1	Coordinating the partnership.....	65
11.3.2	Coordinating patient related activities.....	65
11.3.3	Time allocation.....	66
11.3.4	Profile of the project coordinator.....	67
11.4	SUPPORT FOR THE PROJECT COORDINATOR REGARDING PATIENT RELATED ACTIVITIES.....	68
11.4.1	Patient representative.....	68
11.4.2	Consultation and Home Care Coordinator.....	68
11.4.3	Support in organisation, chairing and report writing of meetings.....	68
11.5	'ADMINISTRATIVE' COORDINATOR.....	69
<b>12</b>	<b>CURRENT EXPERIENCES.....</b>	<b>71</b>
12.1	INTRODUCTION.....	71
12.2	PERCEIVED ADDED VALUE.....	71
12.2.1	Added value of the government his TP-programme.....	71
12.2.2	Participation of the patient.....	72
12.2.3	The rhythm of the meetings.....	72
12.2.4	Obligatory involvement of different types of partners.....	72
12.2.5	Added value of meetings.....	73

12.2.6	Added value for patients.....	74
12.3	THE INCLUSION PROCESS OF NEW PATIENTS.....	76
12.3.1	Selecting patients for the TP.....	76
12.3.2	Informed consent.....	77
12.3.3	Partners proposing new patients for inclusion.....	78
12.3.4	Inclusion meetings.....	79
12.4	EXPERIENCES WITH PATIENT MEETINGS.....	80
12.4.1	Participants.....	81
12.4.2	Content.....	83
12.4.3	Duration of the meeting.....	83
12.4.4	Number of patient meetings.....	83
12.4.5	Location of meetings.....	83
12.5	EXPERIENCES WITH THE STEERING COMMITTEE MEETING.....	84
12.6	PATIENT PARTICIPATION.....	84
12.7	EXPERIENCES WITH FAMILY PARTICIPATION AND PATIENT AND FAMILY ORGANISATIONS.....	85
12.8	CHANGES IN THE PLAN OF TP.....	86
12.8.1	Coordination issues.....	86
12.8.2	Inclusion issues.....	86
12.8.3	Number of partners.....	87
12.9	THE PROJECT COORDINATOR.....	87
12.9.1	Human resources issues.....	87
12.9.2	The role of the coordinator.....	88
12.9.3	Individual patient coordinator role.....	88
12.9.4	Financing of the coordinator.....	89
12.9.5	Workload of the coordinator.....	89
12.9.6	Support for the coordinator.....	89
12.10	PROFESSIONAL SECRECY.....	90
12.11	THE FORMAL PARTNERSHIP.....	91
12.11.1	Maintaining the formal partnership.....	91
12.11.2	Actively involving partners.....	91
12.11.3	Lack of knowledge about the TP within partner organisations.....	92
12.12	DIFFERENT VALUES AND APPROACHES OF PARTNERS.....	93
12.12.1	Different perspectives, language and cultures.....	93
12.12.2	Conflict of interest between ambulatory care and hospitals.....	93
12.13	EXTERNAL CONDITIONS.....	94
12.13.1	The contract requirements.....	94
12.13.2	Critiques and suggestions.....	96
12.13.3	Communication from FPS, NIHDI and KCE.....	97
12.13.4	Patient monitoring.....	97
12.13.5	Other formal collaboration initiatives.....	97
12.14	CRITICAL FACTORS.....	97
12.14.1	Time and previous collaboration.....	97
12.14.2	Promoting the project.....	98
12.14.3	Critical factors for patient meetings.....	98
12.14.4	Critical factors for partner participation.....	98
<b>13</b>	<b>RESIGNING PROJECTS.....</b>	<b>100</b>
13.1	INTRODUCTION.....	100
13.2	REASONS FOR RESIGNING.....	100
13.2.1	Number of inclusions.....	100
13.2.2	History of collaboration between the partners.....	101
13.2.3	Role and employment location of the project coordinator.....	101
13.2.4	Objectives.....	102
13.2.5	Preparation versus implementation of the project.....	102
13.2.6	Coordination model.....	102
13.2.7	Patient monitoring.....	102

<b>14</b>	<b>GENERAL DISCUSSION</b> .....	<b>104</b>
14.1	THE OVERALL RESEARCH AND SCOPE OF THIS REPORT .....	104
14.2	METHODOLOGICAL LIMITATIONS.....	105
14.3	VARIATIONS ON A THEME: DIFFERENT TP-MODELS .....	106
14.4	THE ELABORATION OF A COLLABORATION PLAN.....	107
14.5	COLLABORATION, COORDINATION, PARTNERSHIP, NETWORK...WHAT IS IN A NAME? .....	108
14.6	A LEARNING EXPERIENCE.....	108
14.7	STRUCTURE AND CULTURE.....	110
14.8	MANAGING PARTNERS AND MANAGING PATIENT PATHWAYS.....	111
14.9	PATIENT RELATED ISSUES.....	112
14.10	FUTURE RESEARCH STEPS.....	112
<b>15</b>	<b>REFERENCES</b> .....	<b>114</b>

## ABBREVIATIONS

ABBREVIATION	ENGLISH	FRENCH	DUTCH
EA	Employment Agency	FORMATION - EMPLOI FOREM	Vlaamse Dienst voor Beroepsopleiding en Arbeidsbemiddeling VDAB
CMHS	Community Mental Health Service	Centre de Soins de Santé Mental CSSM	Centrum voor de Geestelijke Gezondheidszorg CGG
FPS	Federal Public Service – Health, Food Chain Safety and Environment	Service Public Fédéral - Santé Publique, Sécurité de la Chaîne alimentaire et Environnement SPF - SSAE	Federale OverheidsDienst – Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu FOD - VVVL
GP	General practitioner	Médecin généraliste	Huisarts
HS	Home Services	Services et Soins à Domicile SSD	Thuiszorgdiensten
ISH	Initiatives Sheltered Housing	Initiative Habitation Protégé IHP	Initiatief Beschut wonen IBW
ISHC	Integrated Services Home Care	Soins Intégrés des Services à Domicile SISD	Geïntegreerde Diensten Thuisverzorging GDT
KCE	Belgian Health Care Knowledge Centre	Centre fédéral d'expertise des soins de santé	Federaal Kenniscentrum voor de Gezondheidszorg
MHCCP	Mental Health Care Consultation Platform	Plateforme psychiatrique de soins de Santé Mental PFSM	Overlegplatform van de Geestelijke GezondheidsZorg OGGZ
NACH	National Advisory Council for Hospital Services	Conseil National des Etablissements hospitaliers CNEH	Nationale Raad voor Ziekenhuisvoorzieningen NRZV
NIHDI	National Institute for Health and Disability Insurance	Institut National Assurance Maladie et Invalidité INAMI	Rijksdienst Instituut Ziekte en Invaliditeitsverzekering RIZIV
PHC	Psychiatric Home Care	Soins Psychiatrie à domicile SPAD	Psychiatrische Zorg in de Thuisituatie PZT
PMSSD	Public Municipal Social Service Department	Centre Public d'Aide Sociale CPAS	Openbaar Centrum voor Maatschappelijk Welzijn OCMW
PYS	Protective Youth Services	Service d'Aide à la Jeunesse SAJ Service de protection de la jeunesse SPJ	Comité voor Bijzondere Jeugdzorg / gerechtelijke jeugdbijstand
SF	Sickness Funds	Mutualités	Ziekenfonds of Mutualiteit
TP	Therapeutic Project	Projet Thérapeutique	Therapeutisch Project

# I INTRODUCTION

This is the first intermediate report on the evaluation research of the “Therapeutic Projects” (TP). The TP were initiated through the National Advisory Council for Hospital Services (NACH) and coordinated by the National Institute for Health and Disability Insurance (NIHDI) and the Federal Public Services (FPS) for Public Health (mental health unit). The aim of these initiatives is to collect experiences in order to draw lessons on how to (re)organise the (mental) health care provision for selected groups (see infra).

## I.1 SCOPE OF THIS RESEARCH

After the formal government programme was conceived and launched and the projects were selected by the NIHDI, the Belgian Health Care Knowledge Centre (KCE) was asked by the Minister of Social Affairs and Public Health to perform a scientific evaluation study of these TPs. The scientific analysis has to contribute insights supporting (further) reforms of mental health care. The formal demand of the Minister was to assess to what extent the organisation models as proposed by the sector through the TP, do actually contribute to the development of needs-based care and reach the aim of continuity of care in a less residential-oriented approach of treatment and support for persons with “complex and chronic” psychiatric problems. The demand of the Minister excluded a focus on the clinical content of the TP.

The research is a typical “Health Services Approach”, as it mainly focuses on organisational issues. It is a policy support project rooted in scientific health programme evaluation research methodologies. The KCE was asked:

- To develop a methodology for the development of a patient monitoring tool
- To design a methodology to assess organisation processes when establishing collaborative models of provision of care.
- To conduct a process evaluation of the TP.
- To assess the particularities of the organisation of care for mental health care target groups as defined by the working group psychiatry of the NACH.

The evaluation process of the TPs is embedded in a long term programme of at least 3 years of TP activities. The projects started their activities in april 2007.

A separate research trajectory, performed and coordinated by another research consortium, is in particular focussing on the issue of patient participation within the TP. The issue of patient participation as perceived by patients, families and family organisations is falling outside the scope of the KCE assignment. Both research trajectories should at the end offer complementary knowledge to support the development of a mental health care policy framework.

The financial resources for the scientific evaluation process are provided by FPS within the framework of the programme for mental health care reforms (except for the KCE supervision).

## I.2 LIMITATIONS OF THIS REPORT

This first report offers a first description of issues on the development of the project plan proposals and organisational models as reported by representatives of the TP.

At this stage data-collection is still ongoing: We interviewed 44 of initially 82 accepted TP. We also analysed only one data-source: data-triangulation with other data-sources is needed in the further research process.

Because of methodological reasons, and the stage of the ongoing process of the TP government programme, this is a non-conclusive intermediate report on a first stage in the ongoing evaluation process of the TP.

- It is descriptive and not evaluative.
- It reports preliminary results.
- It holds no final conclusions or recommendations on the value of TP models.

- **After the formal government programme was conceived and launched and the projects were selected by the NIHDI, the Belgian Health Care Knowledge Centre (KCE) was asked by the Minister of Social Affairs and Public Health to perform a scientific evaluation study of the TPs.**
- **The evaluation process of the therapeutic project is embedded in a long term approach of at least 3 years of TP activities.**
- **This is a non-conclusive intermediate report presenting descriptive results on a first stage in the ongoing evaluation process of the TP.**

## 2 CONTEXT AND AIMS OF THE TP

### 2.1 A BRIEF OVERVIEW OF POLICY INITIATIVES ON ORGANISATIONAL CHANGES IN MENTAL HEALTH CARE

Mental health care in Belgium is still strongly oriented towards a residential, one could even say a hospital-centred model of provision of care especially for people with moderate and severe mental health problems. However, in the second half of the 20th century, several federal policy initiatives announced a slow adaptation of the hospital-centred organisation of mental health care towards a more deinstitutionalised policy framework<sup>a</sup>.

In the 1970's, federal policy measures were taken to stop the increase of psychiatric beds. Policy measures also differentiated the types of beds (e.g. units for children were created and a differentiation was made between long-term and acute beds) and centres for ambulatory care were installed.

Since the 1990's, a lot of federal policy documents and statements were developed, all fitting into the discourse of deinstitutionalisation of mental health care. Measures were launched on the 'reconversion' of psychiatric hospital beds in the form of initiatives of sheltered housing and psychiatric nursing homes. Mental Health Care Consultation Platforms (MHCCP) were installed aiming at consultations between mental health care providers and stakeholders.

The NACH was closely involved in the debate on the reforms in mental health care and the introduction of the Therapeutic Projects in particular.

By the end of the 1990's ('99), an advice of the NACH recommended the development of models of care guaranteeing continuity of care, and mental health care services adapted to the needs of patients. Moreover, an explicit recommendation of the NACH urged for more flexibility in the legal frameworks in order to adapt the model of mental health care provision. In 2000, the NACH advised to further develop models of sheltered housing and psychiatric nursing homes.

#### 2.1.1 Initiatives to stimulate organisational innovations

In 1998, "pilot projects" on discharge management from hospitals were launched in the psychiatric sector. Also in 1998, a recommendation was formulated on the development of initiatives for 'Psychiatric Home Care' (PHC), a model and services missing in the Belgian health care context. A Federal policy initiative was launched in 2001, the so called "pilot projects home care": an overall, publicly available, assessment of these 'pilots' was never performed. The projects have all been prolonged as "pilots", but a structural policy model has not yet been developed.

Other pilot projects for the target groups 'children and adolescents', 'adults', and addiction aiming at introducing new approaches of care: models of home care, outreach, day-care, psychiatric liaison, care pathways (including residential and sheltered living facilities), case management and continuity of care, psychiatric crisis services, etc. are funded since the beginning of the 21<sup>st</sup> century by the FPS.

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<sup>a</sup> In this report we will not elaborate on the complex organisation of health care policy competencies in Belgium. It is worth noticing that 7 ministers have discretionary decision-making power on issues related to mental health care. The federal government has mainly competencies on residential care and care aspects (FPS) and reimbursement within the public health insurance (NIHDI). Regional and community governments have political competencies on the 'non-cure' aspects of mental health care (prevention & social care), and can thus develop their proper policies on other aspects of (mental) health care. Moreover, provincial authorities can take policy initiatives too on issues of mental health care organisation.

It is quite interesting to observe, although formally distinct, that a close link exists with the therapeutic projects, (a) on the level of policy intentions of the initiatives, (b) because therapeutic projects are stimulated to integrate pilot projects home care and (c) because several partners of the TPs have had experiences with different policy initiatives on organisational reforms in mental health care (see *infra*).

### 2.1.2 Therapeutic projects (TP) and transversal consultations

In 2003, the 'Public Health Interministerial Conference' issued a declaration on the need for a new concept in mental health care<sup>1,2</sup>. The major objective of the reforms was to offer mental health services adapted to the individual patient's needs, preferably in his own living environment. A number of core principles were emphasized:

- The delineation of target groups based on age categories,
- The collaboration between caregivers,
- The freedom of choice by the patient,
- The continuity and effectiveness of care,
- The need for coordinated policies between authorities within their respective competencies.

The Minister of Social Affairs and Public Health issued in 2005 a document on mental health following the principles of this "Interministerial Conference"<sup>b</sup>. The document proposes the development of experimental 'therapeutic projects', seeking for alternative organisation models in mental health care, more particularly labelled as '*care circuits*' and '*networks*'. The target population of these new models of organisation are patients with '*chronic and complex mental disorders*'.

The government programme for experimental "therapeutic projects" materialised in 2006. A three year experiential programme was implemented by means of a royal decree of October 22 2006 on article 56 § 2 of the nomenclature<sup>c</sup>, stipulating the conditions for the creation and development of TPs.

Therapeutic projects are intended to implement an 'integrated health services model' in clearly defined catchment areas, providing services adapted to the needs of the patient and promoting his rehabilitation in society and guaranteeing continuity of care. The primary aim of TP should be the organisation and/or coordination of consultations for selected patients. The individual projects are intended to develop experiences in the *organisational* approach offering effective support for different mental illness target groups.

The TP should aim at "complex and chronic" patients with psychiatric disorders, within a clearly identified age group (namely children and adolescents, adults, elderly), and/or a specific pathology (addiction or forensic psychiatry). The TP should consist of a minimum number and type of partners, operate in an explicitly motivated catchment area, and aim at giving needs-based care and guaranteeing continuity of care, through a developed model of collaboration.

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<sup>b</sup> <http://www.riziv.fgov.be/care/nl/mental-health/therapeuticProjects/pdf/demotte.pdf>  
<http://inami.fgov.be/care/fr/mental-health/therapeuticProjects/pdf/demotte.pdf> (last consulted December 2008)

<sup>c</sup> <http://www.riziv.fgov.be/care/nl/mental-health/therapeuticProjects/pdf/residenceCareDialogueFinancing.pdf> (last consulted December 2008)

### 2.1.2.1 *The organisation of the initiatives*

'Therapeutic projects' are financed by the National Institute for Health and Disability Insurance (NIHDI) and the FPS of Public Health.

- NIHDI is responsible for the reimbursement of clinical-related activities under the form of a 'convention' (article 56), an agreement specifying the conditions for the reimbursement of activities. The TPs are funded for inclusion meetings of patients and the three-monthly follow-up meetings of patients within the projects. A yearly lump-sum of 24 000 € is paid for coordination activities.

A variable sum, limited to a max of a yearly 22 500€ is reimbursed, depending on the number of patients taking part in the project. At least every trimester, a patient meeting should take place in which at least three formal partners should participate. If the above mentioned conditions are met, a sum of 125€ per meeting is paid by NIHDI. The first year, a maximum of four meetings is reimbursed; from the second year onwards, a maximum of three meetings. All formal partners should participate in the initial meeting to include a patient.

Each project should include as participants at least : (a) a psychiatric hospital or a psychiatric unit (b) a CMHS or one of the "pilot projects" (home care or outreach), funded through FPS and (c) a primary care partner (an association of general practitioners, Integrated Services Home Care (ISHC) , Home Services (HS)).

- FPS finances for the activities related to the "transversal consultations" and the data-collection support for the evaluation research. For projects related to forensic psychiatry, the FPS coordinates all funding activities

Each 'therapeutic project' is obliged to participate in the so-called 'transversal consultations' to share and discuss the experiences related to the organisation practices of "therapeutic projects". The 'transversal consultations' are organised for 'therapeutic projects' addressing the same target group. For linguistic reasons, each group of 'transversal consultation' is organised separately for the two language groups. This 'transversal consultation' is intended as a learning experience, based on the comparison of day-to-day experiences within the TP. It is conceived as a support platform for the individual TP.

The transversal consultations are coordinated by the MHCCP. One MHCCP coordinates all activities for Flanders. In the French-speaking part, three MHCCP coordinate the 'transversal consultations'. At the end of the governments programme, the different platforms will develop a common report relative to the experiences of the TPs. The 'transversal consultations' (and the resulting reports) will be used as input in formulating policy recommendations on the organisation of mental health services in the future.

Eventually, the 'therapeutic projects and transversal consultations' policy programme should give support to the development of a future policy programme for organisation of mental health care for target groups including aspects of adequate 'care circuits' and 'care programmes', tailored to specific groups of patients.

### 2.1.2.2 *The selection of the TP*

The NIHDI coordinated the call for 'bottom-up proposals' for TPs and the selection of the TPs. Different partners could jointly tender for a TP, taking into account the prerequisites put forward by NIHDI<sup>d</sup>. On top of the conditions mentioned in the previous section, the projects were also assessed on:

- The expectation of a better process of taking charge of a patient, and the extent to which a needs-based care approach was developed.
- The expectation that the TP enables the avoidance of redundancies in care on the one hand and fills in gaps in the care pathway on the other hand.
- The testing of innovative forms of caretaking through collaboration between partners and complementarities of partners.

A working group of NIHDI selected eighty-two TPs<sup>e</sup> that answered to the predefined selection criteria (see Royal decree 22 october 2006).

The working group assessed to what extent the bottom-up proposals met the foreseen criteria, but also considered geographic and mental health domain distributional issues<sup>f</sup>. The FPS organized a particular small programme of 'forensic' projects. These projects were selected from the NIHDI-call but funded separately through FPS financial means. These projects are also included in the evaluation research.

- **By the end of the 1990's, an advice of the NACH recommended the development of models of care guaranteeing continuity of care, and mental health care services adapted to the needs of patients.**
- **In 2002, the 'Public Health Interministerial Conference' issued a declaration on the need for a new concept in mental health care. The Minister of Social Affairs and Public Health issued in 2005 a document on mental health, following the principles of this 'Interministerial Conference'. The document proposes the development of 'therapeutic projects', seeking for alternative organisation models in mental health care.**
- **Therapeutic projects aim to implement an 'integrated health services model' in clearly defined catchment areas, providing services adapted to the needs of the patient, promoting his rehabilitation in the society and guaranteeing the continuity of care.**
- **Each "therapeutic project" is obliged to participate in "transversal consultations" to share and discuss the experiences related to the organisation practices. The transversal consultations are coordinated by the MHCCP.**
- **The TPs were proposed through a 'bottom-up' approach. A working group of NIHDI selected eighty-two TPs that answered to predefined selection criteria.**

<sup>d</sup> <http://www.riziv.fgov.be/care/nl/mental-health/therapeuticProjects/index.htm#3>

<sup>e</sup> <http://www.riziv.fgov.be/care/nl/mental-health/therapeuticProjects/projectsoutline/index.htm> (last consulted december 2008)

<sup>f</sup> <http://www.riziv.fgov.be/care/nl/mental-health/therapeuticProjects/pdf/powerpointPresentation20060327.pdf> (last consulted december 2008)

## 3 METHODOLOGY

### 3.1 INTRODUCTION

This research project is a health services research project. It aims to identify effective and efficient ways to organise, and deliver high-quality care adapted to the care needs of (particular) patients (groups) and to understand the processes facilitating or impeding the functioning of the services.

Evaluation research implies a systematic application of scientific research procedures for assessing the conceptualization, the design, the implementation and the utility of a (health) intervention programme<sup>3,4</sup>.

The evaluation methodology used, is in essence a “programme evaluation” in Dutch speaking literature also referred to as a “plan, process and outcome evaluation”<sup>5</sup>. Programme evaluation is a formalised approach to study the goals, processes, and impacts of projects, policies and programmes. Rossi et al.<sup>3</sup> divide these dimensions into 5 main categories: needs assessment, programme theory, process analysis, impact analysis, and cost-benefit & cost-effectiveness analysis.

- The ‘needs assessment’ examines the nature of the problem that the programme is meant to address. This includes evaluating who is affected by the problem, how wide-spread the problem is, and what effects stem from the problem.
- The ‘programme theory’ is the formal description of the programme's concept and design. Methodological guidelines on programme evaluation have argued that each “social programme” (such as organisational reforms in mental health care) embodies an action theory that reflects assumptions about the nature of the social problem it addresses and the way it expects to bring about a change in that problem. Evaluators should bring that theory to the surface and, if necessary, draw on other sources of information to further differentiate it. The programme theory breaks down the components of the programme and shows anticipated short- and long-term effects. An analysis of the programme theory examines how the programme is organised, leads to desired outcomes and reveals unintended or unforeseen consequences. The programme theory generates the hypotheses to be tested in an impact evaluation.
- The ‘process analysis’ evaluates how the programme is being implemented. This evaluation determines whether target populations are being reached, whether people are receiving the intended services, whether staff are adequately qualified, etc.
- The ‘impact evaluation’ describes and tries to assess “effects” and aims at determining causal effects of the programme.
- The cost-benefit or cost-effectiveness analysis assesses the efficiency of a programme. In this initial phase of reporting, the research does not address cost-effectiveness issues, because we do not have a clear view on the organisational configurations of the TPs. However, cost-effectiveness is an issue that will be discussed in forth-coming reports.

The proposed approach is also related to what has been described as “real world” evaluation research in mental health care<sup>6-8</sup>. In this approach, a lot of attention is paid to the context in which organisational models are being developed. This is in contrast to RCT methods aiming at controlling the “noise” variables as much as possible. The approach recognises arguments to develop and use more broad evaluation approaches in mental health care<sup>9,10,11,12</sup>. Interventions in mental health care are different from a typical biomedical approach in such that they have to be adapted to characteristics of persons, organisation of health care, financing regimes etc. . .

- **This research project is a health services research project. It is a programme evaluation research. Programme evaluation is a formalised approach to study the goals, processes, and impacts of projects, policies and programmes.**
- **An evaluation research is a systematic application of scientific research procedures for assessing the conceptualisation, design, implementation and utility of a (health) intervention programme.**
- **The proposed approach is also related to what has been described as “real world” evaluation research in mental health care.**

## 3.2

### AIMS OF THE EVALUATION RESEARCH

One part of the research addresses the collaboration and organisational model of the TP.

The unit of analysis is the therapeutic project (TP), conceptualised as a collaboration of different types of individual and/or organisational actors. In this report, we will refer to this with the general terms ‘partnership’ and ‘partners’.

This part of the research process focuses at:

- The initial plan of the TP (aims at patient level and level of partners)
- The description and classification of types of coordination and collaboration used in the different TP
- The collaboration and the nature of the relation between partners (and the patient)
- The barriers and facilitating factors of the collaboration within the TP

Complementary to the first topic, the evaluation process monitors general data on patient level included in the TP.

- Using a set of specific scales, the patient profile is analysed in terms of case mix, diagnoses, use of services, satisfaction, quality of life,...

The research evaluates the plan, process and (as far as possible) outcomes of newly introduced collaboration models (the TP) in mental health care for persons with complex and chronic (in literature referred to as persistent) mental health problems.

- The plan evaluation aims at describing and/or clarifying the aim of the project, as well as the operationalisation or implementation strategy. The plan evaluation consists of a base line measurement at the beginning of the implementation of a programme or intervention focusing on the ‘plan’ of the TPs. It tries to describe the underlying vision and ideas upon which an intervention is based. Due to pragmatic reasons, we tried to describe the plans of the TP in its first year of implementation.
- The process evaluation aims at describing and analysing the implementation of the programme or intervention. This evaluation is carried out preferentially during the project or retrospectively at the end of the project. For pragmatic reasons and due to the number of projects, we opted for a retrospective qualitative analysis.
- The product evaluation (also called impact, outcome, or effect evaluation) aims at evaluating the impact of the programme or intervention.

This project does not assess the effectiveness of clinical psychiatric approaches nor of pharmacological interventions.

- **The primary unit of analysis is the therapeutic project.**
- **The research evaluates the plan, process and (as far as possible) outcomes of the TP.**
- **This project does assess neither the effectiveness of clinical psychiatric approaches nor of pharmacological interventions.**

### 3.3 LIMITATIONS OF OUR APPROACH

Due to the nature of the interventions called “TP”, this study will not be able to develop high level evidence on the effectiveness of the proposed organisational models as it is commonly used in biomedical sciences (see e.g. Cochrane levels of evidence). But, as has been argued by other mental health care researchers<sup>13, 14</sup> the project aims at collecting and gathering relevant information and knowledge to be taken into account both by policymakers and by actors, implementing innovative organisational models in mental health care.

The research design has its particularities. In an ideal design, one could expect that a detailed stakeholder analysis would be needed within each TP. Although this research pays a lot of attention to the perspectives of different actors involved in the TP, it is not conceived as a within-case stakeholder analysis. We do discuss the different perspectives of stakeholders within the projects in the interviews, but because of practical reasons and time constraints, we will not perform a case-by-case analysis of the different perspectives of stakeholders within projects. We are aware that for the within case studies, the chosen methodology does not guarantee a full-blown analysis of stakeholders within TP's. However, as we will see further, many interviews were group interviews in which different stakeholders of the TP were participating.

This research does not focus on the patients, family-members or ‘patients and family organisation’ perspectives as a particular target group for qualitative data collection. This important part will be done in a separate research, coordinated by another research consortium.

This research is primarily a process evaluation research. It is limited in its “outcome” assessment ambitions on the level of the programme as a whole. The unit of analysis is the TP, not the government programme. The government programme of the TP describes the framework in which TPs have to operate. The intended expectations of the programme are (deliberately) not defined in terms of precise technical outcome criteria on patient or organisational level. Criteria used are mainly technical administrative criteria in order to obtain funding. The government programme is conceived as a ‘learning experience’ aiming for a bottom-up development of proposals from the mental health care sector. It tries to support the available innovative expertise on mental health care organisation of the sector. The bottom-up approach expects that each individual project clarifies its particular ambitions and objectives in their plans or TP-proposals. The evaluation research should thus first make the inventory of the objectives of each individual TP (by means of document analysis and interviews), in order to assess afterwards (after the three or four year implementation period) the extent in which they reached their objectives and the predefined criteria of the programme. A first step of this research will thus describe and analyse to what extent the different proposals (within the identified clusters) have common or diverging objectives. It is only after this stage, that in the second round of research (see *infra*), we will be able to describe the extent to which individual TPs were able to reach their preset objectives, and to understand the facilitating and impeding factors to reach these objectives (as far as these projects haven been very specific in their aims and objectives).

### 3.4 RESEARCH METHODS

The evaluation research combines different research methods, based on Ovretveit<sup>4</sup>:

- A descriptive part aiming to describe/classify/clarify the collaboration model. “To produce both a good description of the intervention which is being evaluated, and of ‘important’ features of the ‘environment’ surrounding the intervention, so as to enable users to make a more informed judgement of the value of the intervention.”
- A before/after design to assess the impact (outcome measurement) of the TP.
- A comparative case studies design. The aim is to make comparisons between TPs in order to describe differences and similarities, and to identify best-practices.

- “Intervention to an organisation” is a process evaluation design at an organisational level that can help to judge the value of changes in an organisation or a service.

- **The evaluation research combines different research methods: A descriptive part, a before/after design, a comparative case study design and a process evaluation design on organisational level.**
- **Although this research pays a lot of attention to the perspectives of different actors involved in the TP, this research is not conceived as a stakeholder analysis.**
- **The assessment of patient participation and patient perspectives is discussed in a separate research process coordinated by a different research consortium.**

### 3.5 PLAN EVALUATION OF TPS

This first intermediate report focuses on the preliminary findings regarding the plans (visions and implementation strategies) of the TPs.

These plans are embedded in the overall programme, as defined in this case by the policymakers, but are narrower as they are specific for each project. The purpose of the plan evaluation is to clarify the aims, working procedures and the strategy of each therapeutic project. We focus on the question on how the initiators and the leaders of each TP have given a meaning to the government framework.

We follow an inductive research approach. At this first stage, the report is limited to a primarily inductive labelling and organisation of the findings based on the results from the interviews.

#### 3.5.1 Data-sources

Two data-sources are used in a complementary way in *this* report. Interviews are the primary source of information, but formal written documents on the content of the TP have been explored in order to prepare the interviews.

##### 3.5.1.1 *Written documents: formal proposal of TP*

Each TP has written down a model or approach for collaboration for a selected target population in a geographical area, in formal documents submitted to NIHDI. These documents were developed according to a predefined template in order to obtain funding.

#### ***A first exploratory analysis***

A content analysis was conducted on the basis of the principles of grounded theory (as developed by Glaser and Strauss and elaborated by Corbin and Strauss). A preliminary base line analysis of a selection of these dossiers was used to develop an interview guide for the semi-structured interviews at the TP level, and to get a first glance of the different types of collaboration and implementation models of TPs.

In order to identify main dimensions and characteristics of the projects, two researchers separately analysed a randomly selected sample of TP proposals (as they were submitted to NIHDI), to understand the main concepts mobilized by the TPs in general. An inductive content analysis aimed at identifying both core dimensions and concepts underlying the TP. A preliminary intermediate conceptual framework was developed aiming at identifying core concepts.

Subsequently, the members of the research team discussed this preliminary framework to understand the structure of concepts as identified by the content analysis. This process aims at increasing the intersubjectivity in the research process (see also triangulation).

This content analysis and the development of the framework enabled to develop a preliminary overview of the complexity of the TP. This preliminary overview was used to structure the interview guide.

The documents of the project proposals will eventually be used as a complementary information source to the semi-structured interviews, to understand the TP plans. Interviews and other data-sources on the projects will be triangulated: Triangulation refers to the process that more than one data-source or data-collection method is used, aiming at double (or triple) checking results<sup>g</sup> to increase the credibility and validity of the results.

### 3.5.1.2 *Semi-structured interviews*

It was asked that the 'core persons' of the TP (as defined by the TPs themselves) would participate at the interview<sup>h</sup>. These 'core persons' were interviewed using a semi-structured interview guide

#### **Interview guide**

The semi structured-interview guide is aimed at discussing the following components and themes:

- Descriptive component
  - History (including previous collaboration between partners, and drivers to submit proposal in the TP framework)
  - Aims (both at a partnership and at a patient level; trying to detect implicit and explicit aims)
  - Target population (including choices for inclusion and exclusion of patients)
  - Catchment area (geographic area and characteristics of health care provision)
  - Partners
- Organisation and functioning of collaboration
  - Coordination models, mechanisms and tools (including role of coordinators, number and role of partners)
  - Patient coordination mechanisms
  - Preliminary experiences (barriers and facilitating factors = Process evaluation)
- Economic issues and use of resources
- Future perspectives on collaboration or network

#### **Interviews**

Each interview is conducted by at least two persons. One person leads and moderates the discussion while at least one other person takes notes and supports the moderator when issues need further elaboration. Each interview is tape-recorded.

The interviews are done in a semi-structured way: the interview guide is used to set orienting questions, but interviewees were given the opportunity to elaborate on particular issues. The interview guide is used as a check-list: the interviewers were not strictly bound to a sequential use and uniform phrasing of the questions.

The interviews took place in the native language of the projects, either Dutch or French.

After the interview, every researcher who has participated in the interview writes down their preliminary impressions on the interview, in short debriefing notes.

<sup>g</sup> Denzin <sup>15</sup> identifies four basic types of triangulation: 'Data triangulation': involves different data-sources; 'Investigator triangulation': involves multiple researchers; 'Theory triangulation': involves using more than one theoretical scheme in the interpretation of the phenomenon; 'Methodological triangulation': involves using more than one method to gather data. This research process will eventually use different forms of triangulation.

<sup>h</sup> However, for practical reasons, it was in some projects impossible for all 'core persons' to attend the interview.

These debriefing notes are useful support documents to sketch the nature of the interview and to develop a first reflection on particularities of the interview.

The interviews are written down in raw documentation files. These are not literal transcripts, but extensive minutes of the interview. The minutes were written in the language in which the interview took place (Dutch or French). The note taker takes the lead in making the preliminary draft, the second (or third) researcher in the process adds additional information. Aspects or issues that were not clearly expressed (or understood) are discussed between the two interviewers at this stage. The tape is used as a back-up in case of a need for clarification in the notes.

### **Analysis**

The analysis of the raw interview data-files is conducted by means of the QSR software Nvivo 8.

The process of data-analysis is based on an iterative cycle of coding and classification. In a first level of coding, the researchers focus on identify themes, units of meaning as the interviewees express them. At this stage of the coding, researchers remain as close as possible to the text, use the words of the persons as phrased in the minutes. Theoretical concepts are not used by now: the coding is strictly empirical and facts oriented.

In a second stage, this first level coding is discussed within the research team. Codes are grouped or classified, in emerging themes. These themes can be considered as inductively developed preliminary theoretical labels (categories) enabling the grouping of initial codes. An initial coding tree is developed in this way. For each group of codes, we can analyse the quotes from the interviews.

The results presented in this report are limited to these two steps of analysis. In the further steps of analysis, and taking into account that we did not interview all projects yet, further analysis and cross-validation will be needed with these new data. This step will be essential before starting the further analysis and interpretation.

We foresee to start the third level of coding (which is the stage of 'in-depth analysis') as soon as all interview data are collected, and as soon as all plans (written documents) of the TP have been coded too. Based on this overall inductive coding and by means of introducing theoretical insights from literature, we will construct 'a model of understanding' by looking for coherence, differences, hierarchical structures within the data, enabling an in-depth sketch of the different TP's.

- **Two data-sources are used in a complementary way. The primary source is interviews. Formal written documents are explored to prepare the interviews.**
- **Qualitative data-analysis is in this stage of the research limited to the two initial coding steps of qualitative analysis. These coding steps are descriptive, not analytical. As soon as data are collected of all interviews, the next analytical steps can be taken.**
- **Further data-analysis steps are needed in order to draw grounded conclusions.**

## **3.6 PATIENT LEVEL: PATIENT MONITORING**

This report is only dealing with a first analysis of the qualitative research part. However, the project also foresees a monitoring at patient level in order to obtain information on case-mix of TPs and eventually on changes in the situation of the patients on the level of the TP.

### **3.6.1.1 Selection of Instruments**

A literature search was performed to provide an overview of instruments that can be used to assess patient outcomes in mental health care, in order to select appropriate instruments for the target groups of the therapeutic projects i.e. clusters 'adults', 'elderly', 'children and adolescents', as well as 'addictions' and 'forensic psychiatry'.

The target population, domain and psychometric properties of the instruments were identified as well as their relevance for the Belgian therapeutic projects.

Instruments were selected for following domains:

- Severity of symptoms: describing the profile of patients in the TP
- Needs and functioning: describing the needs of the patients based on their functioning with or without already delivered care.
- Use of services: describing the type of services being used, as well as patient's satisfaction with (the organisation of) the whole of received services
- Quality of Life, as experienced by the patient

An overview of the literature search performed for the patient monitoring can be found in the working paper of KCE <sup>16</sup>. After an introduction on patient outcomes in psychiatry, a first part deals with instruments designed for an adult population. The second part analyses specific instruments for the elderly, for the children/adolescents, for the addicted patients. No particular tools were selected for the forensic group.

A prerequisite for the selection of instruments was the demonstration of good psychometric properties (validity, reliability) in a mental health population sample. Furthermore, it was chosen to, whenever possible, select generic outcome measures in mental health care that were applicable to several clusters, including 'addictions' and 'forensic psychiatry' allowing comparison of patient groups. Pathology-specific questionnaires were not retained, except for the cluster 'addiction'.

The aim of the patient monitoring in the TP is to analyse the patient characteristics at an aggregated level (case-mix) without any objective to measure and/or analyse the details of the individual patient at all to assess individual outcomes. The patient monitoring tool aims at analyzing the case-mix of the included patients at TP-level, and changes in this case-mix over time.

In the patient monitoring tool, a domain for 'general information' (containing a self-constructed instrument with 'static questions') was added to obtain diagnostic and socio-demographic data of the patient group.

The proposed selection of instruments and scales was discussed with an expert panel. The panel consisted of people acquainted with research, clinical practice and the use of measuring tools.

Instruments were translated into French and Dutch (if no validated form was available), followed by internal validation of the translation.

### 3.6.1.2 *Development of the web application*

A web application was developed by the FPS. At the time of the writing of this report (winter 2008), this application was not operational.

### 3.6.1.3 *Test phase of patient monitoring*

On the basis of the remarks and suggestions of the testers in the test phase, some adaptations to the content of the test battery as well as to the procedure of the patient monitoring were made<sup>17</sup>. One questionnaire regarding quality of life (Life Skill profile) was omitted from the test battery while it is not obligatory to complete another questionnaire (MANSA) in case of severe cognitive deficits (e.g. dementia). Another major change concerned items about contact with justice: these were grouped in one questionnaire (CSSRI-EU), instead of being spread over several questionnaires in order to avoid repeated confrontation with this sensible subject. In addition, also answering categories were included for intimate questions, allowing the patient not to answer the question or allowing the caregiver not to ask this question.

### 3.6.1.4 Patient monitoring: start and conditions

French and Dutch manuals containing the instrument forms as well as general aims and administration details were developed, for each separate cluster ('children and adolescents', 'adults', 'elderly'; 'addiction'; 'forensic psychiatry'). A training for coordinators was organised in collaboration with the FPS (16/06/2008). An overview of selected instruments for different clusters can be found in Table 3.1.

**Table 3.1: An overview of patient monitoring instruments**

DOMAIN	Instrument	CHILDREN	ADULTS	ELDERLY
General Information	Questions	X	X	X
Severity of Symptoms	CBCL	1,5 – 12 yrs		
	HoNOSCA	13 - 18 yrs		
	HoNOS		X	
	HoNOS 65+			X
Needs and Functioning	CANS-0-3	0 - 3 yrs		
	CANS-MH	4 - 18 yrs		
	CANSAS		X	
	CANE			X
Quality of Life	PedsQL	X		
	ITQOL-97	X		
	MANSA		X	X
Use of Services	CSSRI-EU	X	X	X
	CSQ	X	X	X
	ACSS-MH	X	X	X
Addiction	TOP	(X)	(X)	

- This report is only dealing with a preliminary analysis of the qualitative research part.
- The project also foresees a patient-monitoring. Data of this patient monitoring will be analysed on an aggregated level.

## 4 INTRODUCTION TO RESULTS

This results section offers a *preliminary descriptive* classification of issues raised during interviews which have been conducted thus far.

We interviewed 44 of the initially approved 82 TPs (14 cluster children and adolescents, 26 cluster adults, 4 cluster elderly). An overview of the interviewed projects can be found in table 4.1.

**Table 4.1: Number of projects interviewed**

	Interviewed		Not inter- viewed yet		Total
	FR	NL	FR	NL	
Children and adolescents	7	7	4	5	23
Adults	14	12	6	15	47
Elderly	2	2	1	7	12
	<b>23</b>	<b>21</b>	<b>11</b>	<b>27</b>	<b>82</b>

In a first part, the description focuses on elements or dimensions enabling a better insight in the differences and communalities underlying the organisational concepts and the contexts in which the 'plans' of the TP were developed. At this stage, it is limited to an overall situation description, meaning that a subgroup analysis (cfr clusters) or a search for patterns in organisational models has not been started yet. This more detailed analysis is foreseen for the second intermediate report (2009).

In a second part, a brief description is made of the early experiences of TPs. This part sheds some light on the first year experiences of the projects and the context in which the projects are evolving, and with particular attention for projects resigning.

## 5 HISTORY OF TP

We first briefly describe the reasons and backgrounds of submission of a project proposal.

For a rather large number of TPs, previous collaborations, be it in a formalised or more informal way, have triggered the development of a TP-proposal. The details of the nature of previous collaborations were not always given by every TP, the background and history of the TP was not known to every participant. However, indications are found that for a lot of the projects the development of a TP-proposal is embedded in a longer history of collaboration and reflection on this collaboration. Only for a smaller number of projects the government's call for TP triggered a "first time " partnership, without a lot of previous common collaboration experience.

### 5.1 PREVIOUS COLLABORATIONS BETWEEN PARTNERS

The TPs mention two general ways or types of previous collaboration

- Informal forms: This form is mostly interpersonal relations between health care professionals. It is not structurally embedded in any collaboration model and generally develops on a day-to-day basis. Some partners had previous one-off communications between professionals or organisations without any funding, or any formalised collaboration model. The collaboration is often ad hoc, bilateral, and tightly linked to information needs or individual patient needs. Informal collaboration relies on the fact that partners know each other or have discussed particular topics or activities.
- Formal forms: These forms characterised by previously developed formal partnerships between (most of the time) organisations, characterised by a formal definition of roles and modes of operation, an elaboration of common purposes, and often supported by one or another funding model: for example exempt staff to collaborate, share resources to pay a coordinator or external budget (for example pilot projects in psychiatric care, or provincially stimulated initiatives).

In the French-speaking TPs, previous informal collaborations are cited more often than formal collaborations.

#### 5.1.1 Informal collaboration between partners

##### 5.1.1.1 *Informal collaboration on general mental health care topics*

A number of projects mentioned previous informal collaborations between individual professionals on specific topics such as: diagnostic tools research, organisation of conferences about a specific mental health disorder or exercises to make an inventory of health care provision in a local area for a specific target group.

By means of regular contacts and reflections on topics in mental health care during (yearly) meetings, persons of organisations got to know each other better, which formed the background for submission of a TP proposal.

Many projects emphasised that organisations in mental health care know each other from MHCCP. Informal collaboration developed both during general meetings as well as meetings of several working groups (e.g. 'children', 'forensic psychiatry', persons with mental handicap, etc).

##### 5.1.1.2 *Informal collaboration on patient level*

Previous informal collaboration on patient issues is also developed between individual professionals. Health care professionals who (had) work(ed) for different organisations (e.g. psychiatric facilities) are reported to facilitate contacts. Other initiatives (e.g. "référént hospitalier") have stimulated collaboration on the situation and status of the patient, to solve patient problems.

Flemish TPs of the cluster 'children and adolescents' explicitly stated that many meetings at patient level already occurred between different sectors. Health care professionals in this cluster report to know the professionals of other sectors quite well.

## 5.1.2 Formal collaborations between partners

### 5.1.2.1 *Formal collaboration on mental health care topics*

Some TPs, collaborated in a formal way on different issues.

- Some<sup>i</sup> projects refer to common training of professionals regarding psychiatric issues.
- Others refer to health care professionals deliberately being employed in collaborating organisations (e.g. psychiatrist or psychologist working both in residential and ambulatory mental health care organisation) who facilitate knowledge exchange and further formal collaboration.
- Some formal partnerships functioned without external public financing. Partnerships gathered initially to reflect on, for example extra-mural care, and signed later on a formal cooperation agreement to construct a care pathway or develop programmes of care. Some partners collaborated in 'Initiatives Sheltered Housing' ISH (IBW). Other TPs mentioned that ambulatory and residential mental health services jointly prepared 'pilot projects' (even if for some these activities were not financed by the government).

The local primary care umbrella organisation, 'integrated services home care' (ISHC) was nearly never formally involved in one of above-mentioned collaboration agreements. Individual health care professionals of the first line were sometimes invited to meetings at patient level (e.g. dismissal of a patient; organizing psychiatric care at home), but seldom as a structural partner.

### 5.1.2.2 *Formal collaboration at Patient level*

For the French TPs, only a very limited number of projects mentioned formal collaboration. If any, the collaboration focused on patient issues: some collaborated in the framework of the Belgian "pilot projects" (psychiatric home care or outreach). One project collaborated in the framework of a private funding initiative (pharmaceutical firm).

Some of the Flemish TPs mentioned that psychiatric home care pilot projects succeeded in organising formal and regular meetings between professionals of different health care levels. For some patients, the collaboration is experienced to be very useful for both the patient and (health) care professionals. The latter commented positively on the opportunities offered for information exchange and to express difficulties in care.

Some TPs have previously financed a coordinator for the organisation of multi-disciplinary consultations about patient cases. The role of coordinator is funded by a shared budget of organisations involved, and sometimes through additional public (a.o. provincial) funding (cfr. innovative programmes in mental health care, circuits of care, case management and cooperation initiatives).

Patient meetings organised in these formal frameworks included to take some common responsibility for the patient. Initially, consultations were mostly organised to plan patient dismissal from the hospital. For other formal initiatives, participants were generally not financed for their presence, except for a few projects that reimbursed patient related meetings by means of the budget of the ISHC (GDT) if criteria were met.

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<sup>i</sup> In the examples cited we give 'quantitative' indications in terms of broad categories. It should be clear though that our analysis is not aiming at quantifications. Categories such as 'some', 'little', 'a few' or 'many', 'a lot' give indications whether the issue was more common rather than exceptional. We do not use precise criteria to delineate these categories. We will elaborate on this 'quantitative' matter in more detail in the next round of analysis, when all first round data-collection is finished.

- **A vast number of partners in TPs have previously collaborated, either formally or informally, on mental health care topics. Only a limited number of TPs are partnerships in which a number of partners have never collaborated before.**
- **Previous collaboration at individual patient level was generally informal and based on contacts between individual professionals.**
- **Previous formal partnerships were partly formed in the context of ‘pilot projects’ in mental health care or provincially funded initiatives.**
- **Mental health care organisations know each other from regular meetings within ‘mental health care consultation platforms’.**

## 5.2 THE PREPARATION OF THE TP PLAN

During the interviews, we also focused on the way and by whom the TP-plans, including the definition of the aims, target groups, ways of working, etc were prepared.

The interviews give indications that the preparation and the development of a TP-plan did not happen in an “isolated” context. The preliminary results also indicate that the preparatory pathways are diverse and have been developed within different contextual circumstances.

For some projects the interviewees were not able to give *detailed* information on the preparatory working process of the TP, as they were not involved in that stage or because the TPs are actually a continuation of previously initiated initiatives<sup>i</sup>. We also have indications that the people preparing the TP are not always the same as the people implementing it.

### 5.2.1 Mental health care consultation platforms

The ‘mental health care consultation platforms’ (MHCCP) almost always played an active coaching role at the stage of the elaboration of the TP proposals, at least at the level of coordinating the submission of different proposals.

The MHCCP have taken up the role of communicator on the call for proposals and the selection between NIHDI and the mental health care sector during the meetings of the MHCCP.

Some MHCCP played a more active steering role. They managed a preselection of TP proposals. The platforms organised discussions for avoiding the overlap of TP proposals for a same target group at the regional level, and aimed at an even distribution of types of proposals.

A small number of TPs mentioned an active participation of the platforms in the editing of the proposal. For these projects some persons combine mandates within the platform (e.g. president of a working group) with functions in particular mental health institution involved in developing a TP.

In one province (i.c. Liege) the different TPs were elaborated at the platform level. The platform developed a common organisation and functioning model for all TPs (for each cluster or target group) in that province.

### 5.2.2 The elaboration of the proposal

#### 5.2.2.1 Preparation

For many projects, the conceptual and operational preparation of the proposal was mainly ensured at the level of mental health institutions (mainly psychiatric hospitals). For some projects, the initiative of elaborating a project was taken by a selective number of residential and ambulatory mental health care organisations that already informally collaborated at patient level.

<sup>i</sup> In some projects the people who had prepared the proposal were unable to attend the interview (because of scheduling problems)

For other projects, the proposal is elaborated respectively on the initiative of a hospital or ambulatory service. Some projects seem to be a continuation (and adaptation) of previous initiatives, rather than an entirely new approach.

In most projects, future core partners have actively participated in the discussions during the elaboration of the proposal. The editing of the proposal was mostly performed by persons from the initiating organisation.

Many TPs consider the project proposal as the result of cooperation between partners rather than being determined by a single person. Some individual projects though, stated that the (opinion) leadership of individuals triggered the conceptualisation and the writing of the proposal.

About half of the interviewed TPs explicitly mentioned that they have elaborated their proposals during meetings. In some of these projects, future partners participated. Also primary care partners (e.g. ISHC) could be present during preparatory meetings. Often the members playing an active role in the preparation of the TPs became the members of the future steering committees of these TPs (see *infra*).

The meetings generally aimed to exchange partner viewpoints and to attempt a formalisation of the TP in consensus with all partners.

For many French-speaking projects, health care professionals were mandated to the meetings, rather than the management staff of the potential partners (in only one TP, that resigned in the meantime, the top management of the partners elaborated the proposal). One TP mentioned that not all health care professionals attending were all actively participating in the preparatory meetings.

The content of the discussions at the preparatory meeting was afterwards commonly discussed within each individual participating organisation in order to guarantee support and an endorsement by all for the TP proposal.

- For one particular TP, the discussion within each organisation involved was necessary as vision possibly differed between the management of organisations subscribing to the project and the persons mandated for the meetings.

#### 5.2.2.2 *Content issues of preparing the proposal*

A number of projects have elaborated in the interviews on the content discussed during the preparatory meetings.

Discussions included:

- The choice for a specific target group and the criteria of selecting the target population;
- The development of a common vision on care;
- The practical organisation of the TP, regarding issues as:
  - The care circuit,
  - The individual care plan,
  - Mutual expectations at the level of partners' commitment in the TP; the obligation for formal partners to participate in patient and steering committee meetings,
  - The financing of the participation in meetings,
  - A few TP mentioned that issues such as waiting lists (Does the TP bypass (or not) existing waiting lists for patients?), transfers of patients between partners, degree of shared responsibility for a patient, were particular topics discussed before submission of the proposal.
- Also ethical and deontological themes have been discussed. The medical and professional secrecy appeared as an often discussed topic for adapting the modalities of information sharing (this issue was very often raised in the interviews with the French-speaking projects).

For some projects the discussions went beyond the practical rules of organisation and sometimes even beyond the TP issue.

- Difficulties in previous collaboration between organisations as experienced by health care professionals have been recalled (one French-speaking TP) before elaborating on the TP model.

We have the impression, at this stage, that in Flemish more than in French-speaking TPs, partners of the first line (such as ISHC) tried to build further and integrate operational issues developed in other primary care frameworks outside mental health care (e.g. model of coordination, patient documents): some ISHC (GDT) already developed procedures for meetings and sharing information (e.g. on patients with physical impairments). The ISHC participated actively in the preparatory meetings to avoid that another parallel model of consultation and coordination would be constructed to existing working practices within the ISHC (GDT).

### 5.2.2.3 *Preparation time*

The preparation time of the project is not often explicitly mentioned, but projects seem to differ quite a lot on the time spent on the formal preparation of the TP (both the proposal and the organisational concept). Some had little preparatory meetings, some others mentioned up to fifteen meetings, each one with time consuming discussions. For some TPs, the preparation has been elaborated over one year period while, for others, it was limited to a couple of weeks.

- One project reported that the rhythm of the development of the project was not linear but a iterative process. It experienced it as difficult to involve various organisations because they all have their own rhythm to develop a vision on the project

## 5.2.3 The selection of the partners

The suggestions to propose partners for inclusion in the TP-proposal was often lead by the organisations participating in the elaboration of the proposal. Not all of the proposed partners did participate from the initial preparation stage onwards but some were recruited afterwards, e.g. via the MHCCP.

Not all initially proposed partners were finally included in the proposed partnership for two main reasons:

- Some potential partners have been excluded by the partners during the preparation process.
  - A particular situation was mentioned in the German speaking part of the country; where collaboration with a potential cross-border organisation was not possible within the current framework.
- Some potential partners refused themselves to become a formal partner and this for various reasons.

### 5.2.3.1 *Potential partners excluded*

#### ***Patient and family associations***

The involvement of the patient and family association is, for many projects, controversial and becomes most apparent in the cluster 'adult' and in the cluster 'elderly'. In the projects relative to the cluster 'children', patient and family associations are far more accepted as a potential, even important, formal partner because family members are considered as crucial in the care process.

In many TPs, patient and family associations have been excluded because of the perceived lack of confidentiality about the treatment process. The main argument was that members of the patient association are not bounded by professional secrecy.

- Some TPs reported that the exclusion of patient and family associations was ultimately the result of a strong opposition from a small number of partners within the TP, rather than an overall agreement.

### Social sector

- Especially youth services linked to the legal sector, i.c. Protective Youth Services (PYS) are difficult to accept for several French-speaking TPs in the cluster 'children and adolescents' and this for a number of reasons:
  - Families could be reluctant to go to a CMHS (CSSM) in close relation to a PYS (SAJ/SPJ)
  - Two French-speaking projects mentioned the involvement of PYS (SAJ/SPJ) in other partnership coordination activities, and perceived a risk of redundancy between the two collaboration models
  - One project distinguishes the role of the SPJ from the role of the SAJ as far as the SPJ is concerned, the coercive decisions can not match with the philosophy of the therapeutic approach in the network.
- The employment service ('FOREM') has been excluded in a project because of issues regarding professional secrecy.

#### 5.2.3.2 Partners refusing to participate in TP

Some invited partners refused to participate in the development of the TP for different reasons<sup>k</sup>.

A few ISHC (SISD/GDT) refused to participate in the TP and sometimes reasons are mentioned.

- The target population did not match with their patients (e.g. mental disorders, mental deficiency or forensic). Some Flemish ISHC (GDT) have been asked to participate in several TPs and chose those corresponding the most to the population they usually work for.
- Others refused because of the additional workload of administrative responsibilities.
- A French-speaking ISHC (SISD) refused because the professionals feared interference between the project and their respective professional fields (e.g. the possible loss of autonomy with the intrusion of the psychiatrist and for self-employed professionals, the risk of losing their work).

In one province, the management of a home care organisation decided, for political reasons not to participate, regardless of the added value individual members saw in the TP. This organisation perceives the TP as an intrusion of the mental health professional into the individual health care professionals work. The organisation fears that a TP will induce a change in defining the final responsibilities in providing health care. In spite of many consultations between the provincial platform and the council of this home care organisation, the latter has refused any participation.

Associations of general practitioners have sometimes refused to participate without any clear explanation. Nevertheless, some general practitioners participate individually in consultation meetings as they experience the added value of the TP for their patients.

- A collective general practice ('maison médicale') refused to participate despite the interest of individual general practitioners. The management feared a competition issue on coordination of care.

In the French-speaking projects the CMHS (CSSM) are often cited as reluctant to become a formal partner, mainly with arguments of professional secrecy and information sharing during the patient meetings. But other reasons have been mentioned too.

- One CSSM refused as they fear a loss of autonomy for patients: they assume that, once the health care plan would be defined, there would be no possibility to adapt.

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<sup>k</sup> A methodological remark: the reasons reported are those recalled by the people interviewed of the TP: we did not interview members of the potential partners to trace back their motivations for not participating.

- One CSSM for financial reasons as the fixed allowance was considered to be insufficient for the time investment needed.
- Another CCSM refused because they consider a formalisation of health care processes in procedures as inconvenient, and because of the administrative workload of the TP.

In the Flemish projects additional elements were mentioned such as

- Aspects of time and workload
- Two different partners in separate TPs refused to participate because of cultural differences (of the organisations between partners on the project).
- Some informal partners refused because they would only be involved occasionally, rather than as a structural partner.

In spite of a great interest in the TP, a small social sector organisation for handicapped people refused because its small size did not allow spending time on meetings, particularly the patient meetings.

- **The MHCCP played a mediating role in identifying potential partners and in rationing the number of TP proposals at regional and target group level.**
- **TP proposals may be initiated in a specific organisation and lead by one or a selective number of persons, but was mostly developed with input of the partnership as a whole.**
- **Preparation meetings to define the content of the TP proposal were in a lot of the TPs frequent and time consuming.**
- **Some partners were excluded from a potential partnership, some potential partners refused to participate. Partners refused for reasons of professional secrecy, a fear of a loss of autonomy, or time and work load anticipated.**

## 6 OBJECTIVES OF THE TPs

### 6.1 INTRODUCTION

This section describes the reported aims of the TP, as they are put forward by the interviewees. We limit ourselves to the discourse, without any attempt to further analysis at this stage. It is however interesting to observe that, as is often the case in the development of (health) programmes, the meanings given to a TP differ between projects.

Different types of objectives of the TP are mentioned during the interviews, be it that they are put forward at different levels of detail. Within these, some objectives are mentioned in rather general terms, others are defined at an operational level.

- Objectives with regard to collaboration of (health) care providers and professionals:
  - Operational aims are related to the practical organisation of the TP (e.g. the regular meetings between partners and patients).
  - General objectives: are objectives described in broad, not always very precise terms.
- Objectives with regard to process of the service delivery (e.g. consistency and coherence of care for the patient).
- Objectives with regard to the expected outcomes at patient level, families, community, professionals, other sectors... The expected outcomes of the TP mainly concern patient issues as the TP organisation is supposed to be of benefit to the patient (health status, social life improvement, ...).

### 6.2 COLLABORATION OBJECTIVES

For many TPs, the implementation of 'collaboration' is seen as a necessary step to develop new forms of service delivery for the selected target population.

The most cited collaboration objectives are related to the organisation of professional communication at patient level. Some objectives refer to the collaboration at partnership level.

#### 6.2.1 Patient level

In the responses of the interviewees, the objectives with regard to patient issues are often described at an operational level.

The involvement of patient in the care pathway is often cited as an objective but explanations are not always detailed. For a limited number of French-speaking TPs, the involvement is translated as guaranteeing patient participation in patient meetings. In some of these TPs, patients get decisional rights in the development of care plan. Meetings aim to pay more attention on the patients' needs in the development of a care pathway.

#### 6.2.2 Partners level

##### 6.2.2.1 *Operational objectives*

Many TPs have elaborated during the interviews on operational objectives for professionals. The most often cited operational objective is the improvement of communication between individual professionals, in particular improving the contacts between partners. Most TPs have also detailed the type of partners who are expected to communicate better:

- One TP aims at developing a communication tool for sharing information between professionals.
- One TP defines as an explicit objective to establish a personal contact between the hospital services and general practitioners (before the TP only a clinical written report was sent to the GP).

- Referral of patients from primary care services in health care and other sectors towards ambulatory and residential services. This operational objective mainly relates to projects who aim to detect untreated patients who are living at home.

For some projects, the underlying idea of improving communication is to confront and discuss in meetings different viewpoints of professionals on the treatment of a patient.

- One TP emphasizes that disagreements can be expressed without aiming at consensus..

Professionals have not only to communicate but also to agree on content and ways to share useful information:

- TPs have often mentioned the relevance of information sharing about common patient situations (e.g. for avoiding similar errors in the future or for obtaining background information on the patient situation)
- Some Flemish projects aim at the use of a shared patient file, as currently different types of patient files are being used in the different lines.

Improving and sharing knowledge of individual patient situations is often mentioned as an operational objective of the TP. E.g. to figure out the past pathway of the patient, to understand why the patient has been excluded by mental health care services, sharing information on the disorder, developing an overall, global representation of the patient situation. Some objectives aim at making an inventory of the health care use and trajectories of patients and the perceived difficulties.

A different type of objective is the aim to develop a clear description of the respective roles of all of the professionals involved in the care of a patient included.

Although part of call for TP is developing a therapeutic plan as an operational tool, this is almost never mentioned in French-speaking projects. Only one has developed accurately the content of the therapeutic plan.

#### 6.2.2.2 *The general objectives*

Some partnership objectives are defined in general terms:

- Aiming to develop a complementary model of care in which different professionals stay within their respective competence but with respecting the same philosophy and deontology in a team based approach.
- In one TP the objective is limited to bring together health care and other types organizations.

One TP explicitly refers to 'evaluation of the TP functioning' as an objective to better understand barriers for collaborating with partners and understanding the difficulties in the functioning of the network.

Developing trust between partners involved is sometimes mentioned as an explicit objective.

Another objective is developing knowledge of all actors involved, and this on different issues:

- To know the available services for broadening the possibilities of care for patients and, by means of this, developing a better mobilisation of the available services.
- A better knowledge of the functioning of services provided by the different partners (facilities, admission process, limitations of care, health care professionals, facilities, types of health care provision, vision on care, working habits and target groups).

A particular issue mentioned is "The training of professionals" by means of the contacts and meetings between partners. Through the regular meetings in a multidisciplinary team of professionals individual professionals can learn about mental health problems (e.g. coaching of first line workers by second and third line).

A general objective mentioned is the aim to reduce the distance or gaps between health care lines by means of an independent mediating coordinator and 'integrating' care delivery.

## 6.3 SERVICE DELIVERY OBJECTIVES

### 6.3.1 The transition between organisations

Many TPs emphasize that collaboration should aim at improvement of service delivery.

An interesting observation is that only some TPs *explicitly* mentioned the aim of 'improving continuity of care' (see also paragraph 'motivations'). Those projects mainly focused on the transitions between hospital and ambulatory care. For projects mentioning this issue, the potential harmful effects of transition periods should be reduced. Most of these TPs aim at ensuring the health care delivery *after* the hospitalisation period (few TPs includes the period before patients are going into hospital)

Most projects did not explain this issue in detail. Only a limited number of TPs elaborated on the risks during transition periods:

- Some TPs referred to the difference in communication strategies during an acute crisis. Coordination is needed as there is a risk that different providers set different patient objectives after these crises.
- After emergency situations, very little is currently put in place to provide support after the hospitalisation. Patients stabilised after their hospitalisation but are left without the adequate ambulatory care, they are thus at risk of relapse. With a better preparation of the hospital discharge, patients are expected to have less acute crisis which may both reduce the number of hospitalisations and the length of stay.
- One TP aims at avoiding losing patients after transition periods. An approach is introduced to develop the patient's follow-up over time (without an explicit reference to the role of ambulatory care and hospitals).

### 6.3.2 Simultaneous health care services delivery

The previous section mainly focused on the issue of the organisation of sequential care provision. One projects also referred to the development of simultaneous service provision.

- Another TP aims to link the psychiatry of children with the ambulatory sector (the CSSM) for a complementary care.
- One TP, that resigned, aimed to ensure that there was coherence between the care for the child and the care for the parent (parents were part of the therapeutic approach), and it aimed not solely at developing a therapeutic plan for the child but also for the parent.

### 6.3.3 Accessibility of care

The access of care is often mentioned. On the side one refers to the exclusion from institutions on the other hand there is the issue of patient drops out in the long term care. Projects mentioned that services are provided during acute crisis but long term follow-up of patients is sometimes not organised or coordinated. Many projects have mentioned this objective and some specifically noticed this issue as the main purpose of the TP.

The access of care is an issue for two particular types of patients: (a) the patients who already have used mental health services but often encounter difficulty to access to appropriate care and (b) the persons suffering of mental health disorders but do not receive appropriate care because of their own reluctance in using mental health services on the one hand or because of their ignorance of their psychiatric symptoms on the other hand:

- Access of care is mentioned for target groups with co-morbidity (addiction and mental retardation with psychiatric disorder). On the one hand, these patients are sometimes administratively excluded as patients with co-morbidity (double diagnosis, e.g. psychiatric disorder combined with mental retardation) can not be easily classified within clear-cut administrative categories, e.g. psychiatric disorder. On the other hand, there is the issue of stigmatisation impeding access to care. Institutions sometimes argue that the complexity of symptoms is a reason for excluding them from intake or services delivery by this organisation. E.g. For addicted patients with a psychiatric disorder, neither psychiatric services nor drug addiction services are keen to accept them into care as they do not perfectly match the target population of services. As there is no or little communication, refusing patients without further consultation between these services may deprive the patients of the necessary care. For persons with a mental retardation and a psychiatric disorder, finding adapted structures after their hospitalisations is not easy as they are often considered as psychiatric patients, although their needs can actually be more related to their mental retardation than to their psychiatric disorder. The exclusion works sometimes differently because they cannot easily be admitted or are refused in a psychiatric institution. The TP is expected to offer a solution. Indeed, social services are more inclined to help addicted patients with psychiatric comorbidity, or socially excluded persons with budget problems if they know their psychiatric or drug problems are treated by other professionals.
- A limited number of (mostly Flemish) TPs aim at providing services for those patients who are difficult to reach (e.g. isolated elderly, homeless people, people avoiding care). Elderly depressed persons (even suicidal) are reported as a specific group often not receiving appropriate care. Psychiatric disorders are sometimes undetected, but elderly themselves are reluctant towards mental health care services because, according to them, psychiatric care is still a taboo subject.

#### 6.3.4 A better use of care

Aiming at a better use of health care services is often cited:

- Projects focusing on hospitalisation-related matters describe their objectives variously in qualitative and quantitative terms. One TP mentioned a qualitative improvement of hospitalisations without a reduction of the number, while another project expects a decrease in both the number as well as the duration of hospitalisation. The development of a network would allow a better use of resources, avoiding unnecessary hospitalisations, as alternatives to hospital care would be more easily found when different partners meet each other (e.g. home psychiatric care services with home helpers). Another objective, often cited as a corollary of the decrease of hospitalisations, is maintaining the person at home.
- As sometimes unnecessary services are provided or because of redundancies of care ((health)care 'shopping' behaviour), a limited number of TPs mentioned the objective of developing a more rational and efficient use of care, chosen by the patient or family.
  - In contrast to this, one TP states that overconsumption of care is not considered as a problem because of freedom of choice of the patient.

The improvement in service delivery is resumed by a TP as "putting the patient at the right place at the right moment".

Early and timely health care delivery in order to prevent the worsening of patients is cited by some TPs as an objective:

- One resigning project refers in very general terms to the prevention of the worsening of behavioural problems.
- Other projects aim to increase awareness for substantial psychosocial problems in specific target populations by individual care professionals, enabling to detect alert signs and mobilise specialised providers (partners). Thus, the first line health care providers are quickly informed and able to plan adequate care without awaiting the patient worsening (e.g. elderly with depression/suicide risk).

Managing the various dimensions of the patient's needs (which are not limited to mental health issues (e.g. medical, social,...)) is put forward as an aim in some projects. This objective explains why partners such as employment services (FOREM) are participating in the project.

Some Flemish TPs explicitly mention the development of "care pathways (trajectories)" as the main purpose of the TP. The aim is to implement the care pathway involving different organisations and services from multiple sectors.

### 6.3.5 Family support

Mainly TPs in the clusters 'children and adolescents' and 'elderly', and one project in the cluster 'adults' (persons with mental disorders and mental deficiency), put forward the participation and support of the family as an important issue. References are made to different issues:

- The family is often exhausted. Decisions on a transfer to a residential form of support should also consider the family situation.
- One TP in the cluster 'elderly' targets the family directly as it is said that support of the family will be helpful for optimising the care of the patient (support and even treatment when needed).

Whilst family participation is not explicitly mentioned as an objective in the discourse of many projects, family members are often invited to participate in patient meetings.

## 6.4 OUTCOME OBJECTIVES

### 6.4.1 Patient level

During the interviews, only a very limited number of projects have elaborated on the intended outcomes at patient level<sup>1</sup>. The topics mentioned are mental health status and the reintegration or social issues (family life, employment, social integration, school life, etc.) be it often in very general terms.

Some of the projects mentioned patient objectives as being the directly pursued main aim. But we have indications that a lot of the projects consider the patient's objectives as an implicit and assumed result from the partnership collaboration objectives.

### 6.4.2 Professional level

Some projects have defined general objectives on what they expect from the partnership for the professionals involved, independently of the patient situation. The only outcome objective cited is developing mutual support through the TP for individual difficulties, problems and their acknowledgement in order to support each other.

Most ongoing TPs did not mention professional issues as the main aim pursued. Nevertheless, one resigning TP aimed to implement a psychiatrist network for peer review, in order to support individual psychiatrists.

Table 6.1 gives an indicative general descriptive classification of the mentioned objectives.

<sup>1</sup> We have indications that in the formal written proposals to the NIHD<sup>1</sup> this issue is elaborated a lot more. This (potential) discrepancy will be analysed further in the follow-up research.

Table 6.1: Summary of objectives<sup>m</sup>

	Collaboration objectives		Service delivery	Expected outcomes
	Operational objectives	General objectives		
<b>Patients</b>	<ul style="list-style-type: none"> <li>- Participation in meetings</li> <li>- Decisional involvement of the patient in the health care plan</li> </ul>	<ul style="list-style-type: none"> <li>- Involvement and agreement to the health care plan</li> <li>- negotiated health care plan</li> <li>- patient's freedom of choice</li> </ul>	<ul style="list-style-type: none"> <li>- Continuity of care</li> <li>- Access to care</li> <li>- Better use of care (avoiding redundancies, usefulness services)</li> <li>- Early health care delivery to prevent the worsening of patients</li> <li>- Coherence and consistency of care</li> </ul>	<ul style="list-style-type: none"> <li>- <i>better mental health status</i></li> <li>- <i>social integration</i></li> <li>- <i>Help to maintain at home for elderly</i></li> </ul>
<b>Family or close relations</b>		<ul style="list-style-type: none"> <li>- Better understanding of the care plan</li> <li>- Inclusion of family issues in the therapeutic plan</li> </ul>	<ul style="list-style-type: none"> <li>- Care delivery, also for family (e.g. elderly)</li> <li>- Family support</li> </ul>	
<b>Professionals</b>	<ul style="list-style-type: none"> <li>- Communication between professionals: general practitioners and hospitals, the primary care professionals with specialists or hospitals, between professionals with different viewpoints.</li> <li>- Developing knowledge of individual patient situations</li> <li>- Sharing of information about common patient situations</li> <li>- a clear definition of the respective role of all professionals involved in the care of patients</li> <li>- the elaboration of a structured communication tool between professionals</li> </ul>	<ul style="list-style-type: none"> <li>- partnership: diversity and complementarity</li> <li>- Development of trust relationships between partners</li> <li>- knowledge about partners: available services and functioning</li> <li>- Evaluation of the TP partnership</li> </ul>	<ul style="list-style-type: none"> <li>- Early health care delivery to prevent the worsening of patients</li> <li>- Coherence and consistency of care</li> </ul>	<ul style="list-style-type: none"> <li>- <i>Better support of professionals</i></li> </ul>

<sup>m</sup> The cells are only giving examples of objectives. The outcome objectives are certainly not always very precisely specified by the interviewees

## 6.5 MOTIVATIONS TO COLLABORATE

Besides answers to the explicit question in the interviews on the aims pursued, a lot of indications on objectives can be deduced from the answers on the question why people submitted a TP proposal. These 'motivations' hold implicit references to objectives of the TPs. It is important to emphasize however that explicit aims and motivations to submit are not the same.

As the motivations to submit a proposal and the reported aims overlap quite a lot, this section only describes supplementary issues to the aims, which were raised when discussing the reasons for submitting a TP proposal.

### 6.5.1 Experimental network collaboration

Some projects clearly stated that the TP framework offers an opportunity to experiment with models of organisational and professional collaboration for improved patient care (e.g. preparation for elaborating a patient pathway, for solving problems of specific target groups). The framework of TP has stimulated those submitting the project to develop organisational innovations in mental health care.

### 6.5.2 The formalisation of collaboration between professionals

The formalisation of already existing practices of network collaboration is seen as an important stimulus. The formalisation in the framework of a TP is considered as a means for obtaining funding, but enables also to work within a formal externally imposed framework which regulates the ways of collaboration;

The formalisation implies that regular patient meetings are being financed.

- Before the TP, consultations between health care professionals could only be financed via the ISHC (SISD/GDT). However, many patients with psychiatric disorders were not eligible, as cut-off rules for financing are based on measures of functional independency (Katz score) which is most often not 'low enough' for psychiatric patients. Besides, maximal one consultation yearly can be financed in which the general practitioner needs to be present.

For many interviewees, the formal recognition of patient meetings is expected to improve the possibility to discuss patient issues. Before and outside this framework, patient meetings were not organised on a systematic basis. Moreover, the TP framework allows the organisation of meetings for a larger number of patients. It is also expected that the funding of meetings will enhance informal collaboration.

Some particular TP mentioned other motivations:

- Individual professionals (in particular the general practitioner) have sometimes to face complex patient situations and can feel quite powerless in addressing these issues on their own (e.g. alcoholism).
- In two projects, the TP is seen as a means to improve the knowledge of home carers on mental health disorders and the related behaviours. They see the TP as a means of solving potential conflicts between these professionals and the patients at home.
- Another motivation is to improve the knowledge about both the existence of and the functioning of those organisations which are addressing the same mental health disorder.

### 6.5.3 The local context

Some TPs refer to the regional particularities as a motivation to submit and develop a TP. Some projects aim at developing adapted care in particular geographical areas.

An often cited reason with regard to catchment areas is a lack of locally available mental health services (e.g. the lack of child psychiatrists or a psychiatric hospital).

This argument seems especially important for the east part of the country (south of the province of Limburg, Halle/Vilvoorde, the province of Luxembourg and the German community)<sup>n</sup>. The TP is considered as an opportunity to financially support local collaboration activities.

- One TP operating in a rural region mentioned that, for some particular mental disorder, the number of cases is very limited. Moreover, caregivers are not confronted with a constant flow or number of patients, so building durable and adapted mental health care structures is not feasible (e.g. in the case of anorexia, there are some periods with no incidence, in other periods a couple of cases). For these situations, an adapted local provision of care for these patients has to be organised if residential support is not readily and locally available.
- In one particular TP, operating in a rural area, partners preferred to actively collaborate and offer services in a smaller rural catchment area instead of cooperating within a large catchment area (with a more urban character) and sufficient mental health services available.

#### 6.5.4 The improvement of service delivery

Continuity of care is often cited as a main reason to elaborate the TP. Most arguments focus on continuity within health care (the link between hospital and the community care services) but some projects also mention the continuity between the health care sector and other sectors.

Accessibility is often quoted as a reason to submit a proposal (compare section aims): the problem of waiting lists, unavailable services in the catchment area, management of care trajectories as a means to avoid improper use of health services, deal with stigmatisation as a barrier for access to facilities

- An interaction of these different elements is mentioned as a reason to exclude mental health patients (e.g. the combination of an existing waiting list and the stigmatisation of patients leads to the exclusion of people with mental health problems: in the case of waiting lists patients without a stigma the accessibility problem is only temporary).

#### 6.5.5 The consistency of the provided services

Part of the arguments related to continuity of care holds the issue of 'consistency' or coherence in services provided. Insufficient communication between providers (e.g. a residential institution and individual health care professionals or home services) may be especially problematic during transition periods of patients. Without adequate information exchange, professionals are not able to plan consistent or coherent service delivery, both matching with long term objectives and, above all, with previous services provided. The lack of information exchange may cause the modification of patient objectives over time, or even a radical change in the care plan, depending on the professionals or institutions involved at that stage of care. The TP is then seen as a tool to develop ways to maintain coherence and consistency of care.

- Some TPs mentioned that especially workers in the first line may need specialised information in order to give adequate care to a patient living at home. The same is true for professionals of other sectors than mental health care, such as welfare workers and institutions for handicapped persons. They also need coaching with regard to psychiatric disorders.

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<sup>n</sup> At this stage we only interviewed 1 project in West-Flanders (meanwhile resigned).

### 6.5.6 Other motives

Some organisations initiating the development of a TP consider it as an opportunity to inform other providers (in health care and other sectors) about their activities and working practices, so that professionals know where they can refer to.

Occasionally, interviewees mentioned that they had submitted the proposal, and currently continue the TP, certainly also for strategic reasons (“*We want to be a part of the movement.*”). Partnerships want to be formally recognised in their support of reforms in mental health care. They assume that the current formal collaboration may facilitate future government funding. The government TP-call was, for some partnerships, seen as an excellent occasion to work on a common project on organisational changes in mental health care. Many TPs reported a strong support at the management level to submit project proposals.

- **Some projects state that the TP framework offers an opportunity to experiment with models of organisational and professional collaboration.**
- **For some projects, the TP enables to fund an existing practice of collaboration between partners.**
- **Some TPs refer to the local context as a motivation to submit and develop a TP.**
- **Continuity of care (particularly between hospital and ambulatory care, sometimes within health care, or often between health care and other sectors) is often cited as a motivation to elaborate the TP.**
- **Part of the arguments related to continuity of care holds the issue of ‘consistency’ or coherence in services provided.**
- **Other motives are: to inform other providers (in health care and other sectors) about their activities and working practices, or strategic reasons (“*We want to be a part of the movement*”).**

## 7 SELECTION OF THE TARGET POPULATION

In this section, we summarise answers of the respondents, with regard to their motivations, to select a particular patient group. Of course, it has to be reminded that TPs work within the predefined clusters by the government call for TP and FPS, on the basis of an age category ('children and adolescents', 'adults' or 'elderly') or of a specific pathology, ('forensic psychiatry' or 'addictions').

In the second part we try to disentangle their discourse on inclusion and exclusion criteria and on 'chronic and complex psychiatric' disorders<sup>o</sup>

### 7.1 MOTIVATION FOR SELECTION OF PATIENT GROUP

The reasons for selecting the patient groups are diverse, but are mainly driven by two general types of motivations:

- The needs of patients (perceived difficulties in service delivery) and the coverage of mental health services in the chosen catchment area;
- The expertise with particular patient groups of the partners.

#### 7.1.1 Difficulties in service delivery for a specific patient group

The TPs generally select patient groups for which they perceive specific problems in the provision of care and a need for regular structured consultation between different partners (continuity of care and needs-based care). Several examples are mentioned:

- To offer adequate services or to refer adequately those patients who are considered as difficult to treat (patients in 'dead end' situations; or the most difficult persons that are rejected in the regular facilities);
- 'Revolving door patients',
- The 'wandering patients' who avoid care and are currently not or insufficiently reached, while they are nevertheless considered to be in need (e.g. isolated elderly with depression living at home, homeless people ...).

#### 7.1.2 Availability of expertise for a specific patient group

The TPs generally choose an age category and a psychiatric disorder in which their partners have both experience and expertise, and for which the partners provide health care services in a geographic area. We have indications that a lot of the TPs are primarily organised around the activity domain of a hospital or hospital unit, although this has to be further controlled for clusters.

### 7.2 INCLUSION AND EXCLUSION CRITERIA

#### 7.2.1 Inclusion criteria

During the interviews, only a few projects could explicitly refer to a formal list of inclusion criteria (generally those projects that used very strict and preliminary defined criteria).

Although not elaborated in an explicit list of criteria, the vast majority of TPs use one or more of the following inclusion criteria:

- Age;
- (indication of) a psychiatric disorder, often a specific diagnosis,
- The presence of problems in multiple domains of functioning (e.g. social, accommodation, financial, professional or education, familial problems) and/or behavioural problems;
- Need for regular consultation (keeping in mind the requirements of NIHDI),

<sup>o</sup> Scientific literature use the term 'severe' or 'serious' and 'persistent' mental illness. The Belgian policy framework uses 'chronic and complex'.

- Need for consultation with multiple partners (keeping in mind the requirements of NIHDI),
- Geographical place of living (within the catchment area of TP) or language of the patient,
- Residence of the patient (residential or ambulatory) is an inclusion criterion for some TPs.

On particular topics some comments were given:

#### 7.2.1.1 Age

Tps aimed at children and adolescents specify more detailed age-group categories than the global age clusters (e.g. 0-7 years, or 12 years and older), because of the different needs of age-related subgroups within the clusters, defined by FPS. Tps addressing adults and aged persons generally apply the general age range of a cluster as specified by FPS.

#### 7.2.1.2 Psychiatric disorder

Some projects only include patients with the same psychiatric disorder, whilst other projects include persons with different psychiatric disorders (e.g. personality disorders and developmental disorders). In some projects, the patient may have a co-morbidity of different psychiatric disorders, e.g. developmental and personality disorders, or also a co-morbidity between different disorders, e.g. psychiatric disorders and mental retardation.

Some projects use broad categories of psychiatric disorders (i.c. personality disorders, without specifying the type of personality disorder), whilst other projects only include patients with a specific diagnosis of a disorder (i.c. schizophrenia).

Tps working with a formal diagnosis of the psychiatric disorder are often Tps who selected the target group on the basis of available expertise within the partnership, often the psychiatric hospital or a CMHS. Projects oriented towards social psychiatry do not feel the need of having a diagnosis of a psychiatric disorder.

#### 7.2.1.3 Multiple problems

In some Tps, the presence of multiple problems in different domains is regarded as more important than the diagnosis itself, for example problems regarding psychosocial needs, multiple functioning problems, forensic status. Especially Tps that work with patients living in the home environment focus on needs (multiple problems), rather than the diagnosis.

One TP remarked that one should be careful to label children or adolescents with a diagnosis of personality disorder, because they still evolve. Another project mentioned that some patients themselves do not want a diagnosis of a specific psychiatric disorder, as the diagnosis is experienced as an extra reason or stigmatisation.

#### 7.2.1.4 Other remarks

One project within the cluster 'elderly', explicitly mentioned that the patient may not have had any contact with a psychiatric hospital or a service for mental health care. However, the project has changed this criterion in the first year (see also 'current experiences').

One project in the cluster 'elderly' expects a minimum of a social network around the patient, i.c. a general practitioner and home nursing or contacts with the family.

### 7.2.2 Exclusion criteria

Exclusion criteria are not often made explicit during the interviews. If some patients are excluded, this often happens due to practical considerations, and to a large extent based on experiences rather than initial decisions made in the 'plan' of the TP. For example:

- The initial assessment for inclusion demonstrated no real need for regular follow up (see the contractual required number of consultations in the NIHDI-call).
- The initial assessment showed no real need for involvement of all obliged partners of the project.
- The patient characteristics do not correspond with inclusion criteria age or diagnostic criteria. Some TPs exclude patients who have contact with justice or have addiction problems.
- Patients are sometimes excluded because another TP active in the catchment area is considered more appropriate.
- In 1 TP, IQ is an explicit exclusion criterion because participation of the patient is required in the clinical therapeutic working practices of the TP.
- In 1 TP, persons with depression were excluded, as the aetiology could be organic.

### 7.3 CHRONIC AND COMPLEX

During the interview, we sometimes asked to specify the relationship of the selected target population and the issue of 'chronic' and 'complex' psychiatric disorder. Some projects had difficulties to objectify the issues of long term illness (chronicity) and complexity in their particular project.

A few projects made some general comments on complexity:

- Two particular projects with youth in a 'dead end' situation (not being helped anymore by available services) did not use fixed criteria to define whether a patient has a complex or a chronic psychiatric disorder, because TP is an experiment. They work within the global FPS cluster criteria and try to identify the needs of the targeted group in a flexible way.
- One TP remarked that the 'complexity' or 'severity' depends on the setting where the patient stays. Some behaviour may be regarded as mild in a residential setting, but as severe when the patient is living at home.
- One project does not focus on the psychiatric disorder, but relates the severity to the mental retardation. The TP only includes persons with a light mental handicap and a psychiatric disorder because they are considered to be able to live independently with support in their care pathway (in contrast to persons with a severe mental handicap).
- One project indicates that a diagnosis of a psychiatric disorder (i.c. psychosis) inherently includes the chronic and complex character of the disorder. The project is convinced that these patients will need care for a long time on different domains and will never be as they were before.
- Complexity is being related to the diversity and mix of problems (and the professionals needed) rather than the severity of the psychiatric disorder. 'Complex' is sometimes used for patients who have mental health problems but with multiple other problems in different domains such as accommodation, social, financial, professional or educational and familial issues. This element is mainly mentioned in those projects working with persons who are socially vulnerable or those projects with a social psychiatry approach.
- 'Complex' was also defined as a problem needing consultation and support by different health care professionals to mutually adapt their services, adapted to the needs of the patients

Some projects describe the chronic character of a psychiatric disorder:

- Chronic is used as a label for patients who are diagnosed since a long time or who experience long term problems in functioning. The diagnosis should not be connected solely to a particular life event, e.g. a depression related to bereavement. The duration is often not specified.
- Chronic may also be interpreted as patients with a long history of psychiatric care. In at least one project, a patient must have had at least two or more hospitalisations.

### 7.3.1 Comments

Some projects have formulated comments on the obligation to work with target populations, outlined in terms of diagnosis:

- A number of TPs have partially overlapping partners, but focus on different target groups. These TPs argue the advantage of differentiated working practices according to diagnostic groups. Often a disorder requires an adapted content of the patient meeting and great differences occur in the care approach of the clinician for patients with different diagnoses. However, it has also been mentioned that the *coordination* of activities is independent of the specific psychiatric disorder of the patient.
- Other TPs prefer having consultations and assess their needs even without a labeled diagnosis. They argue that when restricting the TP approach to specific diagnostic categories, there is certainly a risk of excluding a category of patients without a clear or known diagnosis.
- Some projects criticise the use of a DSM-coding as a reference point for complexity, as it solely reflects a biomedical view.

- **The criteria used to include patients differ between the TPs and are not always strictly defined.**
- **A precise diagnosis is not for all TPs regarded as a necessity for the inclusion of a patient.**
- **The complex and chronic character of the psychiatric disorder is often not delimited in specific terms.**
- **Complexity is often defined as an issue of a combination of needs in different life-spheres (requiring support from different professionals), rather than the severity of the psychiatric disorder.**

## 8 SELECTION OF THE PARTNERS

We use the label 'partner' to refer to an organisational entity, individual professionals or other individual persons taking part in the TP.

The partnerships of TPs are composed quite divergently, both in terms of the number of partners as well as regarding the sectors which each of the partners belongs to (e.g. health care (home and residential), social care, welfare, justice sector). At this stage we have indications that the TP-models vary greatly in characteristics of participating partners both within and between clusters.

We distinguish formal and informal partners. Formal partners have signed the contract and committed to participate in the activities of TP. Formal partners are organisational entities. Informal partners on the other hand have not signed the initial contract, but can participate in the activities of TP. Informal partners are often organisational entities, but can also be individual persons.

### 8.1 FORMAL PARTNERS

#### 8.1.1 Type and number of the formal partners

The number of formal partners across the TPs, ranges from 3 up to 53 partners.

Only A few TPs only have the minimally imposed formal partners as required by the NIHDI-call. These TPs have formal partners belonging to the health care sector. Other projects however cooperate with more than one partner of each obligatory represented category<sup>P</sup>.

In most TPs, formal partners are part of the mental health care domain (for example: sheltered living, psychiatric nursing home, day centre, rehabilitation centre, the association of general practitioners), and welfare (for example: Flemish Agency for people with a handicap, specialized centres for addiction, centres for student counselling (CLB), Protective Youth Services (PYS), sickness funds (SF), home help and support services and family support services, coordinating centre for welfare services/CAW) and justice care (legal services).

#### 8.1.2 The choice of the formal partners

It is often a deliberate choice of TPs to limit the number of formal partners. The projects often share the point of view that an increase in number of partners implies an increase in difficulties to motivate partners and to thus manage the (complex) partnership. Despite this point of view, the partnership in some projects could be regarded as highly complex (see *infra*).

The selection of the partners is, as it is to be expected, based on providers offering services for that specific target population. It was also expected that this type of partner would provide an inflow of patients for the TP.

As mentioned before sometimes formal partners were chosen because of previous (in)formal collaboration.

The target population seems to determine the selection of the non-obligatory formal partners and seems to be associated with the clusters.

A number of projects only decided to collaborate with primary care partners, i.c. ISHC (GDT) because of the formal obligations of the governments call for TP. It was not their initial intention to collaborate with these first line partners.

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<sup>P</sup> Some projects assume that the formal partners can only be partners from mental health care services and not from welfare or social care services.

- Still, some TP of the children cluster experience the imposed collaboration with ISHC (GDT) as illogical because of the following reason: ISHC's are described as being more familiar with adults or elderly than with children and youth and are thus potentially less relevant as core partners.

### 8.1.3 The role of the formal partners

A lot of the projects do not seem to have an elaborated model in which the roles of the participating partners have been clearly differentiated in organisational or management terms.

For a number of projects though, partners can be differentiated in terms of 'core' and more 'peripheral' partners. Core partners have a more strategic and steering role regarding strategic decisions about the functioning of the project.

- For the TPs who explicitly mentioned the "core" partners, a clear association is found with those partners who initiated the project.

Sometimes, a further distinction is made between the non-obligatory and obligatory formal partners.

- In one project obligatory partners have to participate in the inclusion meetings and steering committee meetings. The non-obligatory formal partners (sometimes labelled as 'cooperative' or 'functional' ("*samenwerkende*" or "*functionele*")) partners do not have to participate in the steering committee meetings and they only participate in patient meetings if they are actually involved in the care of the patient.

Apart from their role within the daily functioning of the collaboration at partnership level, core and peripheral partners can also be distinguished based on their relationship with potential patients for the project.

Core partners at the level of the patients are those partners who can bring in patients to be considered for inclusion in the TP or who are in direct, intense and close contact with patients. Remarkable to observe is that for many TP only a limited number of partners propose patients for inclusion whilst a majority of partners take a passive role in this. (see infra).

- E.g. in one province, the general practitioner is seen as a very important partner due to his crucial role in the global framework of ISHC (GDT). The general practitioner is the person who has information about the home situation of the patient and has a bond with the patient and his family.
- Ambulatory or residential services, depending on the place where the patient lives (e.g. for elderly living at home, the primary care services are the core partners at patient level).
- Psychiatric hospitals are in many TPs the core partners for the proposal of inclusions.

## 8.2 INFORMAL PARTNERS

In contrast to the identification of the formal partners, informal partners are not always specified in the project proposal. Many informal partners got involved in TP activities because of their involvement in patient care

### 8.2.1 Type and number of informal partners

Informal partners are often services or professionals of social care, welfare services or judicial sector (for example: street corner workers with homeless young people, Municipal Public Social Service Department (CPAS/OCMW), sheltered workshop, integrated youth services, lawyers ...).

Sometimes, partners (organisational entity or individual professionals) from the health care sector participate as informal partners: e.g a psychiatric unit of a hospital, general practitioner, psychiatrist ...

### 8.2.2 Role of informal partners

Informal partners generally do not have a role at the level of the partnership coordination. They are mainly involved with particular aspects of the care of the patient and participate in patient meetings if this is considered to be necessary.

- In particular projects, it was foreseen that informal partners would become involved to give information on specific patients (for example ADHD, immigrants) within the TP.

### 8.2.3 The choice of the informal partners

Even more than is the case for the selection of formal partners, the characteristics of the target population influence the choice of informal partners, taking part in the TP (for example: specific centres for addiction, services for mentally handicapped persons; judicial services, protective youth services...)

## 8.3 FAMILY AND PATIENT ORGANISATIONS

A small number of projects included the 'family and patient organisations' as an informal (exceptionally as formal) partner of TP, mainly influenced by the overall directives of the government programme. TPs generally did not actively contact the patients and family members organisation.

For those projects including patient and family organisations, the role is not always specified, especially with regard to their participation at the meetings. In general, they participate at meetings of the steering committee. Participation in patient or inclusion meetings is not accepted. It can be mentioned that the discussion about participation of the family and patient organisations is an ongoing issue at policy level.

- **TPs vary both in the number of partners, as well as the sectors these partners belong to.**
- **In the TPs formal and informal partners can be distinguished.**
- **In some TPs a distinction can be made between core partners and more peripheral partners. Core partners are more involved in strategic issues and often propose more patients for inclusion. Peripheral partners are included less in strategic issue and generally less active.**
- **The role of the partners in the TP is often not explicitly stipulated, especially not with regard to the management of the partnership.**
- **Only in a few TPs the 'family and patient organisation' is involved as an informal partner.**

## 9 GEOGRAPHICAL AREA OF ACTIVITY

TPs are required to define a catchment area, as stipulated in the NIHDI-call. The label 'catchment area' refers to the geographical area in which partners operate in the framework of the TP and from which patients can be included.

Catchment areas differ in size. Motivations to select these particular catchment areas are described.

### 9.1 SIZE OF THE CATCHMENT AREA

The size of the catchment area differs between TPs:

- Most TPs cover a province, a district ('arrondissement'), or a selected number of municipalities within a province;
- A few TPs cover only a city; some TPs cover a city and the adjoining municipalities;
- One TP covers more than one province.

However, not all TPs necessarily operate evenly across the catchment area. Some focus on particular areas within a main catchment area (e.g. in which the supply of mental health care services is concentrated).

### 9.2 MOTIVATION

The selection of a catchment area is inspired by different motivations:

- Some projects selected the catchment area on the basis of the existing concept of the care region ('zorgregio') of the ISHC (GDT).
- Other TPs determined the catchment area on the basis of:
  - The preceding formal collaboration (e.g. pilot projects)
  - The sector of activity of the MHCCP
- A few TPs chose the geographical working area of an important mental health care service (i.c. a psychiatric hospital and a residential service) as a reference as it is often the only service in the region with expertise for the selected target population.
- The size of the catchment area is determined by the availability of the contractual required different types of health care services and, sometimes, by the number of inhabitants (and thus the estimated prevalence of patients).
- Some projects consider that it is important to operate in a small catchment area:
  - The underlying aim is to focus the TP on the particular health services of a particular area. Some projects deliberately did not want to join urban areas with sometimes more and larger mental health care services.
  - Partners operating in proximity often know each other. Active participation of partners to meetings may be impeded in case of large distances.
- A limited number of projects subdivided their overall catchment area into two or three sub-catchment areas (in one case on the basis of the regional ISHC (GDT) area of activity, in another case on the area of activity of different centres for mental health care involved in patient coordination)

- **The geographical catchment areas of TPs differ in size.**
- **Some projects deliberately select catchment areas according to the availability of types of both mental health care services and other services.**

## 10 COORDINATION OF TP

### 10.1 INTRODUCTION

Coordination is one of the main components of any collaboration or cooperation between heterogeneous entities with their proper purposes and working practices aiming at reaching common aims. Coordination is a general term referring to the processes and supporting facilities and tools to share work related information and adjust the actions of the entities to each other, in order to maximise the results and (predefined) purposes of the collaboration.

The label 'coordination' refers to information exchange processes between partners, and the alignment of activities of partners (mutual adaptation or adjustment) within the TP. Coordination is seen as a means to achieve better results on the level of the partnerships, as well as on the level of patients. For the latter reason, we make a distinction between coordination at the level of the partnership and coordination at the level of the patient. In the future intermediate report, we will elaborate more on the underlying theoretical aspects of coordination, cooperation, collaboration as they are developed in organisation sciences and network theories.

Some preliminary general comments can be made:

- Coordination is put into practice in different ways, relying on a different use of coordination mechanisms (i.c. meetings, tools, bilateral communication, the coordinator as a person...).
  - Within all the projects, the central formal coordination instruments are 'meetings'. Meetings are organised on the one hand for partnership issues, on the other hand for patient issues. Within this general classification, a wide variety of types of meetings is used at each of these levels, and the status of the coordination mechanism "meetings" is quite different between projects.
  - Some projects use additional support tools in order to coordinate activities between partners (formal documents, web applications, email ...).
  - The coordinator is for many projects seen as a crucial 'mechanism'. We will elaborate on this in a separate section.
- The motivation for choosing a coordination approach is, for many projects, inspired by previous collaboration experiences. Previous experiences influence also the labeling of the mechanisms.
- The projects often use different labels for comparable mechanisms: a same label used by the projects sometimes refers to a different content in a comparative perspective.

The interviews showed that not all projects have a clearly defined coordination plan. In most projects, the coordination model is developed gradually during the implementation of the project.

## 10.2 COORDINATION OF ACTIVITIES AT PROJECT LEVEL: MEETINGS

To manage the partnership, different types of meetings can be distinguished:

- 'Plenary assembly' with all partners ( "*Assemblée plénière*")
- Steering committee meetings
  - Support meetings of the steering committee meeting, in which not all partners participate.
- Steering committee meetings combined with inclusion meetings
  - some French-speaking projects (that meanwhile resigned) only had one type of meeting integrating all types of coordination issues (both patient and partnership level), without a real partnership approach

In this section, different characteristics of each type of meetings will be discussed (as far as we have information available in this stage). Table 10.1 gives an indicative general descriptive classification..

Table 10.1: Overview of coordination of project related activities

	Meetings				Informal bilateral communications
		Content	Participants	Organization	
Coordination of partnership	Steering committee meetings	<p>Strategic topics: the mission of TP the rule of functioning of TP (definition and modifications) the constitution of the formal partners philosophic and ethical issues (professional secrecy)</p> <p>Operational topics: recruitment, role and tasks of coordinators the different documents of communication: elaboration, storage, communication conditions the administration tasks the organization of (in)formation sessions for partners exchanging information about each other evaluation of the functioning of the project patient monitoring briefing of subjects discussed in 'transversal consultation'</p>	<p>Type of partners: formal partners informal partners</p> <p>Type of professionals: only managers only clinicians or care providers a mix of these two types of professionals the project coordinator patient(s) and/or their family</p>	<p>separate meetings combined meetings: steering and inclusion steering, inclusion and follow-up issues</p> <p>- organisation of steering committee meetings for all projects in one meeting (different TPs with same/common partners)</p>	<p>agenda and organisation of meetings information about the practices of TP promotion of the TP</p>
	other meetings general assembly	Formal meeting aiming at endorsing propositions made by the steering committee	(for TP with many formal partners which do not all participate to steering committee meeting)		
	daily management committee support and preparatory meetings	no formal decision power preparing the steering committee and daily management activities interviews perceived problems during patient meetings	A selection of formal partners with or without the coordinator		

## 10.2.1 Steering committee

The label 'steering committee meeting' refers to the meetings between the formal partners in which all formal decisions about the functioning of TP are taken.

- Nevertheless, in many projects, informal work groups with smaller group of participants (coordinator, direct collaborators and boss of coordinator) do a lot of preparatory work but no 'decisive' work. These small groups often have a factual agenda setting power, which is later endorsed by the steering committee.

The projects use different labels for the steering committee (e.g. «*projectcomité, stuurgroep, vast bureau, le comité de pilotage, le comité d'encadrement, bureau mensuel, comité de gestion, inclusievergadering, le group porteur, le réunion de candidature*). The labeling is closely associated with the goals of the meeting (e.g. the steering committee meeting is labeled by some projects as 'inclusion meeting' because it is primarily organised to include patients and, if considered necessary, to combine it with steering and management activities of the project.

The differences between the steering committee meetings with regard to the practical modes of organisation, the participants and the content are discussed below.

### 10.2.1.1 Practical issues

#### **Separate or combined meetings**

Only a limited number of projects organise clearly identifiable separate steering committee meetings. In this case the steering committee meeting is clearly delineated and often immediately followed by a clearly delineated inclusion meeting or vice versa.

In most projects, the steering committee meetings are combined with the inclusion meeting (in exceptional cases also follow-up meetings).

Two projects distinguish only one general type of meeting, dealing with different content aspects on an ad hoc basis (one of these projects resigned).

A few TPs operate with a common steering committee meeting for different TPs. This is usually the case when the TPs operate in the same catchment area and have partially converging partners.

Some projects combine the steering committee meeting of the project with the activities of the MHCCP (i.c. Liège).

#### **Agenda and chair**

The chairperson of the steering committee can be the coordinator of the TP or a manager of one of the partners. In the latter case, it is mainly the manager of the partner that has taken the initiative for the preparation of the project.

Only a few projects have given information about the preparation of the agenda of the meetings. As will be discussed further, this is in some TPs prepared during the so-called 'support meetings', in other TPs through informal communication between partners.

#### **Frequency of meetings**

Most of the TPs have not an elaborated operating procedure with regard to the frequency of the steering committee meetings. The frequency of the meetings is not always specified beforehand. The information we obtained is generally based on current experiences rather than on a clear-cut plan (see also 'current experiences').

The frequency of the steering committees varies between the projects. In general, it correlates with other types of meetings.

### 10.2.1.2 Participants

The participants are in most projects representatives of all the formal partners of TP. In a small number of TPs, only the obligatory formal partners participate at the steering committee meeting.

In a small number of TPs, informal partners can participate too.

Usually, the same person belonging to the formal or informal partners represents this partner at all meetings over time.

When comparing projects, different types of representatives participate in the meeting:

- Only (departmental) managers;
- Only clinicians or care providers (also different professionals like psychiatrists, psychologists, social workers); in a few projects, a general practitioner participates in the steering committee meeting (as representative of the ISHC (GDT) or the association of the general practitioners);
- A mixed model of managers and clinicians or care providers

In some TPs, the patient and family organisation can participate.

The daily project coordinator(s) of the TP always attend(s) this meeting.

### 10.2.1.3 Content

Steering committees discuss different topics that can, in general terms, be divided in:

- aspects concerning the care of the patient
- aspects related to the functioning of the partnership

The discussion on the functioning of the project happens for all projects both on a strategic and an operational level.

- strategic topics can be:
  - the vision, the start and the mission of the TP
  - defining the functioning of TP (e.g. the content of the patient meetings, professional secrecy and confidentiality)
  - defining the modifications of the projects (e.g. the partners, the criteria to select patients)
  - philosophical and ethical issues
  - defining the tasks of the daily project coordinator, the patient coordinator or the administrative coordinator of the TP
- operational topics can be:
  - recruitment of a daily project coordinator, a patient coordinator or assigning an administrative coordinator of the TP
  - development of different documents or support tools (e.g. informed consent, folder)
  - management of the financing and the administration of the TP, namely collecting the needed signatures and giving the documents to the administrative coordinator
  - definition of the place of the meetings, the employment place of the coordinator and the storage of the patient-files
  - organisation of (in)formation sessions for partners
  - exchange of information about each other
  - evaluation of the functioning of the project, e.g. the number of included patient
  - discussion about the perceived problems of the TP
  - patient monitoring
  - briefing of subjects discussed in 'transversal consultations'

As mentioned before, only a few projects have a separate, clearly delineated, steering committee meeting. After the onset of the project, this meeting is often combined with inclusion meetings, and for some projects with follow-up meetings. In these latter projects, the content of patient care is a point on the agenda, be it discussed in different ways between projects:

- Most projects discuss inclusion or exclusion of patients;
- In some projects, the steering committee only discusses patient care issues and especially the follow-up of 'difficult' patients;

#### 10.2.1.4 Making decisions

Only a limited number of TPs referred to details of the steering committee decision-making process. For these projects every partner is considered equal in the decision making process. The meeting aims at consensual decisions.

#### 10.2.2 Other meetings with partners of TP

In two French-speaking projects with a lot of formal partners, a separate type of meeting ("*assemblée plénière*") is foreseen besides the steering committee. In this general meeting, all the formal partners are informed, but it does not aim at having in-depth discussions on organisational TP issues. It functions as an endorsement agency of propositions made by the steering committee. The frequency of these meetings is once or twice a year.

In many TPs, other types of meetings play the most important role in the daily management. They mainly deal with on operational issues. Many of these 'meetings' have a more informal character aiming at solving daily problems and supporting the coordinator.

In some projects, separate aspects are handled by different types of 'support and preparatory meetings' (e.g. daily management committee, advisory groups, working groups, ...). Generally, these support meetings have no formal decision-making power, but prepare the steering committee meetings: They take place every month or every trimester, or they are organised in an 'ad hoc' way, as people know they can meet if necessary.

The participants are representatives of a selection of the formal partners. The coordinator always participates in this meeting:

- One project combines the daily management committee with inclusion meetings.
- In one TP, a preparatory meeting discusses inclusions and patient group related problems beyond individual cases. It aims at having more general reflections about inclusion and follow-up.
- One project planned for a separate advisory group meeting to discuss perceived operational problems emerging during different types of patient meetings.
- One project experienced the need to install these support meetings after implementation of the TP (see also 'current experiences/perceived problems'). They were not planned before the start of the project.

#### 10.2.3 Informal bilateral communication

In some projects, the preparation of the steering committee meeting or inclusion meeting is prepared mainly through informal communication in which, generally, the coordinator is involved.

As a support tool to the daily functioning of the TP, a lot of informal bilateral communication between (potential) partners aims at promoting the TP and give information about the practices of TP.

#### 10.2.4 Promotion of the TP

A few projects have introduced lectures on topics, but with an underlying network idea to promote and raise awareness of the TP.

- One project has organised three seminaries for the partners and the general practitioner of the catchment area of the project. This seminar aims at informing and educating care providers to promote the project and create opportunities for professionals to meet outside a clinical context.

### 10.3 **COORDINATION OF PATIENT RELATED ACTIVITIES**

We have organised the different coordination mechanisms and processes for patients along the line of the “pathway” of the patient within the project. We start with a description of the coordination of patient enrolment in the project (inclusion) and patient follow-up related issues. Table 10.2 gives an indicative general descriptive classification.

Table 10.2: Overview of coordination of patient related activities.

			Type of processes	Involved persons	Topics
Coordination of patient activities	Inclusion	Preparation of inclusion meeting	<b>Preparatory work of individual professionals</b> <b>Exceptionally preparatory work</b> <ul style="list-style-type: none"> <li>- meetings</li> <li>- and/or informal bilateral communications</li> <li>- and/or patient documents</li> </ul>	<ul style="list-style-type: none"> <li>- coordinator</li> <li>- professional who propose patient inclusion</li> <li>- support professionals: an external team, children psychiatrist</li> <li>- Sometimes patients and/or family</li> </ul>	<ul style="list-style-type: none"> <li>- preparation of the formal inclusion meeting</li> <li>- inclusion documents: completion and transmission</li> <li>- pre-selection of patients (number of partners, content of care, criteria of inclusion)</li> </ul>
		Formal Inclusion	<ul style="list-style-type: none"> <li>- meetings</li> <li>- (sometimes combined inclusion and follow-up meeting)</li> <li>- and/or informal bilateral communications</li> </ul>	<ul style="list-style-type: none"> <li>- all formal partners</li> <li>- only concerned partners</li> <li>- seldom family and/or patient</li> <li>- exceptionally representatives of patient association</li> <li>- informal partner who proposes the patient</li> </ul>	<ul style="list-style-type: none"> <li>- presentation of patient situations (anonymous or not)</li> <li>- endorsement of the preparatory work</li> <li>- sometimes the elaboration of the care plan</li> </ul>
	Follow-up		<ul style="list-style-type: none"> <li>- meetings</li> <li>- and/or informal bilateral communications</li> </ul>	<ul style="list-style-type: none"> <li>- the directly involved care providers (formal or informal) or representatives</li> </ul>	<ul style="list-style-type: none"> <li>- (re)defining of the objectives of the care of the patient</li> <li>- analysing the needs and demands of the patient</li> <li>- practical agreements or engagements between the partners around the patient</li> <li>-</li> </ul>

### 10.3.1 The process of inclusion

#### 10.3.1.1 Preparation of inclusion meeting

In general, the coordinator manages all proposals of new patient enrolments in the project before the inclusion meeting. Some preparatory work is done and proposals are often documented and supported by tools (see 'tools to coordinate inclusion').

- One project mentioned that exceptionally, a new patient enrolment is proposed during the inclusion meeting, without prior preparation.

Different persons or partners can propose new patients for inclusion:

- In almost every TP the formal partners can propose new enrolments. Any individual care provider is entitled to suggest new patients for enrolment
- In a few projects, there is some limitation to the formal partners who can propose patients :
  - The priority is given to one specific unit of a hospital
  - Only the coordinator (psychiatrist)
  - Four formal partners, namely the services where the coordinators are located
  - Three contact persons
- In a very limited number of projects, the patient or the family can propose to include patients. One project explicitly mentioned that the patient or the family cannot propose to include patients.

Generally, the coordinator prepares the proposals before the inclusion meeting.

- Sometimes, with the assistance of the referral person. In one particular TP, the coordinator is supported by a youth psychiatrist. In another TP the coordinator can rely on an external team to support his/her preassessment.

This preparatory process differs between the projects:

- In some projects, the coordinator only collects the information needed to include the patient in the project but does not preselect.
- In other projects, the coordinator checks whether the patient fulfills the inclusion criteria and/or whether the demand is eligible to be handled in the framework of the TP (at the level of partners, sometimes on the content of care )

The inclusion meeting is in some projects prepared via face-to-face contact, via bilateral telephone contact or via a combination of both (first a telephone check of the eligibility criteria, followed by a specific meeting for obtaining the informed consent of the patient, before finally assessing the needs and including the person).

- In case of a hospital proposal for a patient enrolment, the coordinator of one specific TP organises a meeting with the hospital to check the urgency of the request to include the patient in TP.
- In another TP, in case of a discharge from a hospital, the project coordinator participates at a discharge meeting in the hospital to exchange expertise and views on the patient, and get relevant information for the future care of the patient at home.

In a limited number of projects, the proposals for new inclusions were discussed at the inclusion meeting without any preparation or preselection of the coordinator.

In most cases it is the responsibility of the referral person to inform the patient about the project. This happens mostly by the use of bilateral communication and/or a written document (see also 'tools').

In a few projects, sometimes the follow-up of some patients takes place during the inclusion meeting (of other patients). In one of these projects, the preparation of the meeting is done by a telephone call with the care consultant ('zorgbemiddelaar') who has contact with all the involved care providers of the patient.

### 10.3.1.2 Inclusion meeting

We use the label 'inclusion meeting' for the meetings taking the formal decision to include the patient in the TP. We wish to remind however that projects, though not all, combine inclusion meetings with other meetings.

Most projects use the same label to refer to the inclusion meeting, (i.e. 'inclusievergadering', 'reunion d'inclusion').

- Only a few projects use another name. One project planned to use the name 'Indicatiestellingsvergadering', but this label is not used in daily practice anymore. Other labels are: 'comité d'accompagnemen't; 'reunion de candidature'.

The practical operation of inclusion meetings differ between the TPs. In the following section, we give an overview on the dimensions for which differences can be observed.

#### Separate or combined meeting

As mentioned before, some projects combine the inclusion and the steering committee meeting. In other projects, the inclusion meeting is combined with or integrated in another meeting:

- In one TP, the support meeting of the steering committee (i.e. 'daily management': 'dagelijks bestuur') is combined with the inclusion meeting.
- In a small number of TPs, the inclusion of patients takes place during the patient meeting of other patients.

Other projects organize some sequential meetings to formally include patients.

- One TP has misunderstood the NIHDI-call with regards to the signatures needed for financing the meetings. For them, the managers of the partners, who have signed the NIHDI-contract, can not delegate their signature to the participants of the inclusion meetings. For this reason, the decision to include patients is taken in a separate meeting with professionals. This meeting is followed by a 'formal' inclusion meeting where the signatures of the managers are collected.

#### Frequency

Not every project has explicitly mentioned the frequency of their inclusion meetings, but we have indications that the frequency differs between projects (e.g. every three months, every month, every two weeks).

- In one TP, inclusion meetings take place when minimum 5 patients are presented for enrolment.

#### Content

Describing the content of the inclusion meetings depends, of course, on the question whether separate meetings are organised, whether meetings are combined. Here we focus on inclusion issues.

During the inclusion meeting, it is assessed whether the proposed patients fulfill preset inclusion criteria. This discussion is often very short, and in some cases solely an endorsement of the preparatory work of a coordinator.

In some projects, not all patients proposed for enrolment are discussed at the inclusion meeting, because coordinators have preselected eligible patients.

In some other projects, the patient situation is introduced rather extensively. The coordinator or the referral person presents the new patient. Generally, it is the person who knows the patient the best if this person participates at the meeting. The presentation of the patient is in some cases anonymous, in other cases it is not.

Additionally, we see that inclusion meetings are not limited to inclusion issues. In a lot (but not all) of the inclusion meetings, the development of a care plan of the patient is prepared or initiated.

### Time

The information we have about the time spent on the inclusion of the patient is limited and mainly based on the experiences (see also 'current experiences').

- Some TPs do not spend a lot of time discussing the inclusion of the patient. The coordinator indicates whether a patient can be included or not. The meeting then only endorses this advice without further discussion.
- Other TPs spend more time discussing the inclusion of the patient. Views and expertise of the participants are exchanged and discussions take place about the proposed patient.

### Participants

The participants in inclusion meetings are always representatives of the formal partners of TP. The patient coordinator of the TP is always present. It is not clear at this stage whether TPs have a fixed group for the inclusions.

The professionals involved in the inclusion of a patient vary a lot between the projects:

- only (departmental) managers
- only clinicians or care providers (also different professions like psychiatrists, psychologists, social workers); in a few projects
- (departmental) managers and clinicians or care providers
- sometimes also the care providers
- sometimes, in one province, a general practitioner represents the ISHC (GDT)

Even if the inclusion meeting is combined with another meeting, the participants of both meetings can be different. E.g. the participants at the daily management committee are representatives of the formal partners, whereas the participants at the inclusion meeting are care professionals belonging to the formal partners.

- The referral person is not always present at the inclusion meeting.
- An informal partner can participate in this meeting, if he is the referral person of the patient.
- In most TPs, the patient or family do not participate. In only a few cases, the presence of the family and the patient at the inclusion meeting is required in order to include the patient in the TP. In one project, it was foreseen that both the family and the patient participate but, at this moment, only the patient takes part (see also 'current experience').
- The participation of representatives of the patient and the family organisations is exceptional.

#### 10.3.1.3 *The follow-up of patients*

Once a patient is included, a coordination of the activities is needed for the follow-up of the patient. The Government's call for TPs requires at least one meeting every trimester in the first year and at least three meetings every year afterwards. Because of the formal NIHDI requirements and financing rules, some commonalities are found between projects, but the follow-up of patients is planned and organised in divergent ways, looking also at the participants and the content of the follow-up meeting.

We use the label 'patient meetings' to refer to the meetings taking place after the inclusion of the patient in a TP. These meetings take place to discuss and assess the conditions of the patient and the care needed during the pathway. In the following sections, we will discuss the practical organisation, the participants, the frequency and the content of the meetings. If relevant, a distinction will be made between the first patient meeting and the following patient meetings.

### **Separate or combined meeting**

In general, the patient meeting is organised as a separate meeting. However, in a limited number of projects, the patient meeting takes place at the same time of another meeting:

- the follow-up of the patient takes place during the inclusion meeting
- the inclusion of new patients takes place during the patient meeting

The first patient meetings are generally organised by calling the participants and setting dates. In some TPs, the timing and following dates of patient meetings are set during the ongoing patient meeting.

In a few TPs, several patients are discussed during the same patient meeting.

### **Frequency**

Very little plans of the TP have been explicit on the frequency of the patient meetings. Most of them probably follow the (imposed) trimesterial (or quarterly) meetings to discuss the patients.

- One project set that one monthly meeting would take place or at least two fixed monthly afternoons.
- In a limited number of TPs, the meeting takes place according to the preference or demand of the patient. Preliminary findings on current experiences (see *infra*) show that patient meetings are often organised when partners or the family of the patient need it.

### **Content**

During the interviews, most TPs have not really specified or elaborated on the content of the meeting.

In most TPs, the content discussed during the first and the follow-up patient meetings is similar. Following issues are discussed:

- follow-up of the situation of the patient,
- (re)defining the objectives of the care of the patient,
- analysing the needs and demands of the patient
- practical agreements on and commitments of partners regarding the care of the patient
- sometimes, only issues relevant for *all* the participants of the meeting are discussed, without further sharing of visions and expertise
- In one particular project, only issues introduced by the patient (often practical issues) are discussed.

In some projects, the content of the first and the follow-up patient meetings differs. More specially, the initial meeting focuses on:

- an elaborate description of the patient situation
- a comprehensive discussion about the care pathway of the patient
- an exchange of information and to mutually adapt the activities of the different participants (mainly when participants meet for the first time).
- exceptionally, giving information about the practices of the TP
- an evaluation of the potential participation of the patient in the following meetings

## **Time**

Generally, the duration of the patient meetings is not preset but determined by practical experience. One project reported that the meeting is restricted to 1 hour for every patient. Another project determined a maximum of 1 hour for the first meeting and 30 or 45 minutes for the follow-up patient meeting.

Most of the projects spend approximately one hour per patient. Some projects spend 2 or 3 hours per patient. One project mentioned a difference between the first meeting and the following meetings, namely 1 hour per patient for the first meeting and 10 minutes for the following meetings (see also current experiences).

## **Participants**

The Government's call for TPs implies that all partners of the TP can be involved in patient meetings. At least three of the formal partners have to actually participate in the meeting.

Generally, the participants of the patient meetings differ with the stage of care of the patient. The persons participating in the meeting are often the direct care providers. They represent some of the formal or informal partners.

- In one TP, the participants are a fixed group, but other persons can be invited to the meeting if necessary.
- A few TPs have a fixed group with representatives of the formal partners, who are not involved in the care of the patient.

Sometimes, only a person with discretionary power participates. In many other cases, it is the responsibility of the representative to exchange the information after the meeting with the responsible care provider. In some TPs, the coordinator takes up this task.

In a limited number of projects, not all the care providers involved participate in the meeting, especially in those TPs using tools to support information transfer and communication; i.e. mailbox of electronic care plan.

Some TPs have a changing group of participants because only partners who are relevant in that phase of pathway of the patient participate (e.g. primary care services always participate in the first meeting but not necessarily in the following meetings).

In some TPs, the participants of the first and the following patient meetings differ.

- In one TP, directly involved care providers participate in the first patient meeting, while in the next follow-up meetings a fixed representative of one of the formal partners takes up the agreements that have been made.
- In two TPs, the participants of the patient meetings are the fixed representatives of the formal partners, if the care providers involved indicate that a meeting is not needed.
- In some TPs, the potentially relevant partners are invited to the first patient meeting. Only the relevant partners involved in the care participate in the following meetings.
- In one TP, the actual participants are defined upon the issues discussed. The responsible care providers always participate but, if the needs of the patient are not clarified, the fixed representatives of the formal partners do also participate.
- In another TP, persons of partners participate for the topics relevant to them, or in determined by the relation of the professional with the patient.

In projects in which coordinators are supported by others for particular tasks (see *infra*), the coordinator is not always present at the patient meeting itself. In most of these projects, it was foreseen that the coordinator participates in the first patient meeting, but not in the following meetings. However, in daily practice the coordinator participates in most patient meetings anyway.

The participation of patients varies greatly among and within TPs, and some projects reported struggling with the way patients could participate in these meetings (see current experiences). The participation of the patients in the meetings depends on patient characteristics, their preferences to participate, or the issues discussed. Patients participate in:

- only a part of the meeting
- only the follow-up patient meetings and not the first patient meeting
- the patient is represented by his patient representative, if available
- In some projects of cluster children and youth, parents can participate, but not the child/youngster himself.

### **Other meetings**

- One TP has a separate meeting to discuss particular issues related to patients with specific problems,

### **Informal communication**

Besides meetings, coordination on patient related issues is achieved through a lot of informal, often bilateral communication. E.g.

- between general practitioner and psychiatrist regarding the care of the patient
- A partner needs specific information about a patient
- Practical arrangements, e.g. the transfer of a patient from one institution to another
- Sometimes, bilateral communication is needed between a partner and the patient or family

Some of this informal communication is passed on to all the partners during the next formal meeting (e.g. when the pathway of the patient has changed).

In some TPs, the coordinator has bilateral communication with the involved care providers or the care consultant to prepare the follow-up patient meetings.

- **Coordination is taking place on two core domains: on the one hand activities at partnership level, on the other hand at patient level.**
- **Different coordination mechanisms are used. Meetings are the core coordination mechanisms.**
- **TPs label meetings differently: when comparing TPs, the same label is used for different meetings. But different labels are used too for similar meetings.**
- **The organisation, the participation of partners and the content of meetings differs between the projects.**
- **The coordination of patient related activities is managed quite differently between TPs**

## **10.4**

### **TOOLS**

To facilitate this coordination, meetings are often supported by the use of tools. Similar to the distinction made earlier between coordination at the patient level and at the partnership level, tools can be distinguished for patient activities and for project related activities of the partnership. Table 10.3 gives an indicative general descriptive classification.

Table 10.3: Overview of support tools.

Communication tools		Topics	Form	dissemination	Target audience	
Tools for project related activities	Promotion of TP	<ul style="list-style-type: none"> <li>- TP setting and purpose</li> <li>- Functioning and practical information</li> <li>- Criteria of patient selection</li> </ul>	<ul style="list-style-type: none"> <li>- Folder</li> <li>- Written document</li> <li>- PowerPoint Presentation</li> </ul>	<ul style="list-style-type: none"> <li>- Emails</li> <li>- Telephone contacts</li> <li>- Personal contacts</li> <li>- Letters</li> <li>- Web sites</li> </ul>	<ul style="list-style-type: none"> <li>- Partners</li> <li>- Other organisations</li> </ul>	
	Steering committee issues	<ul style="list-style-type: none"> <li>- Minutes of meetings</li> <li>- Professional secrecy</li> <li>- Practical information about care providers</li> <li>- An organization chart</li> </ul>	<ul style="list-style-type: none"> <li>- Report</li> <li>- Documents</li> <li>- List of contact addresses</li> </ul>		<ul style="list-style-type: none"> <li>- partners</li> </ul>	
Tools for patient related activities	Inclusion of the patient	<ul style="list-style-type: none"> <li>- Registration form</li> <li>- Informed consent</li> <li>- Presentation of the patient situation</li> <li>-</li> </ul>	<ul style="list-style-type: none"> <li>- Forms</li> <li>- PowerPoint Presentation</li> </ul>		<ul style="list-style-type: none"> <li>- Emails</li> <li>- Telephone contacts</li> <li>- Personal contacts</li> <li>- Letters</li> <li>- Web sites</li> </ul>	-
		inclusion decision	<ul style="list-style-type: none"> <li>- Preparatory documents</li> <li>- Report of inclusion meeting</li> </ul>			-
	Follow-up	<ul style="list-style-type: none"> <li>- Care plan of the patient</li> </ul>	<ul style="list-style-type: none"> <li>- Written document</li> <li>- Web application (one TP)</li> <li>- Electronic patient file</li> <li>- List of contact addresses</li> </ul>			<ul style="list-style-type: none"> <li>- only the coordinator</li> <li>- participants</li> <li>- patient</li> <li>- partners</li> <li>-</li> </ul>
		<ul style="list-style-type: none"> <li>- Follow-up of the patient</li> </ul>	<ul style="list-style-type: none"> <li>- Report</li> <li>- Care plan</li> </ul>			-

#### 10.4.1 Tools used to coordinate the management of partners

##### 10.4.1.1 The promotion of TPs

Many TPs mentioned that they had to raise awareness and promote the TP at different levels. Some TPs promote and offer information about the TP mainly by informal communication, while other TPs make use of support tools: e. g. a folder or a written document. Information is generally more elaborated in a written document than in a leaflet.

In general, the written documents and leaflets hold information on: the call for TPs, the partners of the TP, the target population, the catchment area, the aims, an overview of the activities of the TP and practical information about the coordinator as the contact person of the TP.

- A small number of TPs made a PowerPoint presentation as a support tool during a lecture of the project.
- One TP has developed one document for the partners and a separate document to inform a broader audience.

### 10.4.1.2 Other documents

A few TPs made all contact information about the formal partners of the project available via the intranet of a MHCCP.

In one TP, a document has been created to support the issue of professional secrecy during patient meetings. The document describes and delimits what participants in meetings could say and what should be kept untold. They should not judge the patients during meetings, but only to express their thought and feelings about their experiences with the patient.

A few projects have created an organisational flow chart of the project.

Some projects have mentioned to keep reports of the steering committee meetings. We do not have specific information about the structure, content and distribution of these reports.

## 10.4.2 Tools used to coordinate patient related activities

In most projects, the reports of the inclusion and follow-up meetings are communicated electronically or by postal mail.

### 10.4.2.1 Administrative obligations

The NIHDI-call implies to follow particular administrative obligations regarding the registration and the potential financing of the activities of the TP. Many projects use support tools for professionals to meet the administrative requirements of the NIHDI-contract. The obligatory administrative documents are:

- a copy of the inclusion meeting report with the name of the patient and the care providers involved; signed by the representatives who participate in the meeting
- a copy of the follow-up meetings report with the name of the patient and the involved care providers; and signed by the representatives who participate in the meeting.
- a copy of a 'document taking in charge of a patient' in which, after every follow-up meeting, the responsibilities of every partner in the care of the patient are summarised.

### 10.4.2.2 Tools used to coordinate inclusion

A patient enrolment is generally supported by means of written documents in which information is provided about the potential candidate. Several types of written documents are described below.

Most TPs use a separate standardised registration form to propose new patients in the TP. In general, the content of the enrolment registration form includes the objectives relative to the patients, practical information about the patient (e.g. name, age, address), clinical information about the patient (e.g. the pathology; the symptoms or concerns on different levels), the request for care, the needs of the patient, a proposition of care plan and pathway and practical information of the involved care providers and clinicians (addresses, phone numbers, etc ).

The size of this document differs (about 1 to 8 pages) between the TPs, depending on the details asked in the registration form.

TPs use and manage this document in diverging ways:

- In a majority of the TPs, the patient coordinator receives a completed registration form before the inclusion meeting.
- For TPs without any inclusion meeting, a completed registration form and a preparatory document ("*feuille de concertation*") is sent to all the partners of the TP. This form includes the partner agreement about the patient inclusion and the potential proposition of care of partners. Each partner (and potentially other concerned care providers) has then to confirm the inclusion

of the patient, and to confirm his possible commitment by sending back the completed form to the coordinator within 7 (or sometimes 10 days). In case of absence of a formal response of partners, the patient is included in the TP with a tacit agreement of all partners. The partners can also contact the coordinator for more information.

- In one project, the completed registration form is sent by email to the partners who are not currently involved in the care of the patient. Therefore, they can give their informed consent on the patient inclusion and their engagement without being present at the inclusion meeting.
- In one project, the participants of the inclusion meeting receive the completed registration form 1 week before the inclusion meeting by protected email.

#### 10.4.2.3 *Informed consent*

Most TPs do not use a formal or signed informed consent. For those TPs using a formal informed consent letter the length of the document is between 1 or 2 pages.

- Some TPs have a formal document which has to be signed by the patient. This document often also informs about the aims and practices of the TP, or makes a further reference to an explicative document.
- For other TPs, the patient only has to confirm he has no problem with the exchange of information about him during his inclusion in the TP.

#### 10.4.2.4 *Inclusion meetings*

In a few projects the coordinator uses a PowerPoint presentation to give information about the patient during the inclusion meeting.

Some projects use the report of the inclusion meetings as part of the adapted IHCS (GDT) care plan of the patient. Other TPs have created their own report template, even if they also use the adapted GDT care plan.

The content of these reports differs between the TPs:

- In some TPs, only the administrative requirements of the Government's call for TPs, namely the signatures of the participants in the meeting.
- In general, an overview of the commitments of partners and agreements made during the meeting.
- In one TP, the document mentions the partner or the service who has proposed the new patient, a short motivation to include the patient and an evaluation of his situation.

One project does not work with a template. The report is an informal document where the commitment of every partner in the care process is defined in a rather loose way.

### 10.4.3 Tools used to coordinate the follow-up of the patient

#### 10.4.3.1 *Care plan of the patient*

The Government framework requires that the projects work with a care plan: Projects use different labels for this care plan ("*zorgenplan*", "*zorgplan/zorgdossier*", "*plantenlastenname*", "*le petit carnet de liaison*") and the content of these care plans seems quite divergent between projects.

A care plan is adapted to every individual patient. A care plan contains the commitments of the partners and the aims for care and support to maximally enhance the patient's ability to live independently and to support the care professionals. The care plan requires commitments to collaboration between at least 3 caregivers, i.e. a general practitioner, one or more other professional care providers and/or non-professional care providers. Their engagements mentioned in the care plan are evaluated afterwards in order to adapt or end care if necessary.

- In many Flemish (but not all) projects where ISHC (GDT) is a formal partner of the TP, the latter often urges to use their care plan. This is especially the case if the same ISHC participates in several TPs. The tool is seen as a means to create uniformity between the TPs, and to make different health providers acquainted with one common tool. This GDT file was initially developed for people with physical problems.,It is (slightly) adapted to the particular needs of the TP: it contains administrative required documents of the NIHDI-contract, a template for the inclusion meeting, a template for the follow-up meetings, a letter for the advisory physician of the sickness fund, and information needed related to the particularities of the target population of the TP.
- A few projects have added other documents such as medication schemes, practical information about the involved care providers (e.g. a social worker, a nurse, voluntary workers) and clinicians (e.g. general practitioner), and a document for making remarks, questions or announcements open to any health care provider
- In one province, a web application of the GDT is used for the care-plan. Only the coordinator has access to this web application. For the TPs an adapted module is added to the general GDT care plan above mentioned with the specific diagnosis (DSM code) of the patient.
- In some projects (all active in one part of a province), a protected electronic care plan is used to inform carers. Care providers can add comments via an 'electronic mailbox'. The patient has access to this electronic plan too
  - One project uses an additional paper version describing the patient care objectives and the commitments of the partners in a non-fixed structure.

The content of the reports used in the follow-up meetings differs between the TPs. Some reports are made in a free format, other follow more predefined templates.

- Most TP have an overview of the agreements and commitments made during the meeting;
- Some TPs use only the administrative requirements of the Governments call for TP, namely the signatures of the participants in the meeting

The choice of the reporting content form in the follow-up reports differs too

- A few TPs give a short technical ('objective') summary of the meeting.
- At least one TP reports the context, but only if it is considered relevant to clarify on agreements and commitments made. In another TP, the patient defines which information can be written in the report.
- One TP, also reports on the motivation for organizing a patient follow-up meeting consultation

#### 10.4.3.2 *Dissemination of the care plan*

In some TPs, the care plan is only disseminated to the NIHDI. In this case, the report becomes part of the GDT care plan or the patient file, managed by the coordinator.

- One TP explicitly mentioned that the plan is not disseminated among partners because of problems experienced when working with different sectors or psychiatrists.

In other TPs, the report is disseminated to combinations of different persons: The partners who participate at the patient meeting, all the partners; the patient and/or the family of the patient

- One project distinguishes three types of reports of a same patient meeting for different addressees: reports in which partners sign for agreement, an anonymous version for all the partners, and an adapted version for patient and family

- **Different types of tools are being used to coordinate activities.**
- **Tools are used to coordinate patient related activities.**
- **Tools are used to support the coordination of the partnership.**
- **The use, the content, the form, the users and the forms of dissemination vary between the TPs.**

## **II THE COORDINATOR**

### **II.1 INTRODUCTION**

In the section “coordination” we have seen that clusters of tasks related to the coordination of TPs can be distinguished: tasks to coordinate the activities of partners, tasks connected to patient-related issues and tasks connected to the answer the formal administrative requirements (for contract and financing purposes). These types of coordinative activities or tasks are allocated to the same or to different persons. Based on the interviews, the division of labour within the projects has an impact on the content of labour of the persons taking up the coordinator role. The complexity of the division and allocation of tasks explains why the function of “coordinator” is filled in very diverse, leading to rather fundamental differences in the organisational regime. At this stage, the report is only focussing on a general descriptive classification of coordinators, without addressing all the differences in task allocations to coordinators.

In this section we use the following ‘general’ labels:

- The label ‘overall coordinator’ is used for the person who is supervising the project coordinator and the functioning of the TP, in most cases being the chairperson of the steering committee of the TP.
- The label ‘project coordinator’ is used for the persons who are running the project on a day-to-day base: both partnership and patient-related issues. Some projects use the label ‘patient coordinator’ specifically for the patient-related activities
- The term ‘administrative coordinator’ is used for the person who performs the formal administrative requirements for the external financing agencies (NIHDI, FPS). It is often a person supporting the project coordinator

Project coordinator tasks can be executed by more than one person. For example, a small number of TPs appoint multiple project coordinators of different organisations for patient-related activities, while all (daily) partnership related coordination activities are performed by the overall coordinator.

Some TPs report that project coordinators are supported by other persons for patient-related activities, such as communication (with the patient, partners or professionals), chairing and report writing of the patient meeting....

Role, tasks, time allocation and profile of the different coordinators and other persons involved are discussed below. It will become clear that the classification of the different roles and tasks of coordinators is still preliminary, and that further analysis of the differences in the allocation of coordination tasks to coordinators has to be done in future activities.

### **II.2 OVERALL COORDINATOR**

The overall coordinator is most commonly the chair of the steering committee and in this function, supervising the TP and performing coordination at partnership level. The ‘overall coordinator’ is often a person with a responsible clinical or management function, higher in hierarchy than the project coordinator. Daily issues about the TP are communicated between the project and overall coordinator and solved when possible.

## 11.3 PROJECT COORDINATOR

### 11.3.1 Coordinating the partnership

#### 11.3.1.1 *Communication*

The role of the project coordinator at partnership level is commonly to

- promote the TP and procedures for formal and (potential) informal partners, by means of presentations and development of a brochure
- be a central contact person of the TP for professionals within and outside the network, and this for all sectors involved (e.g. PMSSD, justice house,...)
- transmit information between partners in-between meetings (e.g. information of NIHDI, patient monitoring)
- participate in the transversal consultations

#### 11.3.1.2 *Logistic tasks*

The logistic activities of the project coordinator is commonly to

- inventory and/or set the agenda of the inclusion meeting, of the steering committee meeting, as well as prepare documents/templates and propositions for identified problems
- write the report of the inclusion meeting and the steering committee meeting
- write the annual report of the activities of the project

Overall, the project coordinator is the person who is expected to engage and motivate partners, who should be the dynamic force in the project. He, she or they should keep “the wheel turning” (“*de boel draaiende houden*”).

Coordinators seem to function relatively autonomous with regards to operational issues in the TP, under supervision of the overall coordinator. This does not mean however that all coordinators feel supported in all daily activities (see current experiences).

### 11.3.2 Coordinating patient related activities

#### 11.3.2.1 *Preparatory tasks related to patient enrolment*

Most of the coordinators of TPs are directly involved in the preparation and discussion of patient enrolment issues. Different tasks have been mentioned

- communication with the professional who informs the coordinator of a potential eligible patient.
- Data-collection of diagnostic and socio-demographic data, patients’ context and needs as well as currently provided care (or professionals being involved),
- communication with the patient (if partner is not doing this) by telephonic contact or home visit to explain the project and collect information.
- preparation of the patient file to discuss at the inclusion meeting.
- Preliminary (proposal for) selection of patients based on in- and exclusion criteria

#### 11.3.2.2 *Logistic and support tasks*

- The signed informed consent is required before inclusion in the TP, and is collected by the coordinator or the professionals who presented the patient.
- To introduce the patient case at the inclusion meeting, especially when the patient entry has not been proposed by a formal partner
- To manage the patient file (including collecting obligatory documents of the advisory doctors of the sickness funds (“*médecins conseils/adviserend geneesheer*”))

- To write and distribute the report of the patient meeting, and develop a care plan
- To transfer required administrative information to the administrative coordinator (e.g. patient entry file, characteristics of professionals who participated in a meeting)
- To distribute and/or collect patient monitoring questionnaires

### 11.3.2.3 *Communication with partners and patients*

- To contact potential partners that could be involved in the care of a new patient
- To organise the patient meeting
- To chair the patient meeting: ensure that the patient needs are clarified, that the opinion of all participants and patient is well reflected and that aims and decisions/actions are defined in consensus. In follow-up meetings, evaluation of delivered care and change in needs of the patient is performed.
- To identify a 'patient representative' when applicable for the TP (see below 'support for the project coordinator'), in order to assist the coordinator in communication with the patient and detection of problems at patient level. The 'patient representative' may also assist in the organisation of patient follow-up meetings.
- To contact relevant (health) care professionals in case they have not participated in the meeting (eg general practitioner). In some projects also (telephonic) contact with health care professionals and patient before a meeting for follow-up, problem detection and agenda setting
- To act as central contact person (sometimes together with a medical doctor) when a patient case would experience problems or a crisis would occur which needs bilateral or multi-lateral communication in-between meetings when applicable in the TP
- To contact and communicate with the patient and family in some TPs (this task is depending on which partners included the patient and whether a 'patient representative' has been appointed).

When additional persons are involved in the coordinative activities at patient level (see below 'support for the project coordinator'), the project coordinator may get support for certain of above-mentioned tasks such as organisation of the patient meetings, report writing and communication with the patient.

The project coordinator is considered to be a neutral person that is not directly involved as health care professional in the health care delivery to the patient. The client coordinator is, in principle, neither representing the organisation in which (s)he is located.

- Some coordinators indicate that partners initially had difficulties to differentiate the roles of the coordinator, although it is admitted that it was also sometimes difficult for themselves.

### 11.3.3 Time allocation

Project coordinators are employed according to different employment contracts in terms of FTE. The allocation of financed FTE coordinator time between the projects ranges from 8-24h/week with a half-time or 19h/week being most common employment contract

Many coordinators combine the part-time employment as a coordinator with another professional role within the same organisation. Some persons are project coordinators of 2 (exceptionally even 3) TPs.

## 11.3.4 Profile of the project coordinator

### 11.3.4.1 Recruitment

A few project coordinators had participated in the writing of the project proposal, and were therefore considered as optimally eligible candidates for this position. Others were specifically contacted to fulfil this function. Only a minority of TPs published a formal advertisement for the recruitment of the project coordinator.

Most project coordinators were (actively) recruited within the network of partners, and as a result, most of them have (some) relevant work experience within mental health care. This is considered to be important, because the project coordinator should be legitimated by partners and participants in patient meetings by his/her experience and knowledge of relevant health care, social care and welfare facilities in the region.

This is especially true in TPs in which professionals of the “first line” expect specialised knowledge in psychiatric care (eg. explanation of terminology of psychiatrist, applications of concepts of care) as health care professionals of second or third line are not always present during patient meetings. Experience in care in the home environment is explicitly considered as important in TPs focusing on patients living at home.

### 11.3.4.2 Professional background

The profession of the project coordinator is diverse, but generally, he/she has a social (care) diploma: typically nurse, social worker, remedial educationalist, psychologist, criminologist, sociologist...

- It was mentioned in many TPs that psychologists with a lot of clinical experience (e.g. working in CGG) were not interested in this coordinative function that involves a considerable administrative task load.

### 11.3.4.3 Required competencies

During the interviews, we explicitly asked on the necessary competencies one would expect for a coordinator in order to fulfil this role: Several common elements were mentioned:

- good administrative and organisational skills
- knowledge and professional experience of the patient target group including their typical pathway
- knowledge of local or regional health care facilities and professionals, and their functioning
- good communicative (in group context and report writing) and motivational skills
- some maturity at a professional and personal level
- competences in understanding the wider theoretical framework, making some projects comment that academic competencies are useful or even necessary.

### 11.3.4.4 Location of employment

The coordinator is often located in the organisation who applied for the TP: CMHS, psychiatric home care or residential institutions for mental health care.

- An organisation for sheltered housing is also mentioned in a Flemish TP.

Only some projects located their project coordinator in the first line. Some TPs indicate that the “first” and “second” line have a limited capacity due to small size of staff and consequently limited flexibility to (financially and/or staff) increase support for the coordinator when needed, or to easily replace a coordinator when needed.

## 11.4 SUPPORT FOR THE PROJECT COORDINATOR REGARDING PATIENT RELATED ACTIVITIES

### 11.4.1 Patient representative

Some TPs describe the involvement of a 'patient representative'. It is a person who has a close contact with the patient. The projects use different names for this person. In French-speaking TPs, this patient representative is the direct contact person for all professionals involved. Most TPs prefer a (health care) professional and not a family member (except for children cluster). They consider it easier to maintain a certain distance between the patient and the patient representative assuring a more objective view on the patient without conflicts of interest.

Most often, the patient representative is the person who contacts the project coordinator for possible entry of the patient in the TP. This person would ideally be a choice of the patient, but is typically appointed during an inclusion or first patient meeting. The patient can also suggest a suitable person.

The patient representative discusses needs and possible problems with the patient before the meeting, expresses the patients' view during the meeting in case the patient is absent or needs help, and communicates punctual decisions after a meeting. The patient representative is considered as a support by the patient, for whom a meeting with multiple professionals could be experienced as stressful. The patient representative also monitors changes in the situation of the patient (detection of problems or worsening) in-between meetings with the coordinator. The patient representative may change when a transfer of a patient between organisations takes place.

One project attributes the role of patient representative to a partner who does not know the patient, in order to have an objective view during patient meetings. For specific clusters of children, the patient representative may also be a professional of justice who is following the patient, instead of or in addition to a health care professional.

In some TPs, the patient representative is also involved in the organization and/or organization of patient meetings, and exceptionally in writing a brief report afterwards. As such the patient representative supports the project coordinator in his/her coordination tasks.

The patient representative may also be involved in collecting data for the patient monitoring.

### 11.4.2 Consultation and Home Care Coordinator

At Flemish side, some TPs describe the involvement of a separate 'consultation and home care coordinator' ("*overlegcoördinator*" and "*thuiszorgcoördinator*") who is employed by organisations outside health care such as the sickness funds or PMSSD. This person, mostly a social worker, organises, chairs and writes reports of meetings for patients with physical disabilities. This coordinator organises also meetings of professionals at patient level in the TP, without interfering on the content of delivered care.

The involvement of these persons in the TP is currently limited. If any, it occurs typically for patients who live in the home environment at the moment of entry in the TP. The project coordinator of the TP is sometimes present in these meetings organised and chaired by this 'consultation and home care coordinator' to provide specialised feedback.

### 11.4.3 Support in organisation, chairing and report writing of meetings

Some TPs provide administrative support (allocating an additional person for 2-9h/week) to the coordinator for the organisation of meetings and collection of administrative documents to be submitted to the administrative coordinator. Depending on the TP; this administrative support is not, partly or fully financed by the budget of the TP.

In one TP, a clinician is assisting the coordinator by performing an evaluation of the patient status and agenda setting prior to the meeting by means of telephonic contact with all participants. Patient monitoring will also be performed by this person.

Some TPs provide a clinician (psychologist) to support the coordinator for about 4h/week (assisting in chairing patient meetings, and application of patient monitoring instruments).

Exceptionally, in one TP, a secretary also takes notes during patient meetings.

- One TP describes the involvement for 4h/week of a so-called 'project coach', who is experienced in patient meetings due to her experience in another project. The project coach participates in patient meetings to support the patient coordinator. She is also able to replace the coordinator in chairing meetings when necessary. This project can also make use of a psychiatric nurse to evaluate patients' problems and needs in the home environment.

## 11.5 'ADMINISTRATIVE' COORDINATOR

Almost all TPs distinguish a separate administrative coordinator or count on an administrative unit of a formal partner (often a hospital) to fulfil the administrative duties.

The tasks of an administrative coordinator are to:

- Collect required documents
- collect required documents of the patients' sickness funds, such as documents from advisory physicians ("*médecins conseils/adviserend geneesheer*") in order to obtain reimbursement for the patient meetings
- report which partners or (independent) professionals participated in patient meetings (this information comes often from the project coordinator)
- send documents and invoice activities for the NIHDI
- follow the payments by NIHDI
- pay participants in patient meetings, based on redistribution rules defined in the TP (e.g. sometimes different amounts have to be paid to independent health care professionals depending on the particular TP convention).

These administrative tasks are often coordinated by a person of the ISHC. In a number of TPs, these administrative duties are performed by a larger administration unit (accounting department) of the organisation in which the project coordinator is embedded (eg organisation for sheltered living, CMHS, residential institution/mainly hospital). Some TPs indicate explicitly that small organisations cannot make use of a large administrative unit that can support the project coordinator.

The administrative coordinator is commonly not involved in the organisation of meetings at patient level, given a lack of expertise at client level and for privacy reasons. Some administrative coordinators participate in inclusion meetings as the ISHC (GDT) is a formal partner in the TP. The administrative coordinator or responsible of the organisation participates to the steering committee meetings.

In a couple of TPs, the administrative and not the project coordinator is responsible for the organisation of the steering committee meeting, and for the reporting of these meetings.

The administrative coordinator is part of the ISHC unless the ISHC refused to participate in the TP. The administrative person, when being part of the ISHC is not specifically recruited for the TP. In practice, regular staff seems to perform the administrative TP work additional to their regular work. The time investment for the administrative coordination within a ISHC was rarely explicitly mentioned except for some TPs (eg 4h/week). But some projects do report about the burden of this administrative workload in combination with their other tasks (mainly ISHC with limited staff).

A number of larger ISHC (SISD/GDT) coordinate administrative tasks of different TPs within their area of activity. For some regions, an electronic web application has been developed to facilitate data collection of administrative data from the project coordinators.

- **Coordination tasks are not all concentrated in one single coordinating person. Many TPs distinguish a project and administrative coordinator. Sometimes an overall coordinator supervises the project coordinator and functioning of the TP.**
- **Partnership-related activities of the project coordinator are communication within and outside the partnership, as well as fulfilment of logistic tasks regarding meetings with the partners.**
- **Patient-related activities of the project coordinator are communication with (potential) partners including the patient, preparation of inclusion, completion of necessary documents and organisation, chairing and report of patient meetings.**
- **The employment contract of project coordinators varies in terms of FTE.**
- **Project coordinators are commonly recruited within the partnership, and have different professional backgrounds.**
- **Optimal competencies of the coordinator include familiarity with patient group and knowledge of available (mental health) services by means of a certain practical expertise, as well as good administrative and organisational skills.**
- **Most project coordinators are based in services of residential or ambulatory mental health care services.**
- **Project coordinators are sometimes supported by other persons for patient-related activities and administrative tasks.**
- **In some projects, overall coordinators fulfil formal administrative requirements. These coordinators do not participate in patient meetings, but do participate in the steering committee meetings.**

## 12 CURRENT EXPERIENCES

### 12.1 INTRODUCTION

In this section, we summarise the first year experiences of the projects as reported for particular topics. We structured this section in two main parts: the first part summarizes the positive experiences, the second part more problematic issues. The reader will observe that the same topics are mentioned both in a positive or negative way. What some projects have reported as positive is more problematic for others. This section only summarizes experiences as they were mentioned by the interviewees. In the following steps of the analysis more attention will be paid to further classify the experiences in more analytical (and thus summary) categories.

We emphasize that only the perceptions of the interviewees are reported. As is mentioned in the methods section not all stakeholders of the individual TPs were represented. The reported 'experiences' are thus selective descriptions of the people present during this first interviews. In the following interview round of the process evaluation (the second round of interviews with the projects), we will pay more attention to the different perspectives and experiences of partners involved in the project.

An in-depth analysis or validation of the statements of the interviewees has not been done at this stage. From a process evaluation perspective, it is important anyway to get an idea about the meaning people give to their experiences. Even though we are aware that the observations made are still preliminary, this section gives a first indication of aspects on the implementation of organisational innovations in mental health care as perceived by the projects. In the future process evaluation, a lot more attention will be paid to both facilitating factors and barriers for the implementation of collaboration initiatives. It is to be expected that the next phases of the research project will bring a lot more (detailed) information and insights to the surface. Further in-depth analysis is certainly needed before drawing any conclusions.

### 12.2 PERCEIVED ADDED VALUE

During the interviews, we asked in general terms whether and how projects experience an added value of the TP-programme. We asked this as an open question. In general terms, a lot of the interviewees mentioned a potential added value of the TPs. The observations on the added value describe several aspects of the TP-programme.

If projects reflect on the perceived added value, they all implicitly differentiate between an added value for the partners and for the patient. Some projects see a 'stepwise' added value: an initial added value for the collaboration and communication between partners is expected to also become an added value for the patients.

#### 12.2.1 Added value of the government his TP-programme

A number of projects remarked that the template and underlying approach of the government TP programme have an added value regarding patient care.

- A small number of TPs (mainly in the cluster 'children and adolescents', and some in the cluster 'adults') and especially those with previous collaboration experiences had some difficulties to spontaneously define the particular added value of the TP-programme. They consider the TPs as a different, but very comparable approach to previous initiatives in which they collaborated.

A few TPs made positive remarks on aspects of the TP-programme as implemented by the government (NIHDI-FPS). The bottom-up approach is perceived as useful to directly involve and commit the sector. In preceding government programmes, policy makers were perceived to impose the collaboration frame, whilst in this programme suggestions are awaited of the sector. Moreover, the obligation to directly involve care providers in developing models for connecting different types of services to meet patient needs is experienced as important.

The financing installed for patient meetings helps to motivate individual health care professionals from partners of TPs to participate in these meetings. Some projects comment in a positive manner about the possibility to finance a coordinator. It is considered as an added value that one or more identifiable persons are made responsible for, the organisation and chairing of meetings, the administration of the project, as well as the follow-up of the care of the patient

The obligations of the NIHDI-contract are experienced by some projects as an aid to organise and structure the project. The framework states conditions that have to be met. Moreover, the frame is perceived by some to enhance the cooperation of partners (e.g. to activate care providers and partners to include patients in TPs).

### 12.2.2 Participation of the patient

In general terms, several projects experience the obligation to seek approaches for patient participation, as an added value. Only a limited number of TPs made more specific comments:

- It is possible to involve the patient in the discussion. It is mentioned that issues are discussed in a different manner when the patient is present at the meeting.
- It is possible to cross-check some issues directly with the patients, and providers make precise commitments (towards the patients).
- One project noticed that more attention is being paid to the relation with the patient when he is referred to other services. Before the project, patients were treated more “as objects” when they were referred to other services.
- A small number of projects experienced that participation by the patient may increase his/her sense of responsibility in his/her own care.

### 12.2.3 The rhythm of the meetings

The imposed rhythm of meetings (every three months in the first year of the project) is seen as an advantage by some TPs:

- One particular project emphasizes that regular meetings avoid that patient meetings are being limited to a crisis situation. Because of this, it is possible to have a more serene point of view during the regular patient meetings or to anticipate crises.
- Partners communicate regularly and learn to know each other better, which favors the continuity and quality of care.
- It induces a feeling of comfort and security, as professionals will see each other again.
- In one case, the TP accelerates the development of a previous informal network in which partners have been meeting each other for a few years.

### 12.2.4 Obligatory involvement of different types of partners

Positive comments on the obligatory involvement of different types of partners were made. It also became clear that different projects had different understandings on the conditions and the involvement of these partners in the TP:

- The obligations of the TP-contract guarantee that different types of services are involved in the care of the patient, e.g. ambulatory services and hospitals; general and psychiatric hospitals.
- Interviewees mention that the collaboration of different partners with different approaches enables the development of a new approach or vision in the care or treatment for patient situations that previously were considered as ‘dead end situations’.
- A number of TPs mention it improves the exchange of information between the primary care services and specialised services. Some projects emphasized that it is more intervision than supervision as a forum is created in which all partners discuss on an equal basis.

- A small number of French-speaking TPs mentioned that (actually) the meetings were not participative, and that the agenda was strongly dominated by one actor (in two cases the psychiatrists).
- The TP-programme enables to create a connection between the ambulatory and the residential services. Actors become less keen to 'keep' their patients.

The obliged involvement of some primary care partners, which the project initiators initially did not intend to involve (e.g. the ISHC), is perceived as positive.

- One project noticed that the involvement of the ISHC (GDT) for the administrative coordination of the TP is far more than a practical/administrative advantage.
- One project mentioned that the preparation of a discharge from a hospital or prison and referral to ambulatory services is easier as the latter are now actively involved. This contrasts to situations where ambulatory services have to take care of the patient without or with little background information on the condition of the patient.

Some projects see particular advantages in the involvement of the general practitioner:

- A medical point of view is included in the discussion of general (non psychiatric) health problems that are often not considered. It can be an aid to refer the patient faster to the appropriate services for those physical problems (e.g. constipation) which may be related to psychiatric problems (or their treatment) and of which mainly the general practitioner is being informed rather than the psychiatrist.
- In some projects, the general practitioner gets information about practical issues of the patient his home situation.
- Because of additional information, the general practitioner can make a faster evaluation of the situation and can better deal with it, e.g. calm down the patient in a crisis situation.
- The physical participation of general practitioner at the meetings is an advantage compared to previous written or telephone contact
- The patient rediscovers his general practitioner. Previously, he knew only his psychiatrist.

A small number of projects formulated positive remarks on the involvement of specialised services:

- The TP-programme enables a continuous exchange of expertise, even if the patient does not stay in a residential setting anymore.
- Specialised services can help to increase awareness of mental health care problems. The primary care services sometimes focus on practical problems and forget the psychiatric disorder of the patient or they do not always know the pathology of the patient. One project noticed that thanks to the TP-programme, it is possible to better interpret specific signals (e.g. a messy room could be a signal for a psychotic crisis).
- One TP in the cluster 'elderly' saw the subsidiary principle as an added value: psychotherapy will fit in the general care at home and helps to reduce the taboo of specialised services. In this way, mental health care becomes more accessible for aged persons.

### 12.2.5 Added value of meetings

When interviewees introduced the added value of meetings, they seldom differentiated between patient meetings and partnership meetings. The reflections on meetings were, most of the time, rather 'general'. Implicitly, we noticed however that most of the added value is lived through the experiences with patient meetings.

First of all, the mere fact that partners meet each other during meetings is considered useful. Moreover, the fact that professionals of different backgrounds sit together, leads to more in depth analyses and discussions on patient-related topics. It also forms a basis for future and ongoing personal contact.

The meetings themselves seem to support the care providers in defining patient care. Partners can share expertise on topics. Care providers can talk and ventilate their experiences with patients and their situations. Responsibilities in the care of patients are collectively defined, and care offered by every partner is tuned to each other. Moreover, people and facilities learn about the respective activities of partners and the support they can offer (which is often unknown). Moreover, people learn to know whom they may contact directly for particular issues (instead of a more anonymous secretary).

Some projects made very specific remarks on the added value of meetings:

- A first patient meeting is seen as a necessary condition or, at least, an important moment to establish informal collaboration afterwards.
- Sometimes, patients try to set up care providers against each other or try to manipulate them. Patient meetings enable to cross-check information about this and thus avoid internal problems in teams
- Meetings help to find solutions for difficulties in the patient-provider relationship.
- The partners and individual professionals develop more insight in the medical shopping behaviour of some patients (e.g. getting medication prescriptions) and delineate responsibilities of partners.
- One project noticed that coordinating meetings for adolescents with addiction are new as such.
- One project mentioned that the direct involvement of some particular services (e.g. PMSSD (CPAS)) is new in the care of psychiatric patients.

Some TPs referred to the added value of the inclusion meeting:

- The inclusion meeting has an added value if it is not clear for the coordinator whether the patient can be included in the TP or not.
- The meeting saves time for the project coordinator, because it is possible to immediately check which services have to be involved. The coordinator does not have to call every individual service afterwards to organise the care for the patient.

The perceived added value of the meetings goes beyond mere instrumental aspects. References were also made to the development of trust and feelings of reassurance:

- The partners feel and know they can rely on each other if there is this need. A 'feeling' of continuity of collaboration is created, even in problematic situations.
- For the primary care services, the added value could be that they can continue taking care or treating the patient because the TP enables the possibility of qualified support. The TP-model allows that primary care professionals have better contacts for coordinating the care for a particular patient.

## 12.2.6 Added value for patients

Some projects have made some general comments in the perceived added value for patients or noticed that the patients themselves have positive experiences with the project. Again, we quote the impressions from the interviewees.

- Some projects experienced that the situation of the patient often improves and some of them say (very cautiously) that the hospital length of stay seems to reduce, as compared to previous situations.

- One TP in the cluster elderly sees that the project enhances the ability of the patient to manage himself and thus become more independent, e.g. the patient takes the decision to go to an activity centre.
- A project in the cluster 'children' says that some patients improve and come to certain insights, which has a positive influence on their self-confidence.
- One project quotes that the patient has better access to the services he needs and is not confronted with closed doors.
- One project noticed, that the three-monthly meetings lead to a more regular evaluation of the needs of the patient, avoids going too fast and missing important information.
- The patient needs are better detected.
  - As a result, one project has developed new initiatives of care, besides the TP-framework, because awareness developed about particular needs.
- One project noticed that the partners develop a better understanding of the patient's pathology, thus avoiding unrealistic demands, e.g. the partners become more conscious of the side effects of medication.
- One project noticed that the inclusion meeting avoids a situation where a patient needs to have several intake interviews in different services to find adequate care.
- Some projects noticed that the patients themselves feel more supported and taken seriously as several care providers are involved, and that the patients themselves can become more involved in their care.
- One project noticed that the patient has the feeling that the TP helps to keep him away from psychiatry.

But many projects remarked it is too early to develop impressions on positive outcomes or experiences in the care of the patients:

- One project in the cluster 'forensic' explained that forensic patients seldom give positive feedback in a forced context and that satisfaction of the patient is a relative issue. This situation makes it difficult to assess the added value for the patients. The care professionals will always give more positive feedback than the patients.
- One TP even explicitly mentioned that, even if a TP has an added value for the partners, it is still possible that the patients will not function better.

- **In general terms, the TP-government framework is seen as potentially creating an added value.**
- **The possibility to fund a coordination function is well appreciated.**
- **The framework obliges cooperation with partners initially not thought about, in particular general primary care services.**
- **The collaboration with different (subsidiary) services is perceived as useful.**
- **The TP-framework obliges to reflect on patient participation.**
- **The formal collaboration is a means for informal networking, and finding support between professionals and services.**
- **The formal TP-framework facilitates to detect the needs of the patient.**

## 12.3 THE INCLUSION PROCESS OF NEW PATIENTS

During the interviews, many indications are found that TPs are seeking ways to optimise the inclusion strategy and the organisation of inclusion meetings, based on their initial experiences.

### 12.3.1 Selecting patients for the TP

Many projects include already known patients from their day-to-day practices and not new patients to the initial referent (e.g. because of regular hospitalizations).

Some projects have experienced problems to motivate the patients to be included in the project and to get their informed consent. The projects experienced mainly problems with regard to the inclusion of:

- Patients avoiding care, and more particularly because of problems of finding this group and get them in a care provision.
- Aged persons at home and for whom there is still a taboo for asking help in a mental health care setting, while professionals perceive a real need for these persons.
- One project mentions that a lot of the psychotic or schizophrenic patients have refused to be included in the project, because of their reaction inherent to their pathology, to the informed consent procedure.

Some projects struggle with situations in which the patient refuses to be included, but in which the professionals consider an inclusion as necessary. The TP is then confronted with the dilemma of (a) respecting the autonomy of the patient and leaving the choice for seeking help entirely to the patient or (b) a (more) paternalistic or preventive attitude, where the responsibility to take care of the patient is taken, independent of what the patient wants. Some projects recommend interfering, while others prefer to respect the choice and responsibility of the patient.

- One of these projects collaborates with another project where informed consent by the patient is not required and one patient has been referred to this project.

A few projects mentioned that patients were included outside the predefined target population of the project (eg. light ADHD (in stead of severe) but occurring in combination with autism; a psychiatric disorder together with mental retardation or addiction; patients in a dead end situation avoiding care rather than a severe complex psychiatric disorder)

If projects aim at a broader range of psychiatric disorders, it is often experienced that one psychiatric disorder is overrepresented in the inclusions:

- More patients with borderline disorders than developmental disorders.
- Less patients with psychosis or schizophrenia than personality disorders.
- More patients with anorexia than bulimia.

Sometimes, projects are confronted with very particular questions or problems:

- One project wondered what to do with patients who do not speak French or Dutch.
- One project had many proposals for inclusion, but patients disappeared or were difficult to keep in a care provision pathway (they ran away, disappeared...).

Sometimes, patients were considered (often including preparatory work) for inclusion but were ultimately not included or have been excluded after a while. Several reasons for not including or excluding patients were mentioned:

- Death of the patient
- The patient found another solution outside the TP.
- The patient moved to another region outside the catchment area.

- The patient was included in another TP.
- After initial assessment, it was judged that another TP was more appropriate (i.c. referrals were made to TP dealing with mental handicap; or to 'forensic' TP).
- The patient does not have a clear diagnosis.
- An improvement of the situation of the patient.
- The need of the patient was not appropriate for the activities of the TP, e.g. the patient only needed more home support, but no need to coordinate different services. In one case, a patient was refused as it was considered that work was being substituted from other regular care providers (i.c. PMSSD (OCMW)).
- The patient or the parents of the patient do not want to participate in the project anymore.
- The patient has moved to a residential setting coordinating all the necessary care.
- A patient in the project for children and adolescents has become 'an adult'.
- Patients were not included as too much time elapsed between the proposal of the patient and the organisation of the inclusion meeting.

It has to be mentioned though that most of the projects did not report extensively on not-including patients.

- One project considered it as difficult to refuse a patient not meeting the inclusion criteria, (i.c. the diagnosis of a personality disorder) while his needs were clear. This project decided to include the patient anyway.

Some comments were formulated on the diagnostic inclusion criteria in a project working with children:

- The use of the DSM-IV is perceived as too medical and emphasizing the medical diagnosis. The dysfunction of the child is broader and requires the intervention of several types of professionals.

Some projects have included many patients at the end of the first working year of the project. Some of them noticed that these patients are in actually not the patients with the chronic and complex psychiatric disorder, for whom the project has been created.

### 12.3.2 Informed consent

A few projects have experienced specific problems with regard to the informed consent.

- One project experienced that obtaining an informed consent both by patient and by family is not always possible. Therefore, it was decided to still consider persons for inclusion, even if the informed consent was only obtained from one person.

Some concerns have been expressed with regards to the status and value of the given informed consent:

- The target population of some projects (i.c. patients with a mental handicap) will never refuse questions of care providers.
- A TP in a particular catchment area is in a position of coordinating a partners being the only to provide care (i.c. addicted patients with a psychiatric disorder), patients have little real opportunity to refuse informed consent for obtaining this care.
- Some psychiatric patients give their informed consent for the wrong motivation (e.g. some patients think they will obtain a quicker discharge from the hospital, but do cooperate less or not at all once they stay at home). Comparable remarks were also made on the informed consent, given by the family, e.g. they consider the TP as the least bad choice (e.g. a TP instead of

an enrolment in an institution), rather than really agree with the approach of the TP.

A few projects in the cluster 'children and adolescents' mentioned problems with regard to the informed consent of the family, mainly because the family experienced it as an intrusion.

### 12.3.3 Partners proposing new patients for inclusion

Generally, the partners who are proposing the most patients for inclusion are formal partners in the project, often the ones who initiated the proposal.

- Only in a few projects (e.g. in the cluster 'forensic'), informal partners proposed most patients, e.g. prisons, services related to justice, social services..
- In one project working with patients with a mental handicap, the ambulatory services proposed most patients, although a hospital has initiated the project. The reason mentioned is that the ambulatory services need to involve other services, while in the residential settings these services are automatically provided.

In some projects, mainly residential services propose new patients. In other projects, the primary care services are the most active partners in proposing new patients.

In only a few Flemish projects, the CMHS proposed many patients. A few projects mentioned that these services are in general not familiar with the target population of the TP. In the French-speaking projects, the CMHS are more active partners to propose new patients. The CMHS are often cited being reluctant for proposing patients. In general, it is noticed that the psychotherapists have difficulties to explain the project to the patient, due to their individual relation with the patient, which focus on the emotional and the psychological perception. Their individual therapeutic relationship with the patient differs from the network approach of the project. Therapists and patients are afraid that their relationship may be endangered, as well as that inclusion in a network reinforces a 'label' on the patient (e.g. addiction) which may be experienced as stigmatisation.

Sometimes a shift in the partners is observed, thus resulting in the proposition of new inclusions:

- In one project, a specific unit of a hospital has a priority Position in proposing inclusions. As a consequence other partners were very reluctant to propose new patients in the first year. Gradually some changes in attitude occurred.
- In another project, initially three contact persons proposed the most patients, but after a while other partners got more engaged in proposing patients too.

In most projects, the number of proposals is often unequally shared between a small number of core partners, while other formal partners did not propose any patient for inclusion and/or observe a lack of commitment of partners. Several reasons are mentioned to explain the reluctant attitude of some partners:

- Partners fear additional work, mainly because of the perceived and expected work within the administrative obligations of the NIHDI-contract. Although, some French-speaking projects mention that after a first experience with inclusion, partners admit that the administrative work is not that important.
- Although partners show a real interest for the project, some of them fear a loss of autonomy in their approach (e.g. CMHS (CSSM)) (see also infra).
- Partners do not propose patients because it is a new initiative; however some projects expect that after a while, partners would be more inclined to propose patients.

A number of projects mentioned that the formal and informal partners have to be activated to propose patients for inclusion. A lot of projects focus on the need to inform and promote the TP.

In some projects, the managers signed the TP contract but the care providers lack information on the purpose, workload and content of the TP. In some projects a lot of explanations had to be given and partners had to be convinced on the involvement of social, educational or legal services. It took a lot of time to communicate about the inclusion criteria used to be able to identify the target population.

Some projects experience particular difficulties to get proposals from the primary care services. Interviewees refer to a mental barrier in these services and time constraints for promoting the project more actively in primary care:

- Some interviewees refer to the fact that the ISHC is an 'umbrella organisation' of different types of services, which is not always a facilitator to realise direct contact with primary care professionals of all of these services.
- Some projects observe a certain distance because of a false estimation on the anticipated workload and the administrative requirements. Primary care services think it is their task to make a preselection of eligible patients to include, while the TP itself sees this as a task of the coordinator.
- People from regular home care do not feel able to identify the target population of the project and they do not have any psychiatrist to do the diagnosis.
- The primary care services are used to organize the care themselves, outside the TP framework.
- The general practitioners will first look for other solutions than proposing patients for inclusion in a mental health care project (and often refer too late to the project), they consider the patient as 'their' patient.
- Some general practitioners withhold to propose new patients because ambulatory services, i.e. CMHS (CGG), do not succeed in really supporting the primary care services (e.g. outreach at home).

In contrast to these problems, a few projects experienced problems to include patients, proposed by the primary care services:

- it lacks a psychiatric diagnosis.
- Patients with a comorbidity of a psychiatric disorder and addiction: addiction was initially an exclusion criterion as the project has not expertise with this population. The patients were included anyway.

### 12.3.4 Inclusion meetings

The reflections on inclusion meetings were diverse and ranged from very punctual issues to more general ones.

A few projects wondered about the usefulness of the inclusion meeting in those cases when the preparatory work already clarifies whether a patient should be included or not.

#### 12.3.4.1 *Participants*

A number of projects experience difficulties realising the necessary participation of each formal partner at the inclusion meeting.. Many partners have to be activated and motivated to participate in the meeting. Moreover, within the TPs, the administrative requirements are perceived as conflicting with the experienced need of the participation of all the partners at the meeting..

Projects report that representation of formal partners is not always guaranteed:

- The professionals cannot be easily replaced in their own service, because of a shortage in staff.
- The project has many formal partners.
- Some organisations refused to participate when the inclusion meeting was organised too often (e.g. every three weeks).

We have indications that more problems occur in those projects organising separate inclusion meetings. If the inclusion meeting is combined with the steering committee meeting, it seems that projects experience fewer problems realising the obliged participation of all formal partners.

Even if not all the formal partners participated at inclusion meetings, some projects collected Signatures afterwards (by e-mail or personal contact). to obtain the funding anyway

- In one project, only the partners involved in the patient care participate in the inclusion meetings, and other signatures are collected afterwards.
- In other projects, the patient's enrolment in the project is entirely realised by e-mail.

#### 12.3.4.2 *Number of inclusion meetings*

A few projects mentioned that the number of inclusion meetings has increased, mainly to realise the preset caseload of 30 patients in summer 2008.

- One project, combining the inclusion meeting with the follow- up of other patients, experienced a need to increase the frequency of the inclusion meetings, i.c every month instead of every three months.

Other projects decreased the frequency, after an initial start up phase. In most of these projects, the inclusion meeting is integrated into the steering committee meeting. E.g. one project now organises an inclusion meeting, every month instead of every two weeks, because it was initially necessary to have a lot of meetings about the functioning of the project, but this need decreased after the onset of the project.

A few projects have changed particular aspects of the inclusion meeting:

- While initially a project chose to organise an inclusion meeting when five patients could be proposed, the project had to change this initial approach because it took too long to organise an inclusion meeting (at the time of the interview, the project, had only a caseload of three patients).
- While, initially in one project , the family could participate in the inclusion meeting, it was decided after a while to only meet the patient, because it took too much time to arrange attendance of the family.

- **A number of projects experience problems in realising the necessary participation of each formal partner at the inclusion meeting. There are indications that more problems occur in projects organising separate inclusion meetings.**
- **A number of projects mentioned that formal and informal partners needed to be activated to propose patients for inclusion.**
- **A few projects have changed elements of the inclusion meetings' organisation.**
- **A number of projects have experienced problems with the informed consent for including patients.**

## 12.4 EXPERIENCES WITH PATIENT MEETINGS

Some projects made some general remarks on their experiences with regard to the participation of the partners. Some of these experiences and problems were already mentioned in previous sections.

There appears to be some confusion on the conditions defined by the government's programme on the partners or professionals required to participate in the meetings for obtaining funding.

Some particular experiences were also mentioned with regard to their participation to the patient meetings.

- TPs experience that partners have less problems to share information about the patient, in contrast to the situation before the onset of the TP.

- One project in the cluster 'forensic' experienced that the partners are more open to take care of the patients than in previous situations.
- Some projects mentioned that the partners are motivated and take their responsibilities in the care of the patient. One project explicitly made a distinction between the engagement of the formal and the informal partners, whereas the experiences with their formal partners were positive. Another project noticed that the partners who have included the patient during the inclusion meeting are interested in the follow-up of the patient and ask information about his situation. Another project experienced a similar motivation, but did not want to express on the continuity and durability of this motivation.
- One project noticed that the participation of the PMSSD (OCMW) is not always the same. Sometimes, they do not want a meeting organised in their buildings or they want it to be financed, while other times, they want to participate in the meetings.
- One project noticed that the partners do participate in the project; but more because of political reasons than because of intrinsic interest in the objectives of the project.

#### 12.4.1 Participants

Guaranteeing participation of partners (professionals) in follow-up meetings is considered by many projects to be a difficult issue. Several reasons are mentioned for these difficulties in partner participation in follow-up meetings or their reluctant attitude to be involved in the care of the patient:

- Professionals do not always perceive a need for a meeting, because the situation of the patient is judged as stable.
- One project noticed that it is more difficult to organise patient meetings when parents proposed to include a patient living at home. In this situation, the coordinator is hampered to contact the parents for organising the meeting because they are not at home, or have lost their interest in organising a meeting. Contacting and convincing partners they know, is experienced as easier.
- In some French-speaking projects, reference is made to the geographic distance for meetings.
- Partners do not consider it useful to be included in a discussion:
  - The primary care services do not see the need to participate in meetings for prisoners that will only be freed within four or five years.
  - It is considered difficult to involve psychiatric hospital services for patients that were discharged since a longer time (with the argument that their expertise is considered useful). Especially for projects in the cluster 'adolescents', a longer lasting involvement of the residential services is experienced as difficult for patients that have been discharged
  - The specialised ambulatory and residential services are often not considering the follow-up meeting as useful because they consider that everything necessary about the follow-up has been discussed in an initial meeting.
  - Although professionals (i.c. consultant of protective youth services (BJB)) could give clear advice on the management of the patient, external conditions (such as waiting lists), impede immediate action, and thus also restrict the motivation of that partner to participate in the meeting.
  - In one TP, many addicted patients do not even consult a general practitioner; they function with crisis mental health services.
- Most TPs experience difficulties to motivate psychiatrists to participate in a follow-up meeting.

- In a couple of French-speaking TPs, psychiatrists are reported to be sceptic towards the TP- approach, as well as to have difficulties with the formal rules of the TP-programme.
- The financial compensation is not sufficient to motivate psychiatrists.
- Many partners complain about the time investment for patient meetings, i.e. the time for the meeting and travelling.
  - The distance to be covered, which is on average greater in rural regions.
  - Especially obliged participation in meetings about patients that are not treated within that hospital service is often considered as unneeded time investment.
- In some projects, individual partners have to be involved in many (patient) meetings especially if the TP has a small number of formal partners.
  - Small organisations with limited staff have more difficulties in attending patient meetings as these interfere with regular duties that cannot easily be transferred to colleagues.
  - Primary care services often report a high workload related to direct patient treatment, leaving limited time for meetings.
- Some TPs reported that psychotherapists do not generally participate as their professional approach (philosophy) conflicts with the approach, proposed in the TP.

A few projects mentioned some consequences of non-participation of partners. Particular remarks were made on the efficiency of the meetings too, at the point that even the relevance of the meetings in particular circumstances was questioned:

- The primary care services (or other services) feel sometimes left alone without the coaching and continued valuable feedback of the ambulatory and residential services.
- A few projects in the cluster 'children' state that patient meetings are not (or less) useful if a required partner is not represented (i.e. consultant of protective youth service), in the case in which the partner has decisional rights and does not agree with the care plan, proposed by other partners.
- Questions rise on the decisional power of the professional, representing a partner (especially when no medical doctor participates in the meeting or the patient is not being treated by that hospital), e.g. in a crisis situation where the patient has to be hospitalised. Intended decisions have to be discussed then with the medical supervisor in the hospital. This extra follow-up is time consuming, and can delay the care, needed for the particular patient.

In many projects, the participation of the general practitioner was an issue. Their participation seems to depend on different factors:

- Their motivations, as some of them do not believe in the relevance of meetings. An administrative coordinator mentioned similar experiences with meetings organised in the framework of ISHC activities (GDT).
- The general practitioner is more motivated if he works in a group practice or is member of the association of the general practitioners.
- Their participation depends on the living situation of the patient. Problems with the participation of the general practitioner are mainly experienced if an adolescent stays in a residential setting. for a long time
- The financing can be an aid to motivate general practitioners to participate at the meetings.

A few projects experienced that general practitioners are motivated and engaged because they know they will only be invited if their participation is needed or because they experience problems with that patient.

- One project noticed that the participation of the general practitioner has improved after the promotion of the project. Before this promotion, the general practitioners did not know they also could propose a new patient for inclusion in the project.

Many coordinators made efforts to organise patient meetings in a way convenient to the general practitioner. Measures were taken to meet at locations near to the general practice, adapting the moments of meetings (e.g. at lunchtime), accepting that the GP only participates for a limited time (15 or 30 minutes) or only at the first patient meeting and/or reports are sending afterwards or having contact by phone; e.g. Luxembourg).

#### 12.4.2 Content

Projects experienced that the content, the way of discussing and the practical organisation of patient meetings is strongly influenced by the participants of the meeting.

- In a small number of projects, several cases of patients are discussed during a 'patient meeting' if the same partners are involved in the care of different patients.

#### 12.4.3 Duration of the meeting

Some projects mentioned that meetings on individual patients last approximately one hour.

- One project mentioned that the duration of a meeting depends on the situation of the patient and the participants of the meeting. Sometimes, time is needed to ventilate frustrations; sometimes, there is only a brief overview of what has happened since the last meeting. The time can range from 1 hour to 2 hours.

#### 12.4.4 Number of patient meetings

The organisation of patient meetings differs between projects. Some projects organise 'collective' patient meetings in which different cases of patients are discussed sequentially during the meeting. Other projects organise separate meetings for each individual patient.

As mentioned before, the NIHDI-contract requires four patient meetings during the first year of the project. It is however interesting to observe that the number of the patient meetings seems to differ between the projects anyway:

- A few projects explicitly mentioned that sometimes patient meetings for a particular patient are organised more than once a trimester, as they encounter a clinical necessity (e.g. a crisis situation).
- One project experiences that more patient meetings were organised at the start of the care process of the patient than later on.
- In contrast, other projects experience difficulties to organise a meeting every three months.

Some projects were unable to organise the intended patient meetings, because they could not mobilise the professionals.

#### 12.4.5 Location of meetings

Only a few projects organised a patient meeting at a fixed location, i.e. the coordinating centre. Other projects organise the meetings at different locations:

- One project deliberately changes the location of the meetings within the partnership, so that partners can become acquainted with the infrastructure and functioning of every partner.
- Another project has not a fixed location, because it is considered obvious that the coordinator is the 'flying pilot', as he is paid for it.

Most of the projects mentioned that the location of the patient meeting often depends on the situation of the patient and/or the partners:

- A few projects mentioned that the location of the meeting depends on the general practitioner.
- In one TP, the meeting takes always place at patient's home. In some other projects, this happens sometimes.

- **The organisation of patient meetings differs between projects.**
- **The content, the way of discussing and the practical organisation of patient meetings is strongly influenced by the participants of the meeting.**
- **Guaranteeing participation of partners (professionals) in follow-up meetings is considered to be a difficult issue by many projects.**
- **In many projects, the participation of the general practitioner was an issue. Many coordinators made efforts to organise patient meetings in a way convenient to the general practitioner.**
- **TPs experience difficulties to motivate psychiatrists to participate in a follow-up meeting.**
- **Follow-up meetings on individual patients last approximately one hour (a range between 1 and 2 hours).**

## 12.5 EXPERIENCES WITH THE STEERING COMMITTEE MEETING

Very little information on the functioning of the steering committee meeting was collected at this stage yet:

- As mentioned before, some general remarks are made on the participation of the partners. Projects did have less problems with the participation of the partners in the steering committee meeting, as opposed to their participation in the patient meetings..
- A few projects have mentioned that the number of the steering committee meetings has changed during the implementation of the project. In general, the frequency of these meetings has decreased, e.g. initially every two weeks, but every month later on. .
- One TP experiences that the care providers are less interested in the discussion of management issues than the managers themselves.

## 12.6 PATIENT PARTICIPATION

In general terms, projects have different experiences with patients' participation in the TP. Patient participation is not an easy process. Remarks were made that the meetings are stressful events for the patient. But projects struggle with the way on how to incorporate patient participation in their approach.

- Some projects experience that patients are intrinsically motivated to participate in the meetings. Moreover, patients experience it as important to see all the involved partners together and to explain their situation.
- Patients seem to agree most of the times with the propositions, made during the patient meetings.
  - One TP developed a satisfaction questionnaire about the meetings to be used by the patients,. In general the comments were positive. However, patients do not like the fact that elaborate information is given about their situation. Therefore, the TP has limited the information, given during the meetings.
- A good preparation of the meeting with the patient is important because participating in a meeting is a stressful event for him.
- A few projects noticed that the psychiatric disorder of the patient has an influence on the choice of the professionals for a more structured versus a supportive approach during the meeting.

- Based on some (negative) experiences during patient meetings, some TPs decided that the patient can only participate in a meeting if it is a clear advantage to the patient to hear something from the professionals.

Interviewees often remarked that another discourse takes place when the patient participates in the meeting. However, professionals are not familiar to discuss about the care and the disorder of the patient and to express their experiences, in the presence of the patient. It is a learning process for the professionals too:

- One TP explicitly mentioned that the partners of the TP were, at the beginning, a little retained with regard to the participation of the patient. After initial experiences, some partners learned that the participation of the patient makes them more aware of the needs of the patient. However, other partners have not changed their opinion.
- Some TPs decided that the patient only participates in a part of the meeting, to enable the professionals to discuss issues without the presence of the patient.

In a small number of projects, it is decided during the inclusion meeting whether the patient can participate in the patient meeting or not.

- In one of these projects, only half of the included patients participate in the meeting. Priority was given to learn to work together between partners. Participation of the patient in the meeting was not considered as a primary aim.

In the projects in which the patient can participate, the patient is present most of the time. But a number of projects have experienced some problems too:

- Sometimes, the patient does not want to participate.
- Sometimes the professionals want to ventilate about the experiences with the patient and do not want that the patient participates in the meeting.
- One project noticed that the patient often expects that the meeting will be a therapeutic session rather than a meeting on the support offered.
  - In a few projects in the cluster 'children and adolescents', parents with psychiatric problems themselves want to talk about their proper problems, instead of the care for the child.

- **Projects have different experiences with patient participation in patient meetings.**

## 12.7

### **EXPERIENCES WITH FAMILY PARTICIPATION AND PATIENT AND FAMILY ORGANISATIONS**

Only a few projects have briefly discussed their experiences with the family participation in meetings. Most of the interviewed patients have no experience with the issue. Some projects resist to the participation of these organisations to patient meetings mainly because of reasons of privacy and professional secrecy.

Some projects seek practical ways to include the 'family and patient organisation' in meetings. It can be noticed that they are often sceptical and question whether the 'family and patient organisations' can add relevant information. Particularly their participation in patient meeting is often put into question. Moreover, one project noticed that this organisation struggles with the use of specific jargon and lack the necessary communication skills.

- One project experienced that participation of the 'family and patient organisations' at the steering committee meeting was not so relevant for the organisation itself. The participation at patient meetings could potentially be more useful for this organisation.

## 12.8 CHANGES IN THE PLAN OF TP

Some projects explicitly mentioned that they changed aspects or that they are preparing changes on the original project proposal. Only a limited number of projects have explicitly mentioned not having changed the initial plan of the proposal.

### 12.8.1 Coordination issues

Some projects introduced changes with regard to the coordination:

- In one project, it was foreseen that only the CMHS (CGG) would coordinate patient-related activities. After implementation of the project, a residential setting became also responsible for the coordination of patient related activities.

Two projects experienced the need to install support meetings:

- One project organises meetings with the care providers. They experienced the need to get feedback and reflect about the functioning of the TP with professionals rather than with a group of managers, representing the partners in the steering group.
- In another project, a specific working group, in which the initiators of the project participate, was created to prepare documents and discussion items for the steering committee meeting.

A very limited number of TPs considered a change of the catchment area.

- One TP wants to make their area smaller, i.c. one province instead of two). Another project feels limited as they only focus on one city.

### 12.8.2 Inclusion issues

A few projects consider that more partners can propose new patients for inclusion. Initially, some projects limited the partners who can propose new patients, because they thought to be overwhelmed by proposals.

A few projects have changed their criteria to include a patient in their TP:

- One TP initially set as a criterion that the patient should have contact with any care service. After the initial experiences, a contact with a general practitioner is sufficient. Moreover, because of this change, anyone involved can propose patients, even those who are not formal partners of their TP.
- Another TP has changed two criteria i.c. the need for a diagnosis and the place of living of the patient. Initially, a formal diagnosis of a psychiatric disorder was expected. Currently a general indication in a case description that the patient has a psychiatric disorder is sufficient. While initially the patient had to live at home without having had any contact with psychiatry, patients may now have had contact with a geriatrician or stay at the hospital, be it that a discharge of the patient is expected soon.

Some projects have considered broadening age criteria, mainly to get more inclusions:

- One project has considered using age criteria ranging from 0 till 10 years old instead of 0 till 7 years to get more inclusions from the ambulatory services.
- One project has adapted the age range from 35 till 50 years to 25 till 50 years.
- One project considered rising the age criterion up to 25 years instead of 18 years, as other projects in the cluster 'addiction'. However, one partner of the project, i.c. a hospital, did not want to change the criteria.

### 12.8.3 Number of partners

A few projects have included more formal partners from different sectors. Some reasons were mentioned:

- One project included the association of general practitioners, as general practitioners are the first persons who are in contact with the target population.
- One project included a protective youth service because of their experience with situations of problematic parenting or problematic behaviour of children and adolescents.
- A 'drug intervention centre' because this centre accepts occasionally persons of 17 years old.
- The only outpatients' clinic in the catchment area of the project.

Some projects consider an increase in the number of formal partners in the future:

- The involvement of a home nursing organisation looks interesting for one project to follow-up medication at home after discharge from a hospital.
- An employment agency (FOREM) was requested to become involved, because they are often confronted with addicted unemployed persons and want to refer these persons to care services.
- Initially, school services, schools and protective youth services were not involved as formal partners because of the NIHDI-contract, but they are needed. The project remarks that the list of obligatory partners in the TP-contract is not adapted to the specific psychiatric problems of children and adolescents.
- One project is considering a new formal partner offering specialist services outside the province, as financing these partners is recently become possible. The project is hesitating however, as they fear to increase the complexity and the complications for managing the TP.

Some other projects did not consider increasing the number of the formal partners, because it would complicate the management of the project.

In a few projects, some formal partners have withdrawn as formal partners, generally because they did not experience any added value of the project, or because of a duplication of ongoing work.

- **Some projects changed aspects or prepare changes in the initial project plan. Only a limited number of TPs explicitly mentioned not having changed the initial plan of the proposal.**
- **In a few projects, some formal partners have withdrawn as formal partners, generally because they did not experience any added value of the project, or because of a duplication of ongoing work**

## 12.9 THE PROJECT COORDINATOR

### 12.9.1 Human resources issues

Temporary operational problems are experienced in case of a resignation of the coordinator and personnel changes.

- These personnel changes caused a temporary inactivity in the TP during several weeks, especially for those partnerships without a history of collaboration. These projects seem to rely heavily on the role of the coordinator, as the person who needs to develop and guarantee the dynamics of the project.

Some coordinators experienced problems combining two halftime functions for fulfilling the tasks of a coordinator. One coordinator who combines two functions experienced difficulties because of role conflict, influencing his role as coordinator of the TP.

## 12.9.2 The role of the coordinator

Many projects experience that partners of TPs may have high expectations of the coordinator:

- Partners expect coordinators to be able to work towards a consensus between participants both on treatment goals and actions, even when conflicts or different opinions are in operation. Coordinators are expected to be mediators and problem-solvers both for partners and individual professionals, as well as for patients and family. Moreover, many partners expect the coordinator to perform all the necessary support work with regard to the patient meetings.

Some coordinators report that at the onset of the TP, coordinators were often seen as representatives of the organisation in which they are embedded or an organisation for which they worked previously, rather than a 'neutral line-independent' person, coordinating the TP for all partners.

- This was reported in cases where the coordinator was familiar with the patient in his function as a clinician.
- In a number of projects, the coordinator had to take up a double role (coordinator and representing an organisation), in order to fulfil the formal rules on the presence of three formal partners to obtain financing.

The role of an independent 'external' coordinator for organising patient meetings is new for many partners and professionals. Generally, a period is needed to delineate roles and to mutually adapt to expectations.

A number of French-speaking TPs remark that the coordinator has only limited authority during patient meetings, because professionals act more as members of (different) autonomous organisations than as part of one TP team.

Sometimes patients too perceive the coordinator more as a professional care giver than as a neutral or independent person.

- Some projects report this may be induced by the role and attitude of the coordinator during the patient meetings. Some coordinators report that they are actively chairing the meeting with professionals when there is a lack of clinical expertise amongst the persons present in the meeting (e.g. primary care services), rather than being a neutral observer
- Some interviewees experience difficulties to find the optimal balance of direct contact with the patient and keeping a certain distance.

## 12.9.3 Individual patient coordinator role

Some projects experienced particular problems with the individual patient coordinators roles and obligations:

- Some projects report difficulties in optimising the communication between patients and the TP. The communication with the patient is often done by other persons than the individual patient coordinator which makes it sometimes difficult to trace back what has been discussed or not.

A few projects introduced some problems related to the persons doing the individual patient coordination:

- In one project, normally the person who has proposed the patient becomes the individual patient coordinator. However, sometimes, this person refuses to take up this role. In that case, someone else is designated taking into account the expected care needs in the pathway of that particular patient.
- One project noticed that volunteers more than professionals, will take the role of individual patient coordinator, because professionals lack time.
- One coordinator, combining project and individual patient coordination, experienced the combination as very difficult, but he was obliged to combine both roles anyway.

- One project mentioned a potential conflict of interest between protecting the patient interest and the interests or visions of the professionals. E.g. if the patient coordinator knows details about the patient which could be useful and relevant, but the patient himself does not mention these issues, it is perceived difficult to choose what to bring in the meeting and what not to.

#### 12.9.4 Financing of the coordinator

A lot of the projects experience the public financing for a qualified coordinator as a shortcoming. Many projects experience that a good coordinator needs at least some professional experience. Within the financing framework, it is not possible to recruit a person with more than seven years experience or persons with an academic level.

- Some TPs preferred to recruit a coordinator with the competencies considered as needed. Some reduce the working-hours for coordination activities, others provide additional funding, which often is provided by the organisation in which the coordinator is embedded.

#### 12.9.5 Workload of the coordinator

Most TPs indicate that the workload of the coordinator for running the TP is larger than initially estimated. Some coordinators report to have a substantial amount of overwork at home.

- Some TPs notice that the administration of the project consumes a lot of time (especially for part-time coordinators). The time for administrative tasks is often at the expense of the time for the care of the patients and does not allow much extra work in the project, such as promotion activities or further reflection on the content of work (e.g. selection of coordination model, long-term aims). Even in projects with an administrative coordinator, it is noticed that the project coordinator still has a vast amount of administrative tasks, e.g. agenda and reports of the meetings, providing information...
- The administrative part is by most considered as the less pleasant part of the job. Especially coordinators with large clinical experience seem to have difficulties (both motivational and organisational) with performing administrative duties, and experience this part as tedious and laborious.
- A small number of projects explicitly remark that the project coordinators did not have the required qualifications or training for the administrative duties.
- One partner considered to stop because of the required administration within the NIHDI-contract, but to continue the project with a different funding format.

#### 12.9.6 Support for the coordinator

Most project coordinators indicate that they receive support from their supervisor or coordinators of other projects who prepared the proposal.

- In a few projects, the coordinator gets support during the meetings of the project or participates at two types of meetings, to get expertise of residential services.

However, some coordinators express a sense of loneliness, as all questions and (part of) responsibilities are addressed to them while they are not part of a team that can support or give feedback when in doubt.

Coordinators do not always know how to cope with tensions/difficulties during specific meetings (between partners, with the patient) or within the partnership. In this regard, participation to the 'transversal consultations' is useful to meet other coordinators and getting informed about working practices elsewhere.

As mentioned before, some TPs have provided additional administrative support for the coordinator. However, a number of projects experience problems in developing adequate support for the coordinators.

During the project, a number of project coordinators had to take up tasks (preparing meetings, follow-up of care plan, preparation of inclusion...) that initially were planned to be executed by some of the partners in the TP.

- Partners within a number of TPs are not eager to help in the organisation of meetings or chairing (and report writing) of patient meetings, as the time investment for participation to meetings is already considered as high.

One TP mentioned that a specific training for the coordinators of the project is needed in order to develop the competences required.

- **At the onset of the TP, coordinators were often seen as representatives of the organisation in which they are embedded or an organisation for which they worked for previously, rather than a 'neutral line-independent' person coordinating the TP for all partners.**
- **The role of an independent 'external' coordinator for organising patient meetings is new for many partners and professionals. Generally a period is needed to delineate roles and mutually adapt to expectations.**
- **In some projects the project coordinator has only limited authority during patient meetings, because professionals act more as members of (different) autonomous organisations, rather than part of one TP team.**
- **Most TPs indicate that the workload of the project coordinator for running the TP is larger than initially estimated.**
- **Some coordinators express a sense of loneliness. A number of projects experience problems in developing adequate support for the coordinators.**
- **A specific training for the project coordinators is needed in order to develop the competencies required.**

## 12.10 PROFESSIONAL SECRECY

Professional secrecy and confidentiality has been an issue discussed intensively in many TPs. In French speaking TPs this argument is often used as a reason why partners do not participate actively. The participation of professionals not submitted to a deontology or duty of professional confidentiality and secrecy in follow-up meetings is an issue in a lot of the TPs, (e.g. teachers).

- In some French-speaking TPs, interviewees reported that some health care professionals (psychiatrists) misuse the argument of medical secrecy to limit information exchange and their participation to the TP. According to the interviewed persons, the distinction between medical and professional secrecy should not hinder the participation of health care professionals in patient meetings.
- One project remarks that a similar problem arises for persons who coordinate patient meetings, without being personally involved in the TP (for example, persons from sickness funds or PMSSD (OCMW)).

This same argument is used in some projects to exclude patient and family organisations from patient meetings.

Some professionals even report that they consider themselves as inappropriate observers in patient meetings of other organisations.

However, many projects try to cope with the issue in a pragmatic way:

- Some projects try to assess the relevance of information provision for the care of the patient and adapt the information sharing to these needs (e.g. telling the patient is incontinent if nursing is needed more often).
- Some projects report that in all meetings it is repeated that all participants are held by a rule of duty of professional secrecy.
- Some projects explicitly ask the patient for a formal agreement for exchanging information during the patient meeting.

Many TPs state that neither the patient files nor reports of meetings hold personal information, not relevant for the care of the patient. Only few TPs sent anonymous reports to the direct involved health care professionals. Some projects report anonymously on patients presented for inclusion.

- **Professional secrecy is an intensively discussed issue in many TPs.**
- **The participation of professionals not submitted to a deontology or duty of professional confidentiality is a barrier in some TPs.**

## 12.11 THE FORMAL PARTNERSHIP

Many interviewees reported that maintaining the partnership has proven to be a difficult task. The difficulties are various.

### 12.11.1 Maintaining the formal partnership

Some formal partners have threatened to quit the project (but they eventually continued participating).

- General practitioner associations resigned for different reasons, including the imposed patient monitoring (part of the evaluation research), but also because of a disagreement on the relevance of the TP.
- In one TP, a general practitioner association quitted but could be replaced by a first line organisation to ensure the three obligatory types of partners (first line, second and hospitals). Nevertheless, some individual general practitioners continue to participate in follow-up meetings.

Some partners prefer to collaborate as informal partners as this role releases them of the administrative constraints of the NIHDI-contract (e.g. inclusion meetings). The most often cited reason is the obliged presence to the regular follow-up meetings, which is experienced as too constraining.

Some partners have refused to further participate as formal partners because of distance and time issues or because they had no patients to propose for inclusion.

### 12.11.2 Actively involving partners

Besides the problem of maintaining the formal partnership, many projects experience problems in activating individual partners. We already addressed this issue in previous paragraphs. But many other remarks were made.

Some projects experience problems in actively involving 'home care coordinators' and 'consultation coordinators' of Sickness funds or PMSSD (OCMW) because:

- Their role is often limited to organise a patient meeting, without getting involved in content issues.
- The 'home care coordinators' experience already a work overload within regular tasks in the PMSSD. While it were the managers of PMSSD who signed the TPs, the care professionals are confronted with the additional work of the TP.
- These persons are not financed for their work in the project.
- The local autonomy of the PMSSD impedes to organise meetings or to align them in a common approach. Different PMSSD have different attitudes toward the objectives and working practices of the TP.
- Some projects mention that the 'home care coordinator' experienced the TP as a threat, because similar meetings were already organised within the pilot projects PHC.

To solve this problem, one interviewee suggested installing a temporary tandem of the coordinator of the TP and the 'home care coordinator' during an initial phase of the project. In the long run the 'home care coordinator' could take up the activities oneself.

Some projects mentioned that the expectations of some partners (formal and informal) towards the TP are too ambitious to realise:

- Some partners expected the project to solve all problems of 'difficult' patients (for which institutions experience problems).
- One project (meanwhile resigned) could not realise intended care. Partners expected a sharing of expertise by means of 'outreaching' or psychiatric home care for elderly but were not able to realise it.

### 12.11.3 Lack of knowledge about the TP within partner organisations

In the previous parts, the need to promote and inform partners and professionals about the nature and intentions of the TP was already mentioned.

Many TP experience a lack of knowledge on aims and functioning of the TP on the level of individual professionals of formal partner organisations.

- Information was not always sufficiently transferred from the managers, who signed the contract, towards individual staff members or professionals.
- Some TP's reported that health care professionals felt obliged to participate to the TP because their management signed the contract. But these professionals do not always experience the need for (regular) inter-organisational patient meetings. Even more, they (in the French-speaking projects, often psychiatrists are mentioned) do not necessarily agree with the (working) principles of the TP
- Individual professionals may be more focused on and interested in individual care provision than collaboration with other agencies.
- The interference of other (pilot) projects launched in the past increases the need to clarify the specific purposes and rules of the TP.
- Some TPs report that the perception of partners may be still influenced by historical facts. For example, waiting lists have been long in the past for a CMHS (CGG), which perception may prevent inclusion in the TP, although the real situation can have changed drastically.
- Some professionals (mainly in the cluster 'children and adolescents') are satisfied with the already existing informal collaboration and feel no need for other initiatives.

A number of projects have learned that one cannot rely on the internal communication of each individual partner to raise awareness about the purpose and approach of a TP. Many projects try to counter the lack of knowledge and possible disagreement within partner organisations by intensifying the promotion of the TP for health care professionals within partner organisations.

Some projects report that initially reluctant services did promote patients for inclusion, after intensifying an information campaign. Nevertheless, a few projects mentioned that even after one year, not every care provider could be informed about the project, i.c. mainly the primary care services.

- **Some partners prefer to continue participations as an informal rather than formal partner as this role releases them of the administrative constraints.**
- **Many projects experience problems in activating individual partners. Health care professionals are not sufficiently aware about the TP.**
- **Some TPs reported that health care professionals felt obliged to participate in the TP because their management signed the contract, although they do not always experience the need for (regular) inter-organisational patient meetings.**
- **Some projects mentioned that the expectations of some partners towards the TP are too ambitious to come up to it.**

## 12.12 DIFFERENT VALUES AND APPROACHES OF PARTNERS

### 12.12.1 Different perspectives, language and cultures

A few TPs indicate that collaboration between different sectors, i.c. health care, social care, legal and educational services, revealed some problems:

- Communication problems as the ambulatory and especially residential services often use their proper professional language and jargon to be explained to the primary care services, extending the duration of patient meetings.
  - Partners have particular perspectives on, and objectives for the patient. Professionals of the residential services are more pathology oriented; schools are more focussed on school performance; health care professionals may focus more on the functioning of the patient.
- In a few projects, some tension is reported in the collaboration between the 'legal' approach and the mental health care approach.
  - One project, cluster 'forensic', experienced that the centre for public welfare (CAW) and justice institutions have an opposite vision with regard to the informed consent and the participation of the patient. Justice works within a restraining model, whereas the centre for the public welfare works protective and asks an informed consent of the patient for everything that will be done. In the project, an agreement had to be made on how to handle this issue.
- A few TPs (first line initiative) express that primary care services experience a need 'to be met with an attitude of respect by the specialized ambulatory and residential services.
- A few French-speaking projects experienced that partners are not used to collaborate and take decisions in consensus. Typically, decisions are taken unilaterally by one partner, i.c. a residential psychiatrist, and then communicated in the partnership. This contrasts to the ambition to take decisions collectively.

### 12.12.2 Conflict of interest between ambulatory care and hospitals

Many projects still experience a barrier or even a conflict of interest between ambulatory care and hospitals, mainly because all partners have financial interests in 'keeping' the patients within their facilities:

- Some TPs referred explicitly to the competition between residential and ambulatory mental health care organisations in the treatment of patients, sometimes even with services which are complementary.

Some projects have difficult discussions on who should coordinate the care of the patient. This could be a cultural issue, but is also related to interests of different stakeholders.

- Some French-speaking projects report discussions on the appointment of the individual patient coordinator (medical or not).

- **Collaboration between different sectors, i.c. health care, social care, welfare, legal and educational services, reveals differences in values, priorities, language**
- **Many projects still experience problems because all partners have (financial) interests in 'keeping' the patients within their facilities.**

## 12.13 EXTERNAL CONDITIONS

### 12.13.1 The contract requirements

Many projects referred to the contract obligations imposed by the NIHDI and FPS.

#### 12.13.1.1 *Caseload of TP*

The NIHDI-contract obliges a caseload of minimum thirty patients. The number of included patients in the projects (interviewed in autumn 2008) ranges between 3 and 41. Some projects meanwhile stopped the initiative because of a lack of inclusions.

A number of projects have made remarks on the preset caseload:

- One project says that some projects were not able to include thirty patients, because they strictly applied a number of preset inclusion and exclusion criteria.
- Another project considered it not necessarily negative to not have included thirty patients, because it may indicate that patients do not need the project.
- A number of projects was satisfied to use broad inclusion criteria or categories (e.g. the broad category of personality disorders), as it leaves more opportunities to include a lot of patients.
- One project states that the focus on the number of inclusions absorbs so much energy that projects are forgetting the aim of the TP-programme.
- One project warns for a quantitative instead of a qualitative evaluation, due to the preset caseload. It was noticed that projects are evaluated as 'good' if thirty patients are included without considering other factors.
- One project commented that the government is not being informed about the experienced difficulties to reach the imposed caseload. They consider it as important information, because it could be an indication of a gap in the care supply for that target population or a lack of collaboration in that region, rather than a problem of the TP functioning.

Some projects gave possible explanations for difficulties to reach the threshold:

- TP can interfere with other projects or consultative structures in the catchment area, e.g. pilot project psychiatric home care, projects home support, projects foster care.
- The partners who could propose new patients have been restricted to the formal partners; while informal partners were more familiar with the target population of the project.
- One project mentioned that the coordinator could possibly not perform well in keeping contact with the care professionals involved in the daily care of the target population.

#### 12.13.1.2 *Number and types of partners*

Many projects report to experience problems with the participation of minimum three formal partners in the follow-up meetings. However, projects interpreted the formal rules differently<sup>9</sup>.

- Some projects expressed that every 'type' of the obligatory partner must participate in all types of patient meetings. As some projects do not have many formal partners, it reduces the possibility of obtaining the formally required signatures.

<sup>9</sup> We have the impression that a lot of confusion and even misunderstandings exists on the formal obligations for inclusion and follow-up meetings.

- Especially when the ISHC signed the TP agreement problems are mentioned to collect the necessary signatures. Even if a lot of primary care services participate in the patient meeting, only one formal signature can be collected, as technically the ISHC is considered as one unique partner.
- As mentioned before, some projects collect signatures afterwards even if partners did not physically participate.
- Some projects included partners only to respect the rule of the three formal partners, without really needing them to be involved in the care of the patient. This pragmatic approach has particular consequences for the objectives of the TP.
  - Care providers or professionals can feel themselves as inappropriate observers when they participate in meetings about patients of other organisations that they do not know.
  - It can be stressful for a patient that e.g. a hospital participates in a meeting, as he could get the impression that he will be hospitalised again. Similarly, it could be strange for the patient if an unknown service to him, participates in the meeting.
- Especially projects aiming at elderly living at home experience difficulties to involve three formal partners.

### 12.13.1.3 Number of patient meetings

Many projects experienced problems with the frequency of the meetings.

- Projects experience problems to find a common date within a trimester, especially in summer time (because of holidays and professionals' obligations).
- Non health care partners stated they cannot be obliged to follow the formal rules imposed by the NIHDI (e.g. participation at regular meetings). Specifically, Flemish CMHS report an interference of TP obligations and the required proportion of direct client-contact time as defined by law of the Flemish government. Meetings are not considered as direct contact with the client.
- These CMHS consider collaborating as an informal partner however, as non-interesting option since it could give the impression that this partner is not needed.
- In some cases, professionals perceive no need for patient meetings in a the predefined pace. Some projects mention that regular consultations are needed at the onset of a care path. After a while however, this need decreases.
  - It is also mentioned that the period of three months between the first two patient meetings, i.c. the inclusion meeting and the actual organisation of the follow-up meeting, is too long for patients who are discharged from a residential organisation, e.g. a psychiatric hospital.
  - A few projects noticed that patient meetings are only relevant to prepare transfers. For patients with a long term residential stay, consultations are not needed in the preset pace.
  - A TP (meanwhile resigning) mentioned that for teenagers the regular meetings can be "iatrogenic" in situations where the condition and situation of the adolescent has improved.

### 12.13.2 Critiques and suggestions

Some interviewees perceive a contradiction between the externally imposed obligations and the purposes of the government programme:

- Defining the project as an experiment is in contradiction with the obligations of the NIHDI-contract, imposing a straightjacket which impedes care provision, adapted to the needs of the patients.

Some suggestions were formulated to change the public financing model:

- One project preferred a fixed sum financing to a pay for performance model, because in the current approach patient meetings are not financed if one of the required partners can not participate (even for exceptional reasons).

With regard to the obligatory partners it is criticised:

- that the collaboration between partners is formalised within the federal mental health care and hospital legislation framework which is not perceived as the best as social services operate in an another framework.
- The obligation to collaborate with some partners is experienced to be in contradiction with the idea of needs based care. Some projects select partners more for administrative reasons than patient needs based reasons, while other care providers are almost impossible to include as formal partners

Some interviewees suggested applying the obligations in a more flexible way. A TP should be able to follow the tempo of the patient and adapt to the specificity of the varying target populations.

- One project already manages the formally required three monthly meetings of the NIHDI-contract with some flexibility, e.g. it organizes a consultation in the beginning of a trimester and the following consultation at the end of the next trimester.
- With regard to the frequency of the follow-up meetings, several suggestions were formulated varying from imposing a number of four patient meetings, without any timing; over suggestions to impose six-monthly patient meetings; to a proposition to only finance a maximum number of patient meetings. It is also suggested that one should be able to temporarily interrupt support for patients, and re-include the patients if there is a perceived need.

With regard to the participation of the required three formal partners at the follow-up meetings, many projects pleaded for more flexibility in applying the rules:

- Allow flexibility with regard to the involvement of the required partners, because sometimes only two partners are actually needed to be involved for that patient situation.
- A more flexible attitude towards the participation of the general practitioner in follow-up meetings is recommended by some projects.
- Some interviewees suggest it would be better to define the number of partners to participate in patient meetings instead of requiring the participation of the *formal* partners this would allow more flexibility to finance the contribution of ambulatory and/or primary care (comparable to existing GDT models).

On the general approach of the government's TP-programme.

- One interviewee did not support the bottom-up approach (to collect ideas and models for collaboration), but expected clear directives and conceptual frameworks from the government, grounded in evidence and scientific work. Government agencies should also invest more in supporting the development of organizational innovations.

### 12.13.3 Communication from FPS, NIHDI and KCE

Besides the strictly contractual issues, many remarks were made on the lack of clear communication from the public agencies (references are mainly made to FPS), which has induced a lot of confusion.

- The management of the FPS is criticized for unclear, sometimes even contradictory communication. At the start, information was difficult to understand because of the huge quantity of information. Especially the fact that vast amounts of information were provided, while other punctual questions remained unanswered, is perceived as problematic.
- A number of projects criticized that obligations and conditions changed after (or were not communicated before) the submission of proposals (references were made to the tasks for evaluation research, mainly the patient monitoring). Some other projects complain that the “rules” were not clear enough.
- For many TPs, there is no clear communication about the respective role of the different institutions (e.g. some were surprised to know that their annual report for the NIHDI is communicated to KCE).

### 12.13.4 Patient monitoring

After the proposal was launched to submit bottom-up proposals for TPs and TPs were selected, the KCE was appointed by the minister to develop an evaluation research. Part of this evaluation research includes a patient monitoring. For many projects, this patient monitoring is cited as an impediment to the formal composition of the partnership.

### 12.13.5 Other formal collaboration initiatives

Some projects have experienced problems because of the existence of other pilot projects or initiatives of collaboration. The distinction between the TP and the pilot project PHC, as a partner of the project, is not always clear, because both have to organise meetings to coordinate the care of the patient. It lacks a model or approach that is covering all these projects, including local and provincial initiatives in different sectors.

- **Some interviewees think that the contractual obligations, as imposed by the NIHDI and FPS, should be applied in a more flexible way.**
- **Many remarks were made on the lack of clear communication from the public agencies (references are mainly made to FPS).**
- **The patient monitoring is cited by some projects as an impediment to the formal composition of the partnership.**
- **Some projects have experienced problems because of the existence of other pilot projects or initiatives of collaboration.**

## 12.14 CRITICAL FACTORS

Based on their experience, a few projects could already point to a number of (sometimes very punctual) critical factors that may influence the good functioning of the project.

### 12.14.1 Time and previous collaboration

Time to collaborate seems a critical issue. Some projects referred to the time needed, in order to learn to know each other and avoid mutual misunderstanding.

Some projects noticed that the previous collaboration between partners was a facilitating factor. Former collaboration is considered important as partners already know each other, know about the individual working practices, trust and respect each other.

- Some projects deliberately chose a modus operandi similar to previous collaboration projects.

- One project noticed that limiting the discussion time to include patients has a positive influence on the good functioning of the inclusion meeting and the motivation of the partners to participate.

#### 12.14.2 Promoting the project

Many projects experienced that promotion of the project, to inform the care professionals and to motivate them to participate is crucial. However, projects previously collaborating need less effort and time on promoting the project.

- One project mentioned that it takes more time to convince informal partners about the usefulness of the project.

In this strategy, it is not sufficient to use tools, such as folders or website. Personal oral explanations are needed.

- Some projects have organized introductory lectures, other projects use existing lunch sessions, and a limited number relies on word by mouth information

#### 12.14.3 Critical factors for patient meetings

One project noticed that the presence of a 'neutral' coordinator to moderate the meeting, favours the good functioning:

- One project noticed that patient meetings who are chaired by two persons function better.

One project considers it crucial to provide enough background information and introduce some procedural issues in the patient meeting:

- The coordinator introduces every participant at the meeting.
- The coordinator informs the patient and the participants about the context of the meetings.
- The coordinator manages the time of the patient meetings
- Every participant leaves after the meeting and does not stay for having a conversation, so that the patient does not think they are talking about him.

#### 12.14.4 Critical factors for partner participation

Actively approaching and motivating partners have a positive influence on their participation at the meetings. Personal contact between the coordinator and partners within the project can help in developing commitment of partners:

- One TP mentioned that personal contact was essential to initiate the collaboration with the responsible general practitioner, the psychiatrist or the psychologist during follow-up meetings (instead of representing these directly involved practitioners by someone else).
- An acknowledgement of the potential contribution of each partner guarantees commitment of individual partners.
- If professionals experience support during the meeting, they will continue to participate. Moreover, they should only be solicited if there is a perceived need to have a follow-up meeting.
- The obligations of the NIHDI-contract are sometimes an aid to activate the partners to participate at the activities of the project.
- Financing the activities of the project is sometimes a trigger for the partners to participate, although one project noticed that partners need to be intrinsically convinced that the project is a surplus.
- If more hospitals (units) participate in a TP, they can alternate their participation to follow-up meetings.
- One interviewee noticed that the partner participation differed between projects, depending on the aim of the project. Participation was experienced easier if the TP focuses on developing the care pathway of the patient, rather than on the actual care of the patient.

- **Time to collaborate in order to learn to know each other and avoid mutual misunderstanding is needed.**
- **A 'neutral' coordinator to moderate meetings favours the good functioning of the patient meetings. Providing enough background information and introduce some procedural issues in the patient meeting is useful.**
- **Promotion of the project to inform the care professionals and to motivate partners is crucial.**
- **Actively approaching and motivating partners have a positive influence on their participation at the meetings. Personal contact between the coordinator and partners can help.**

## 13 RESIGNING PROJECTS

### 13.1 INTRODUCTION

This section briefly summarizes comments of some of the projects that resigned from the government programme in the first year of operation.

15 TPs withdrew: 5 Flemish and 10 French-speaking projects. One of the 'resigning' Flemish-speaking projects merged with another TP in the same cluster in the same region, and can thus be considered as a particular case of resignation.

Of these 15 resigning TPs, we interviewed at this stage of the research, 4 Flemish- and 5 French-speaking projects (see Table 13.1).

**Table 13.1: Overview of the projects**

Current status		Interviewed		Not interviewed		Total
		FR	NL	FR	NL	
ongoing	Children and adolescents	2	6	2	5	15
	Adults	14	10	3	14	42
	Elderly	2	1	1	7	11
<b>ongoing Total</b>		<b>18</b>	<b>17</b>	<b>6</b>	<b>26</b>	<b>67</b>
resigning	Children and adolescents	5	1	2		8
	Adults		2	3	1	5
	Elderly		1			1
<b>resigned total</b>		<b>5</b>	<b>4</b>	<b>5</b>	<b>1</b>	<b>15</b>
<b>Grand Total</b>		<b>23</b>	<b>21</b>	<b>11</b>	<b>27</b>	<b>82</b>

Of the 10 French-speaking projects that resigned, five are located in Brussels, three in province du Hainaut and two in regions 'Liège and Luxembourg'. Seven of the French-speaking resigning projects are part of the cluster 'children and adolescents'. The five resigning Flemish projects are found in Brussels, the province Limburg and West-Flanders, and more equally distributed over the clusters.

The semi-structured interview for these projects was similar to the other projects. But specific attention was paid to the factors and argumentation of the interviewees on the reasons why they stopped their TP-contract.

As is the case for the whole intermediate report, we need to continue the interviews with the resigning projects in the near future. In this report, we only describe the discourse of the interviewees without triangulating with other sources of information (such as the formal resignation letters). It is clear that no definitive status can be attributed to the observations reported here.

### 13.2 REASONS FOR RESIGNING

#### 13.2.1 Number of inclusions

As mentioned before, the NIHDI-contract requires that each TP would obtain a caseload of thirty patients after one year (period was extended to 1.5 years) to receive full financing. Not all TPs were able to fulfil this requirement and resigned.

Most of the resigning projects experienced problems to convince the partners of the TP on the added value of the project. Many of them struggle to convince professionals of the partners on the relevance and added value of the patient meetings. Particularly, these projects had difficulties to motivate partners to participate at the project and to propose new patients for inclusion.

- Two separate TPs (with almost the same partners) decided to merge because the age category (0 till 6 years) initially put forward was too strict to realize the preset caseload.

- Two projects did not reach the required threshold of 30 inclusions, because they maintained their strict preset inclusion criteria and only included patients that belong to their target population.

### 13.2.2 History of collaboration between the partners

A lot of the resigning TPs had no history of previous formal collaboration. Although some partners had collaborated informally, often the informal collaboration at patient level was limited.

- One project referred explicitly that partners lack experience with collaboration, and are because of this, difficult to convince. The lack of a 'pilot project' (such as Psychiatric Home Care) at regional level was felt as a handicap to convince partners and professionals that the TP had something more to offer than just meetings.

However, even TPs where partners previously collaborated resigned.

For both situations, the most common argument was that they found it difficult to convince the partners about the added value and objectives of the project.

- Some projects referred to the professional position of (health) care professionals. The remark was made that professionals considered the idea of collaborating with other professionals and partners as intrusive on the delicate therapeutic relationship between the individual professional and his patient. Issues of professional responsibility were raised, especially by health care professionals (often psychiatrists) with no or little experiences with shared responsibility for a patient. Moreover, the patient meetings are regarded as additional work.

### 13.2.3 Role and employment location of the project coordinator

Indications are found in the interviews that the role of the coordinator can be of utmost importance. References are made to the knowledge, experiences and networking of the coordinator in the local context, and the qualifications needed for fulfilling this role.

It seems that projects experienced problems if the project coordinator does not know the different partners very well and has little familiarity with the services. Without any support from persons more familiar with the partners, the coordinator often experiences a lack of authority to convince professionals of partners to participate.

Partners and their professionals also attribute meaning to the organisation coordinating the project. These meanings have impact on the perceived legitimacy of that coordinating agency.

- One project refers to the perception of partners on waiting lists of a small CMHS (CGG), induces an image of a slow working centre. Because of this image, partners are reluctant to propose new patients for inclusion.

It has also been mentioned that the employment location of the coordinator can contribute positively or negatively to the functioning of the project. Interviewees experience that a project coordinator not embedded in an organisation directly working with the target population of the project, can impede the chances to motivate professionals to propose patients for inclusion.

- One project aims at patients living in the community. The choice for this target group was strongly influenced by a primary care organisation. As the employment location of the coordinator was not in that primary care organisation, the coordinator had not much contact with primary care services and professionals, making it difficult to mobilize these organisations to propose patients for inclusions.

### 13.2.4 Objectives

Some of the resigning projects struggle with a clear definition of their proper objectives, and especially in connecting with the intentions of the government programme. Here, we find indications that the bottom-up approach of the call for proposals can lead to particular problems. This could be an important observation, as in previous section, we already observed that many TPs are not very particular in their plans and often leave plenty of room for interpreting the objectives.

It is interesting to see that many of the resigning projects remain very general in the definition of their objectives (as presented by the interviewees).

- A TP wants to increase the coherency in parents and child care by improving the communication. The objective was not to develop a therapeutic plan for children.
- One project refers in very general terms to the prevention of the worsening of behavior troubles.

In some situations, the definition of the partnership objectives did not even fit at all within the objectives over the government programme

- One TP aimed only at implementing a psychiatrist network for peer reviewing. This objective was motivated to create support for psychiatrists who often work in isolation. The purpose was not related to patient problems.

### 13.2.5 Preparation versus implementation of the project

In the section on experiences, it was already mentioned that projects often struggle with the gap between people who prepared the projects and the ones who have to implement the project. We have indications that for resigning projects, this could be a particular issue:

- In one TP, the elaboration was mainly done by the top management of the partners without any feedback with the professionals of the partners.

In the interviews with the resigning projects, it was mentioned that they struggled with disseminating and transferring the objectives and ideas underlying the TP concept, towards the 'fieldworkers', or the professionals, working with patients.

- One resigning project had difficulties to 'spread the message' and convince the participating partners and professionals to commit to the (intended) activities of the TP.

### 13.2.6 Coordination model

Not all projects have a really elaborated model on the coordination of the different activities needed in a TP. For the resigning projects it seems even more apparent, both for TPs with rather high level of complexity of the partnership, as for projects with lower levels of complexity.

- One French speaking mentioned not to have discussed or reflected on a coordination model at all. They combined all types of 'issues to be discussed' in one general rather informally organized meeting.

### 13.2.7 Patient monitoring

Some French-speaking projects explicitly resigned because of the patient monitoring. Besides arguments on the content of the monitoring and issues of privacy, the projects judged that the patient monitoring would interfere with the personal therapeutic relationship with the patient. This resistance to the patient monitoring seems to be an issue of principles for the professionals involved in the partnership.

- **A number of projects resigned because they did not reach the imposed threshold of 30 inclusions.**
- **Resigning projects experience difficulties to convince the individual partners about the added value of the project.**
- **Resigning projects seem to have less precise objectives and less elaborated visions on coordination issues.**
- **In some of the resigning project, a gap is mentioned between the people preparing the project and the people who had to implement.**
- **Some projects resigned because of a fundamental opposition towards the patient monitoring. One of the reasons cited was that it would interfere with the delicate therapeutic relationship between patient and professional.**

## 14 GENERAL DISCUSSION

In this section, we discuss the research goal, methodological issues related to this stage of the research, and develop some initial reflections on issues emerging from these preliminary findings and aspects that need further exploration in the next stages of the ongoing research.

### 14.1 THE OVERALL RESEARCH AND SCOPE OF THIS REPORT

This report is the first intermediate report of a three year research process on innovations in the organisation of mental health care for people with 'complex and chronic' mental disorders. These innovations are known as the Belgian government programme called 'therapeutic projects and transversal consultations'. The government programme intends to develop practical experiences with new organisational modes in mental health care. The individual projects are intended to develop experiences in the *organisational* approach offering effective support for different mental illness target groups. The government programme describes a general framework. This general framework does not elaborate on detailed intended results or outcomes, neither does it propose precise outcome criteria to assess the success of a TP. The framework is set as an invitation to obtain proposals from the sector in a 'bottom-up' way in order to develop organisational reforms in Belgian mental health care.

The formal demand of the Minister to the KCE was to assess to what extent the organisation models as proposed by the sector through the TP contribute to develop needs-based care and reach the aim of continuity of care in a less residential oriented approach. The demand of the Minister is not to focus on the clinical content of the TP. The research is a typical 'health services approach', as it mainly focuses on organisational issues. The proposed approach is related to 'real world' evaluation research in mental health care. In this approach, a lot of attention is paid to the context in which organisational models are being developed. Attention will primarily be paid to implementation lessons of projects in order to maximise therapeutic outcomes. The overall research project will ultimately aim at developing a core framework of topics and issues to be considered for implementers of collaboration and networking models in Belgian mental health care, based on the empirical part. The evaluation research of the TPs is the empirical grounding for this.

The unit of analysis are TPs, and the research will try to draw conclusions for organisational modes emerging in the clusters as defined in the government programme ('children and adolescents', 'adults', 'elderly', 'addiction' and 'forensic'). In order to draw relevant conclusions for a future policy programme for the organisation of mental health care, the long-term research will also pay attention to effectiveness and efficiency issues, as far as data (from different sources) will allow to. The bottom-up approach implies that each individual project clarifies its particular ambitions and objectives in their plans or TP-proposals within the general framework. A first step will thus consist in making the inventory of the objectives of each individual TP (by means of document analysis and interviews), in order to assess after the three (or four) year implementation period, the extent in which they reached the predefined criteria put forward in the proposals.

This particular report is an atypical KCE-report, in the sense that it is not aiming at developing final conclusions or any policy recommendations. Moreover, the research itself is rather atypical for KCE as it evolves over a time period of at least three years. In the ministerial assignment, it was clearly stated that the KCE should report on intermediate results on a yearly basis. It has thus been a deliberate choice of the KCE to present these preliminary descriptions, especially since the mental health care sector expects feedback from the research process during the ongoing three years trajectory.

It cannot be repeated enough that the results presented in this report do not allow for final conclusions or recommendations on organisational innovations in mental health care. This report only summarises preliminary descriptive results. Nevertheless, these preliminary results trigger the development of some reflective thoughts.

The preliminary findings sketch aspects on how organisational innovations are perceived in the sector and help to raise questions and issues that certainly can be developed further in the follow-up reports.

- **This intermediate report is not aiming and does not allow to draw final conclusions or make definitive policy recommendations.**

## 14.2 METHODOLOGICAL LIMITATIONS

This intermediate report is bound to very specific methodological limitations.

The report is only in an intermediate phase of analysis and data-collection is not finished. It is limited to a first step qualitative analysis.

First, remarks have to be made on the sample. The research design aims at a 'full cover' analysis of the TP-programme. This implies including all awarded TP-proposals in the data-collection. At this stage, not all TPs accepted by the NIHDI were interviewed yet. We have interviewed 44 of the initially accepted 82 projects. Currently, 67 of the initially accepted 82 projects continue their activities. In the first months of 2009, the interviews with the projects not interviewed yet will be continued.

The sample bias is one of the methodological elements explaining why the descriptive results are certainly not saturated yet, as it can reasonably be expected that new information can come from other projects. At this stage, it is thus methodologically unsure whether all relevant descriptive dimensions related to the plans and designs of TPs are already covered. Moreover, the external validity of the findings in this report is not guaranteed because of the sample bias.

Second, these findings solely report on the results of interviews with the sector. The use of only one data-source (be it in an in-depth way) implies necessarily that this report relies heavily on the perspectives, meanings and stories of the interviewees. Without a triangulation of other sources, these perspectives only offer one particular viewpoint or angle on the projects. For the future stages, other sources and documents have to be added to the analysis. The research will further triangulate the findings from the interviews with written sources (mainly the NIHDI-proposal documents) on the TPs. At this stage, the information of the formal written proposals is only used at a general level, as background material for the preparation of the interviews. A content analysis and an integration of other data-sources need to be pursued in the analysis of the interviews.

Third, at this stage, the descriptive classification is developed inductively. The labelling and classification emerged from the information obtained from the interviews. This inductive approach clearly shows its added value as it enables to classify issues as they are perceived by the developers of the TPs. However, we need to confront the experiences of the Belgian TPs with existing research on mental health care reforms and theoretical insights too. In the next step, these descriptive findings will be triangulated and complemented with insights on (interorganisational) network theories, research on the organisation of collaboration models in mental health services and conceptual texts on continuity of care, needs-based care etc. The confrontation with insights from scientific literature will enable to develop statements on the underlying models of collaboration and networking.

Fourth, many of the interviews were group interviews. Not all (formal and informal) partners involved in the respective projects were necessarily present during the interview. Some interviews were clearly being dominated by one particular partner (interviewee) of the project. This implies that we can expect to have collected a selective story on the TP. This way of collecting data does not allow disentangling potential different visions of the respective stakeholders involved in the project. As stated in the methods section, this research is for practical reasons not conceived as a within-case stakeholder analysis. However, in overall terms, the research team was positively surprised by the openness of the respondents, even on operational difficulties experienced within the projects and on different meanings and perspectives of actors involved.

Fifth, this intermediate report is limited to an *overall* descriptive classification. Such a general description is only a first step and needs further refinements and data-analytical steps. We did not yet analyse the findings at cluster level (as they are defined by the policy programme). Neither did we start yet to disentangle the intra- and inter-contextual factors that could potentially explain the choices for and experiences with organisational configurations of a TP. For a further in-depth analysis, a next methodological step will consist of cross comparative analysis on several dimensions of the organisation of a TP (both within and between clusters, and (if relevant) for other patterns emerging). In a way we could say that the current description by the researchers still lacks a detailed contextualisation.

Taking into account these methodological limitations, the necessary care is needed to interpret the findings at this stage of the research.

However, the preliminary results offer plenty of indications on relevant issues with regard to the implementation of the government programme. The findings stimulate to raise questions, formulate comments and develop reflections for the future stages of the research.

- **This intermediate report is bound to very specific methodological limitations. Precaution is needed to interpret the findings at this stage of the research.**
- **At this stage, not all TPs accepted by the NIHDI were interviewed yet.**
- **At this stage, the descriptive classification is developed purely inductive, on the basis of information obtained from interviews. Future steps will require triangulation with other data-sources.**
- **In the next step, these descriptive findings will be triangulated and complemented with insights from scientific literature.**
- **This intermediate report is limited to an overall descriptive classification. It needs further refinements in the next steps. An analysis focussing on which patterns emerge in the organisational configurations within and between clusters or in different contexts is still needed in the next step.**
- **The preliminary results offer plenty of indications on relevant issues with regard to the implementation of the government programme.**

### 14.3

#### VARIATIONS ON A THEME: DIFFERENT TP-MODELS

A first important observation is that the 'therapeutic projects' develop different models of collaboration. All TPs operate and adapt to the conditions stipulated in the call for TPs, but in their very proper ways.

The bottom-up strategy has induced a lot of variation in the underlying organisational approaches of the TP. This bottom-up strategy allowed that not a deterministic or unique organisational model was imposed, but that the mental health sector was given the freedom to propose organisational models within an overall framework. As mentioned before, this bottom-up approach was (to a certain extent) appreciated, as in this way 'ivory tower' models were not being imposed. As an immediate consequence, indications are found that a number of projects need to learn to develop both a vision and working practices within their properly defined TP (see paragraph 'learning experience').

In the discourse of the interviewees, the general meanings given to a 'TP' are shared (except maybe for some resigning projects): many TPs stress on the one hand that good linkages between primary health care and secondary mental health facilities are needed on the other hand that the development of linkages with other social, legal or welfare services is necessary. Many projects seek ways to put in place referral or linkage models between providers, within catchment areas (be it of different size), and most interviewees recognize the importance of avoiding "gaps" and unnecessary duplications of activities in the care pathway of the patient. Some projects seek ways to provide care and treatment for those patients who lack provision of appropriate care.

Within this idea of continuity of care, a number of projects also mention the issue of consistence and coherence in care between the different providers. However, differences between projects are apparent in the way they are trying to meet some of these objectives, and generally little specificity is found in the answers on particular objectives. Quite a number of projects seem to focus on the phase of discharge from a hospital, rather than on an integral illness pathway. At this stage, we have some indications that different accents are put depending on the 'cluster'.

Different choices are made in structuring the partnerships. The structural characteristics have an impact on the way partnerships are coordinated: the number of formal and informal partners and the collaborating sectors (health care, social care, justice and welfare, etc.) affect the organisational configuration, especially on the 'formalisation' of the coordination. The coordination or management of the partnerships varies from rather formalised procedural and layered modes of coordination (with different types of meetings) on a smaller scale and informally organised network or collaboration models.

The models chosen seem also to be influenced by the context (or in organisational terms: 'environment'-related elements). Indications are found that the target group influences the importance paid to participation of patients and families (e.g. for projects relative to children and elderly seems have a more open perspective on patient and family participation).

The allocation of tasks to the coordinators and the division of labour between persons (coordinators) differs between projects. It is quite interesting to observe on how the role of coordinators is being defined differently between projects.

The roles of the partners and the elaboration on how their individual objectives and working practices fit within the partnership objectives are not always clearly elaborated in the plans of the TPs.

Part of these organisational differences is not only structural issues, as if the complexity or the environment is determining the model. Part of the differences between TPs is to be explained both by the vision on and by the meaning given by the actors involved.

- **The bottom-up strategy has induced a lot of variation in the underlying organisational approaches of the TP. The mental health sector was given the freedom to propose organisational models of collaboration within an overall framework. This shows in the observations.**
- **The general meanings given to a 'TP' are shared by a vast majority of projects. However, differences between projects are apparent in the way they are trying to meet these general objectives.**
- **Part of the organisational differences are not only structural, but differences between TPs are to be explained by the meaning of the actors involved and the visions on how to develop a TP.**

#### 14.4 THE ELABORATION OF A COLLABORATION PLAN

Although an analysis is not made yet of the written proposals, it emerges clearly from the interviews that, for many projects, plans are developed in rather general ways. The plans –logically— are mainly written to address the administrative requirements of the TP-call. The plans are not conceived as practical guiding tools for the implementation of the collaboration. Within a context of innovations and experienced-based development of mental health care organisations, 'loose plans' certainly allow for a process of 'learning by doing'. On the other hand, the active use of an 'instrumental' plan can be very supportive in 'keeping on track' with regard to objectives and working practices. We find indications that the management model of the 'plans' is not necessarily as such being used as an orienting tool for a lot of the projects (also because some of the developers of the proposals, are not the ones implementing the plans). At this initial stage, many projects (especially those with little or no previous collaboration experience), mainly seek ways to adapt to the formal external conditions imposed by NIHDI and FPS, and develop experienced- based coordination around the patient and between partners.

In the following study, we certainly need to elaborate further on this issue, also by analysing the literature on organisational innovations and intergenerational management.

- **For many projects, plans are developed in rather general ways. The plans are in most cases not conceived as practical guiding tools for the implementation of the TP.**

#### 14.5 **COLLABORATION, COORDINATION, PARTNERSHIP, NETWORK...WHAT IS IN A NAME?**

Giving meaning to the content and objectives of an innovation or practice is often illustrated in the 'labelling' of components of an intervention. At this stage of the research, we made a pragmatic choice to communicate on our observations of the TP: we used the rather vague term of 'partnership' as an indicative term for the cooperation and collaboration within the network. For the future research, we will certainly elaborate on the use of concepts, on the basis of insights from inter-organisational network literature. Up to now, we have observed that projects do not use a consensual way of defining the components of their TP.

- The best practical illustration is found in the use of the word 'coordinator', which is often used as were it a common and well understood part of the project, while a disentangling of coordination activities clearly demonstrates that the roles of coordinators vary a lot.
- A second example can be found in the labelling of the types of meetings: Although similar labels are used (best example: inclusion meetings) very different practices are put in place when projects are compared.
- Another indication can be found in the role of the respective partners of the TP. Indications are found that not all partners (or more abstract 'actors'), play the same role. We found indications that some are considered as 'core' partners, others are more 'peripheral' partners. Although this is an issue for the future process evaluation, it is worth disentangling these nuances, in order to get a better understanding of the practical use of coordination mechanism, and particularly the balance between formal and informal modes of coordination.

The different labelling of the TPs can be explained, as the process of submitting TP proposals has been a bottom-up approach. It is clear that the labels and the underlying meaning are contingent to the particularities of the project and the interpretation of the external call for proposals. Moreover, TPs are practical experiences and not academic exercises of reflection. However, a common core of terminology, identified by clear attributes would certainly be helpful to describe and to better understand the organisational processes and differences between TPs. More clarifying conceptual classifications could be of very practical value too. This aspect will be worked on in the future steps of the research (grounding the classification in theories and experiences of TPs).

- **The labels used within the projects and the underlying meaning are contingent to the particularities of the project and the interpretation of the external call for proposals.**
- **A common core of terminology, identified by clear attributes would be helpful to describe and understand better the organisational processes and differences between TPs. More clarifying conceptual classifications could be of very practical value too.**

#### 14.6 **A LEARNING EXPERIENCE**

The development of a TP is a form of (inter)organisational innovation that shows to be a learning experience. The adoption of an organisational change both requires changes in the minds of people, and in the structures and ways of working. The TPs are a 'practice of change' that includes learning processes by all partners.

The external conditions, in particular the programme as conceived by the government agencies, are an aid to adopt a change process. However, a government framework is certainly not sufficient, as the actors need to develop the capacity to implement.

For many projects, the organisational change process is a continuous back and forth movement, including setbacks and unforeseen events. It is clear that not all partners and participants adapt to new modes of organisation at a same pace. The key players in the partnership need to be convinced about the potential advantages of a new approach (and they are not necessarily convinced from the start). From the interviews, it becomes clear that developing a TP is both a matter of creating added value for each individual participant (through practical experience), as well as a matter of developing practices that are compatible with perceived needs, norms and values of all participants in the TP. The interviews give indications that a TP is a practice of developing a 'negotiated order' with all actors involved. This learning aspect seems to consume a lot of energy, especially since a lot of the TPs are building capacity on their own. They are not supported in their practical development by an external agency (which should be the 'transversal consultations', in which experiences are shared) at this stage yet.

Tps can be divided into those partnerships that already collaborated in the past and have a longer tradition of reflection and practical experiences with inter-organisational collaboration and those without. Quite a number of TPs have chosen partnerships in which partners had experiences in other innovative initiatives (except for the inclusion of primary care services). These partnerships rely, to a certain extent, on these experiences. Previous collaborations, be it formal or informal, contribute to the models underlying the TP. Moreover, the interviews offer indications that the mutual knowledge and previous contact increase the chance of developing a shared meaning about the objectives of the TP.

In the previous paragraph, we already referred to the project plans as a written reflection of the organisational concept and activities. These theoretical plans have to be translated into practice. The interviews give indications that for some TPs, a kind of 'knowledge gap' exists between the people who reflected conceptually and the ones who put the project in practice. Some projects report to be struggling with the fact that the people who prepared the proposal of a TP are not the ones that need to implement the intended model. Some (other) projects have mentioned that the conceptualisation of the project depended, to a large extent, on the (opinion) leadership of one or some individuals. We also found indications in projects that the people preparing the TP are not the ones implementing the model. Moreover, it was mentioned in a lot of projects that the expectations towards the coordinating persons were quite high with respect to operational and conceptual issues.

Although different, but a similar issue is the knowledge gap in those projects where the management negotiated and agreed to collaborate in a TP, but in which the individual professionals have to do the practical day-to-day implementation work. In some partners of projects, it was mentioned that the visions of the management of organisations are not congruent with those of the individual professionals. Even in the case that professionals would agree on the idea, some discomfort or even resistance rises, often because of the imposed additional workload and obligations related to the TP-programme.

Part of the learning experience of the projects is developing 'feasible' and 'workable' practices for all actors involved. The initial reported experiences show that some projects are adapting their working practices, in order to attain a feasibility and workability level for all actors (organisations and individual professionals) involved. In this context, the projects themselves experience the government's framework (including particular conditions) sometimes restraining, in order to meet these demands within the projects. Some of these conditions are considered as impeding the development of 'needs-based care' rather than stimulating it.

- **The development of a TP shows to be a learning experience. The adoption of an organisational change both requires changes in the minds of people, as well as in the structures and ways of working.**
- **Theoretical plans have to be translated into practice. For some TPs, a kind of 'knowledge gap' exists between the people who reflected conceptually and the ones who put the project in practice.**
- **Sometimes, visions between the persons who conceptualised the TP and the ones who have to implement them are not compatible.**
- **Part of the learning experience of the projects is developing 'feasible' and 'workable' practice for all actors involved; projects are adapting their working practices in practice, in order to attain a feasibility and workability level for all actors.**

## 14.7 STRUCTURE AND CULTURE

The development of an organisational network is not solely an issue of developing structures. It is also a cultural issue of shared values, interorganisational norms, expectations and common understanding of the missions and approach of the TP. In order to develop an organisational collaboration, a shared meaning on the objectives and working practices at all levels within the TP and with the members of individual partners has to be developed.

This process has to be supported by rather important efforts to inform and promote all actors involved. Many projects (especially those with little previous collaboration experience) need to raise the awareness of partners in the aims and working procedures of the TP: part of the difficulties with which the TPs are confronted is disseminating sufficient information to the people, mainly those involved in direct patient care. The people involved need to understand what the new working practices mean and how it will affect them personally. Part of this can be realised through experience and the learning process, but certainly at the initial stages plenty of efforts have to be spent on information dissemination and promotion of the project. Clear opinion leadership, explaining in precise and practical terms on the ambitions of the TP and 'convincing' people through interpersonal processes and influence is experienced by many projects as crucial elements. For this reason, it seems that the persons responsible for the promotion and interpersonal contacts can rely on social networks and have a certain legitimacy to spread the news. Part of these promotion activities seems to build trust relationships between actors (often) from very different backgrounds with their proper professional values, norms, working experiences and opinions on professional practice. We find indications that norms and values are not necessarily the same for all types of sectors involved, and that one of the difficult aspects of 'integrating' care is also mutually adapting these norms and values within the new approach.

- **The development of an organisational network is not solely an issue of developing structures. It is also a cultural issue of shared values, interorganisational norms, expectations and common understanding.**
- **This process has to be supported by rather important efforts to inform and promote all actors involved. Part of the difficulties of the TPs is disseminating a (sufficient level) of information to the people, mainly those involved in direct patient care.**
- **Part of these promotion activities seems to consist of building trust relationships between actors (often) from very different backgrounds with their proper professional values, norms, working experiences and opinions on professional practice.**

## 14.8 MANAGING PARTNERS AND MANAGING PATIENT PATHWAYS

Various components of mental health and other services (primary care, mental health services in primary care, mental health services in general hospitals (acute beds), specialised mental health institutional care and non-specialised institutional care, formal and informal community care, legal and welfare services) need to collaborate in the new model of mental health care. The way these services are organised, is expected to have an important bearing on their effectiveness and ultimately on whether they meet the aims and objectives of a mental health policy.

The preliminary results give indications that the TP have to manage a collaboration model on two main axes: on the one hand the particularities of managing the partnership, on the other hand the management of patients.

It is quite remarkable to observe that all TPs heavily rely on 'meetings' as the core mechanism of coordination and collaboration, both on partnership issues as patients-related issues. Besides these meetings, quite a lot of informal communication is taking place, be it most of the times bilaterally and often on very operational issues.

We have indications from the interviews that TPs do not always have an evenly developed vision or approach on the handling of the two main axes simultaneously. The discourse of the respondents is sometimes primarily focussing on the 'management of the patients' and the challenges and difficulties with regard to the coordination of patients. Other projects mainly sketch the 'management of the partnerships'. It is precisely the mix of these two axes that can help to explain the learning difficulties of each of the projects and sometimes also the confusion about many of the activities within the TPs.

A future challenge for the TPs would potentially be to develop a more 'integrated' model in which the management of the patients is organisationally fully embedded in an inter-organisational model of the partnership.

Projects are struggling with the vast number of parallel 'experimental' projects and initiatives (in different health care sectors) taken by different provincial, regional and federal authorities, too. It lacks any streamlining of these activities. Many partners of the TPs are sometimes also participating in other organisational initiatives, outside the TP-programme, but seem to be confronted with the lack of an overarching common policy framework.

- **TPs have to manage a collaboration model on two main axes: on the one hand the particularities of managing the partnership, on the other hand the management of patients. TPs do not always have an evenly developed vision or approach on the management of the two main axes simultaneously.**
- **It is quite remarkable to observe that all TPs heavily rely on 'meetings' as the core mechanism of coordination and collaboration, both on partnership issues as patients related issues.**
- **Many partners of the TPs are sometimes also participating in other organisational initiatives, outside the TP-programme, but seem to be confronted with the lack of an overarching common policy framework.**

## 14.9 PATIENT RELATED ISSUES

Another research consortium is responsible to research issues on patient and family participation and their perspectives. However, the analysis of other patient related issues remains underdeveloped in this preliminary report. The analysis did not focus on cluster-specific issues, neither did it pay much attention on how the differences and particularities of the patients clusters could have an impact on modes of organisation and on particular problems. We have indications though that, even within the clusters, TPs are offering services to a wide variety of patient groups.

This is certainly an aspect on which we have to elaborate in the future steps of the research, in order to get a better insight whether collaboration or network mechanisms need to be adapted to the particularities of the target groups too.

Tps are not very specific too about their target groups. Many projects have rather implicit objectives with regard to patient outcomes. It seems that the efforts of the projects are currently mainly absorbed by streamlining and mutually adapting the facilities involved.

The concept of 'chronic and complex' is handled in very different ways. It seems that most projects do not use very precise definitions or delineations of 'chronic and complex'. It will be interesting to get a better grip on how the criteria 'chronic and complex' are used as inclusion criteria for patients.

- **Many projects have rather implicit objectives with regard to patient outcomes. It seems that the efforts of the projects are currently mainly absorbed by streamlining and mutually adapting the facilities involved.**
- **The concept of 'chronic and complex' is handled in very different ways.**

## 14.10 FUTURE RESEARCH STEPS

The primary next step after this report is to continue the first round of interviews on the TP-plans with the remaining projects. When this data-collection round is finalised, a more in-depth interpretation will be possible based on the preliminary findings presented in this report. Moreover, other data-sources need to be explored further: the next step will triangulate the findings of the interviews with the content of the TP-proposals in order to sketch the communalities and differences in the choices for collaboration and networking within the TPs. The future analysis will pay more attention to the following questions: What is 'general'? What is specific to a cluster? Are there differences between the TPs associated with other patterns (if any)?

This further analysis will not be limited to a purely inductive approach: experiences of the Belgian TPs will be confronted with existing research on international mental health care reforms and with theoretical insights and core concepts (e.g. networking, continuity of care, needs-based care etc) too. A further analysis is needed on the issue of collaboration and levels of integration of different parts of the TPs. The field of inter-organisational studies on innovations can potentially support to develop a better understanding on how people (both on the levels of channels of communication and influence) and organisations (structures, leading organisations etc) are 'networked'. This is expected to be of added value to understand the factors facilitating and impeding (barriers) the functioning of TP, within each particular TP-setting. The triangulation with insights from scientific literature will enable to develop statements on the underlying models of collaboration and networking.

The second intermediate report will explore the theoretical issues, and make a final analysis of the first round of interviews with all projects. The report will analyse all collected data, data-sources with regard to the plans and scientific insights and theories to draw more substantiated conclusions.

For the future stages of the process-evaluation, we have to develop a better understanding on how the issue of complexity and 'long term support needs' are emerging in the different clusters and for the different age groups. The future analysis will also need more reflection on what is the 'organisational core' needed to implement effective and efficient changes in the mental health care sector. An in-depth analysis on context and the leadership aspects in the development of a TP needs further exploration, and will be an essential part of the process evaluation. For a government programme, it seems important to understand to what extent the issue of severity and persistence (or complexity and chronicity) relates (or not) to requirements for the organisational model of health care. Data-analysis of the patient monitoring will be integrated. These different findings, gathered in the long-term empirical process, will help to draw final conclusions and recommendations with regard to the implementation of the TP government programme. It is hoped for that at that stage, the parallel research process coordinated by another research consortium on patient participation can shed additional light on the issue of patient participation, as part of these organisational reforms in mental health care.

- **The primary next step after this report is to continue the first round of interviews on the TP plans with the remaining projects.**
- **This further analysis will not be limited to a purely inductive approach: experiences of the Belgian TPs will be confronted with existing research on international mental health care reforms and with theoretical insights and core concepts. The triangulation with insights from scientific literature will enable to develop statements on the underlying models of collaboration and networking.**
- **The future stages of the process evaluation will develop a better understanding on how the issue of complexity and 'long term support needs' are emerging in the different clusters and for the different age groups.**
- **The future analysis will reflect on what is the 'organisational core' needed to implement effective and efficient changes in the mental health care sector.**

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