

Hervormingen in de geestelijke gezondheidszorg: evaluatieonderzoek 'therapeutische projecten' - tweede tussentijds rapport

KCE reports 123A

Het Federaal Kenniscentrum voor de Gezondheidszorg

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tweede tussentijds rapport

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VOORWOORD

Toen de overheid in 2006 de oproep lanceerde voor het opzetten van therapeutische projecten in de geestelijke gezondheidszorg, was het de bedoeling om – binnen een gegeven kader – ruimte te laten aan het lokale initiatief. Dat er meer dan 80 initiatieven in het programma gestapt zijn, is op zichzelf een positief signaal. Maar hoe zien die initiatieven eruit? Beantwoorden ze aan de bedoelingen van de initiële oproep? Het project is nog niet ten einde, en dus is het te vroeg om hier reeds zware uitspraken over te doen. Dit rapport geeft een tussentijds beeld, maar het evaluatiewerk is niet voltooid. Sommige delen van het werk werden ook afgebroken, met name de patiëntenmonitoring, maar ook dat zegt iets over de grenzen waarbinnen innovaties met sterke verankering op het terrein moeten opereren.

Dit tweede tussentijdse rapport is in meerdere opzichten atypisch ten opzichte van andere KCE rapporten. Het handelt over een project dat over meerdere jaren loopt en gefinancierd wordt met aparte middelen – maar het volgt wel de KCE werkprocessen. Het werk is sterk georiënteerd op kwalitatieve data. Het rapport geeft een tussentijdse stand van zaken – maar een aantal tendensen en patronen lijken hier toch al uit te kristalliseren. Dit tweede rapport reikt een aantal mogelijke aandachtspunten aan wanneer programma's voor organisatorische innovaties in de geestelijke gezondheidszorg in de toekomst worden opgezet, zowel op het niveau van het overheidsprogramma's als aandachtspunten die kunnen meegenomen worden door de actoren in het veld wanneer ze samenwerkingsinitiatieven willen opzetten.

In de loop van het onderzoekstraject werd de onderzoeksequipe substantieel herschikt. De nieuwe onderzoeksequipe heeft in het afgelopen jaar heel veel inspanningen geleverd om zich op korte termijn in te werken in een toch complexe materie en zet zich in om dit project tot een goed einde te brengen in de geest waarin het KCE projecten uitvoert. Wij wensen alvast ook alle medewerkers van de projecten nogmaals te bedanken voor hun medewerking en rekenen nu al op hun verdere inzet om verder informatie toe te leveren in de eindfase van het onderzoek. Ook het RIZIV en de FOD Volksgezondheid bedanken we voor hun steun en interesse in het werk van het KCE. Samen met hen kijken we uit naar de verdere conclusies die we uit dit boeiende initiatief zullen kunnen trekken.

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Samenvatting

DOEL VAN DIT TWEEDE TUSSENTIJD'S RAPPORT

Vooraf: Dit rapport is geen typisch KCE-rapport. Het vervolledigt het eerste tussentijds rapport en dient gelezen te worden in het verlengde van de vorige executive summary.

In 2006 werd een programma voor therapeutische projecten (TP's) in de geestelijke gezondheidszorg gestart door de Belgische federale Minister van Volksgezondheid. Dit programma had als doel om ervaringen op te doen met nieuwe 'netwerk-georiënteerde' organisatiemodellen in de geestelijke gezondheidszorg. TP's dienden met patiënten met een "complexe en chronische" psychiatrische problematiek te werken, binnen vooraf afgebakende clusters (i.e. 'kinderen en jongeren', 'volwassenen', 'ouderen', 'verslaving' of 'forensische psychiatrie'). Het programma omschrijft een algemeen kader waarbinnen elke individueel project eigen 'bottom-up' voorstellen kan doen voor samenwerkingsinitiatieven. Therapeutische projecten hebben als doel om een 'geïntegreerd samenwerkingsmodel van voorzieningen' te implementeren in duidelijk gedefinieerde werkingsgebieden, met een aanbod van diensten dat tegemoet komt aan de noden van de patiënt, een continuïteit van zorg garandeert, en de integratie van de patiënt in de maatschappij bewerkstelligt.

Het Rijksdienst Instituut Ziekte en Invaliditeitsverzekering (RIZIV) specificeerde dat elk project ten minste volgende partners moet opnemen: een psychiatrisch ziekenhuis of een psychiatrische afdeling; een Centrum Geestelijke Gezondheidszorg of een 'pilot project' (psychiatrische thuiszorg of outreaching), gefinancierd door de Federale OverheidsDienst (FOD); een eerstelijnsdienst (een huisartsenkring, geïntegreerde diensten in de thuiszorg (GDT)).

Het RIZIV is verantwoordelijk voor de terugbetaling van zorggerelateerde activiteiten. Dit is geregeld in een conventie (artikel 56) die de voorwaarden bepaalt voor de terugbetaling van activiteiten. Het FOD staat in voor de terugbetaling van de activiteiten gerelateerd aan coördinatie en 'transversaal overleg', alsook voor de ondersteuning van dataverzameling voor het evaluatie onderzoek (nl. een patiënten monitoring). Voor de For-K projecten (cluster 'kinderen en jongeren' in forensische psychiatrie) financiert de FOD alle activiteiten.

Het KCE werd door de federale Minister van Volksgezondheid gevraagd om in te staan voor de wetenschappelijke evaluatie van de implementatie van het programma door middel van de analyse van de plannen, ervaringen en resultaten van de geselecteerde projecten. Dit evaluatieonderzoek is gestart in 2007.

Dit is een tweede tussentijds rapport van de studie naar Therapeutische Projecten. Een eerste tussentijds rapport werd gepubliceerd in februari 2009. De focus van de twee tussentijdse rapporten is de analyse van de plannen van TP: een analyse van de interpretaties en voorgenomen doelstellingen van elk individueel TP en hun reflecties over en reacties op samenwerkingsinitiatieven. Het tijdschema van de interviews liet toe dat eerste implementatie-ervaringen van de TP's al konden geschetst worden. Dit tweede tussentijds rapport legt meer dan het eerste de nadruk op clustergerelateerde patronen. Andere eventuele patronen die tot uiting komen in de data, worden eveneens vermeld.

De aanvankelijke bedoeling van het KCE was om een "kwalitatieve" onderzoeksbenadering te combineren met een "kwantitatief" gedeelte, nl. informatie die bekomen werd van de initiële projectvoorstellen en interviews dienden aangevuld te worden met patiënten data die verkregen werd door een patiënten monitoring. Deze werd echter stopgezet door het FOD in september 2009 (officiële communicatie in januari 2010), omwille van technische implementatieproblemen.

Hoewel enige voorlopige lessen geïdentificeerd worden, kunnen in dit stadium van het onderzoek geen finale conclusies over effectiviteit van samenwerkingsmodellen noch overheidsaanbevelingen worden geformuleerd.

METHODEN

Het eerste tussentijds rapport was gebaseerd op een onvolledige dataset van 44 projecten van een totaal van 82 projecten. Voor dit tweede tussentijds rapport werden de overblijvende 37 projecten geïnterviewd tussen januari en maart 2009 (1 project heeft geweigerd om geïnterviewd te worden). Deze volledige dataset (81 TPs) werd geanalyseerd via kwalitatieve data-analysetechnieken die beschreven worden in het eerste tussentijds rapport.

RESULTATEN

De resultaten zijn gebaseerd op de interviews met vertegenwoordigers van 81 TPs, nl. 23 in de cluster 'kinderen en jongeren', 46 in de cluster 'volwassenen' en 12 in de cluster 'ouderen'.

PERCEPTIE VAN TP'S OVER HET PROGRAMMA

In het algemeen vertonen de therapeutische projecten een positieve houding ten aanzien van de algemene doelstellingen van het programma. Voor sommige TPs biedt het programma een opportuniteit om te experimenteren met samenwerkingsmodellen tussen organisaties en deskundigen. Voor andere projecten voorziet het TP in de eerste plaats een financiering voor een bestaande samenwerking tussen partners.

De meeste projecten formuleren specifieke opmerkingen bij de administratieve vereisten van het TP-kader. Projecten hebben gemengde opinies tegenover de verplichte deelname van het type formele partners in de samenwerking. De verplichte participatie van voorzieningen van tweede en derde lijn wordt gezien als een mogelijkheid tot continue uitwisseling van expertise. In bepaalde clusters wijzen geïnterviewden echter op een mogelijk risico van medicalisering (een medische benadering van psychiatrische stoornissen) en stigmatisering, voornamelijk voor projecten die werken met kinderen en adolescenten. De verplichte betrokkenheid van de eerstelijnsdiensten/thuiszorgdiensten (voornamelijk met betrekking tot de participatie van de huisarts) wordt in het kader van vermaatschappelijking van geestelijke gezondheidszorg gezien als een belangrijk gegeven. Hun betrokkenheid in de dagelijkse werking rond de patiënt wordt echter niet altijd als relevant beschouwd voor elke betrokken doelgroep. Hun verplichte betrokkenheid stimuleert wel het delen van expertise. Voor patiënten is de huisarts vaak hun eerste contactpersoon en vertrouwenspersoon.

Projecten reageren ambigu op de frequentie van opvolgvergaderingen, zoals opgelegd door het TP-kader. Deze timing wordt ervaren als niet in overeenstemming zijnde met het tempo en de evoluerende noden van de individuele patiënt, noch aangepast aan de kenmerken van de doelgroep. Toch wordt erkend dat deze regelmatige vergaderingen een manier zijn om te netwerken en informele contacten tussen partners en deskundigen uit te bouwen. Deze vergaderingen maken het mogelijk om van elkaar te leren en stimuleren verder een continu reflectieproces op het aanbod van zorg.

DOELSTELLINGEN VAN DE TP'S

TP's interpreteren het programma op verschillende manieren. Als gevolg hiervan is er een grote variëteit in de TP-doelstellingen zoals vooropgesteld door de individuele projecten.

De ingediende plannen (RIZIV-voorstellen) worden meestal niet gezien als praktische werkinstrumenten voor de dagelijkse uitvoering van TP. Voor vele projecten werden de voorstellen pragmatisch geschreven om te beantwoorden aan de administratieve vereisten van het programma.

In de meeste projecten zijn beoogde doelstellingen van het project vrij algemeen gedefinieerd. Elementen als 'continuïteit van zorg' en 'zorg op maat' worden vaak geciteerd als een hoofddoel van TP, maar deze doelstellingen worden slechts zelden in detail uitgewerkt.

De meeste TP's maken niet spontaan een onderscheid tussen doelstellingen voor patiënten en doelstellingen voor partners/netwerk. Veel TP's leggen eerder de nadruk op doelstellingen voor partners/netwerk dan op doelstellingen voor patiënten. De doelstellingen voor partners/netwerk worden dan impliciet gezien als een middel om doelstellingen voor patiënten te bereiken.

In veel gevallen worden TP's uitgewerkt om een antwoord te bieden op moeilijkheden die zorgprofessionals ervaren in hun dagelijkse activiteiten (i.v.m. geen continuïteit of onaangepast aanbod van zorg, de doelgroep, praktische problemen, enz.). Het voorgesteld samenwerkingsmodel en de doelstellingen zijn hoofdzakelijk gebaseerd op deze dagelijkse lokale ervaringen.

De meerderheid van de TP's ontwikkelden voorstellen in functie van voorafgaande, formele of informele, samenwerkingsverbanden tussen professionals of organisaties. Slechts enkele TP's hebben zich in een volledig nieuw samenwerkingsinitiatief geëngageerd.

De TP's selecteerden hun doelgroep, hun werkingsgebied en hun werkingsmodel overwegend op basis van activiteiten van de betrokken kernpartners, en op deze van de initiatiefnemende partner in het bijzonder.

Sommige projecten brengen meer specifieke doelstellingen naar voren: vb. het ontwikkelen van een samenwerkingsverband tussen verschillende sectoren die betrokken zijn in de geestelijke gezondheidszorg; het beperken van zowel het aantal hospitalisaties als de duur van het verblijf en de patiënt thuis laten verblijven als alternatief voor hospitalisaties; het verbeteren van de toegankelijkheid van zorg of evolueren naar een meer rationeel en efficiënt gebruik van zorg. De doelstelling om de toegankelijkheid van zorg te verbeteren wordt vooral in de cluster 'ouderen' en 'verslaving' naar voor gebracht als een hoofddoelstelling.

In bepaalde regio's werd de uitwerking van projecten begeleid of soms zelfs gestuurd door de overlegplatforms geestelijke gezondheidszorg, vb. in het definiëren van de doelstellingen van individuele projecten.

VERSCHILLENDE SAMENWERKINGSMODELLEN

De therapeutische projecten hebben heel verschillende samenwerkingsmodellen voorgesteld om drie centrale groepen taken te coördineren: m.n. 'administratieve taken' (het verzamelen en versturen van de vereiste documenten naar het RIZIV), 'de coördinatie tussen partners' en 'de coördinatie van zorgactiviteiten rond de patiënt'.

De 'administratieve taken' worden in het algemeen georganiseerd op twee manieren: ofwel worden ze gedelegeerd aan een administratieve afdeling van één van de partners (vaak de GDT of de administratieve dienst van ziekenhuizen), ofwel, in een beperkter aantal TP's, worden ze uitgevoerd door de project coördinator.

De organisatie van de coördinatie van de partners en de coördinatie van zorgactiviteiten verschilt tussen de projecten. Bepaalde patronen treden hierbij op:

- Een meerderheid van de projecten stuurt activiteiten van het netwerk (op strategisch en operationeel niveau) via stuurgroepvergaderingen. Dit zijn formele vergaderingen met vertegenwoordigers van de formele partners. De inhoud en de frequentie van deze vergaderingen verschilt tussen projecten. Enkel een beperkt aantal projecten stuurt de activiteiten van het netwerk op een andere manier.
- Vergaderingen zijn een zeer belangrijk coördinatiemechanisme in alle projecten. De inhoud, timing, frequentie, locatie, participatie, status en mate van formalisering van deze vergaderingen varieert in sterke mate. Terwijl sommige projecten tot 3 verschillende soorten vergaderingen onderscheiden op verschillende locaties, hebben andere projecten slechts één enkele geïntegreerde vergadering die alle verschillende aspecten van het TP behandelt.
- Projecten gebruiken verschillende formele instrumenten voor de coördinatie van activiteiten (stroomschema's, gestandaardiseerde procedure voor communicatie en besluitvorming, zorgplan, enz.). Het gebruik van deze hulpmiddelen varieert tussen projecten. Het gebruik en de ontwikkeling van zorgplannen varieert sterk tussen projecten.
- De rolomschrijving en de verdeling van de taken tussen coördinatoren varieert sterk tussen de projecten. De verdeling van coördinerende taken (ondersteunende en kerntaken) tussen personen verschilt zowel op het niveau van de coördinatie van patiëntgerelateerde taken als op het niveau van netwerkgerelateerde taken.

Factoren die deze verschillen verklaren zijn: de complexiteit van het netwerk (het aantal en het type (sector) van de partners); de kenmerken van de doelgroep; zowel culturele (regionale) invloeden als voorgaande samenwerkingservaringen. In deze fase van het onderzoek is het niet mogelijk om clustergerelateerde patronen te identificeren.

EEN LEERPROCES

De ontwikkeling van een TP als een samenwerkingsinitiatief is een leerproces. Projecten wijzen op een aantal factoren die samenwerking bevorderen of bemoeilijken.

Communiceren met partners en deskundigen om de doelstellingen en de werkingsmethoden van het project duidelijk te maken wordt als heel belangrijk ervaren. Projecten begrijpen dat daar tijd voor nodig is. Een (bedoeld) cascade model van informatieoverdracht, waarin formele partners informatie over de doelstellingen overdragen naar hun individuele zorgprofessionals, leidde in vele TP's in een gebrekkige informatieoverdracht. Projecten wijzen ook op moeilijkheden om individuele professionals te betrekken bij deze nieuwe werkwijze en hen te overtuigen van het belang en het nut ervan.

Vele projecten ontwikkelen het samenwerkingsmodel in de loop van het implementatieproces (de eigenlijke werking van het project), veel meer dan gebruik gemaakt wordt met een duidelijk vooraf gedefinieerd samenwerkingsmodel.

Legitimiteit (het aanvaarden van de rol van de coördinator) en vertrouwen opbouwen tussen partners en coördinatoren worden als cruciaal ervaren. Samenwerking is meer dan enkel een instrumenteel gegeven. Een gebrek aan wederzijds vertrouwen (vaak gebaseerd op een gebrek aan informatie en op verschillende belangen) hebben een negatieve invloed op de betrokkenheid van partners en/of deskundigen en op het functioneren van het project. De administratieve verplichtingen verhinderen soms het actief betrekken van bepaalde partners en op die manier ook de ontwikkeling van vertrouwen. Reeds bestaande (goed functionerende vormen van) samenwerking bevorderen de ontwikkeling van vertrouwensrelaties.

Het TP-kader vereist onder andere dat informatie over patiënten tussen verschillende betrokken partners gedeeld wordt. De projecten geven aan dat het tijd vraagt om eventuele weerstand of vooroordelen ten aanzien van de deelname van de patiënt aan vergaderingen te overwinnen.

TOEKOMSTIGE ONDERZOEKSTAPPEN

De data die verkregen werd tijdens de eerste ronde van interviews tonen aan dat hervormingen zoals een TP-programma, plaatsvinden in een zeer complexe context. Ze worden beïnvloed worden door verschillende actoren (individueel en georganiseerd) met verschillende belangen en met hun eigen gewoontes, werkwijzen en doelstellingen die eigen zijn voor elke sector; en door culturele verschillen.

De volgende onderzoeksstappen bestaan uit een tweede ronde van dataverzameling met de lopende projecten. De nadruk komt te liggen op hun ervaringen bij de implementatie van hun TP. We zullen op een meer deductieve manier werken, in die zin dat hypothesen over effectiviteit van netwerken uit de wetenschappelijke literatuur getoetst zullen worden in de verzamelde empirische data over de ervaringen van de projecten. De doelstelling is een beter inzicht te verwerven in de bevorderende en belemmerende factoren voor de implementatie van een samenwerking in een lokale context.

Scientific summary

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GLOSSARY

ABBREVIATION	ENGLISH	FRENCH	DUTCH
CMHS	Community Mental Health Service	Centre de Soins de Santé Mentale CSSM	Centrum voor de Geestelijke Gezondheidszorg CGG
CPW	Centre for Public Welfare	(nonexistent)	Centrum Algemeen Welzijnswerk CAW
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 d’Habitations Protégées IHP	Initiatief Beschut wonen IBW
ISHC	Integrated Services Home Care	Services Intégrés de Soins 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 Mentale PFSM	Overlegplatform van de Geestelijke GezondheidsZorg OGGZ
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 Psychiatriques 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
SAS	Schools Advisory Service	Centre Psycho-Médico-Social (PMS)	Centrum LeerlingenBegeleiding (CLB)
TP	Therapeutic Project	Projet Thérapeutique	Therapeutisch Project

I INTRODUCTION

I.1 THERAPEUTIC PROJECTS: COLLABORATION IN MENTAL HEALTH CARE

This is the second intermediate report on the evaluation research of the “Therapeutic Projects” (TPs), reporting the state of the art of an ongoing evaluation research on a policy programme on reforms in Belgian mental health care.

The background of this research is extensively described in the first intermediate report^a. In 2006 the Federal Minister of Health Care launched the programme “Therapeutic projects and transversal consultations” as an initiative to stimulate new collaborative working practices in mental health care. The objectives of this programme can be summarized as the development of ‘needs-based care’ for persons with ‘complex and chronic’ psychiatric problems, more community oriented care with a guarantee of ‘continuity of care’ and developing collaboration between different professionals involved in the care of patients. The government’s programme also tried to introduce the use of care plans as a tool to support the activities around the patient. The programme is coordinated by the Federal Public Service (FPS) and the National Institute for Health and Disability Insurance (NIHDI).

This research is a health services research focusing on collaboration and organisational issues. It does not focus on the clinical approaches used within the projects. The overall scope is to assess the plan, process (implementation experiences) and impact of TPs. The Belgian Health Care Knowledge Centre (KCE) has been asked to assess to what extent the organisational and collaboration models of the TPs contribute to the intended objectives of the government’s TP-programme.

Other aspects such as patient and family participation, and the role of patient and family organisations are studied by another research consortium.

I.1.1 Objectives of this second intermediate report

This second intermediate report is a state-of-the art report elaborated along the same research lines as the first intermediate report, but completes it on several aspects. It has to be kept in mind that the implementation of the TPs is still ongoing and that additional data have to be collected on the implementation process and impact of the TPs. An overall analysis will only be presented in 2010. As is the case for the first intermediate report no definitive conclusions can be drawn from this report.

This reports completes the first intermediate report on the plan-evaluation of the TPs and analyses the choices on the TP-design and some of the experiences of all 81 TPs interviewed (1 TP refused an interview). The first intermediate report described the data from the first phase of interviews of 44 TPs conducted from July 2008 until September 2008. This second intermediate report adds information on the plans and first implementation experiences from additional 37 projects. These interviews were conducted during a second phase and by a different research team from January 2009 until the end of March 2009.

^a http://www.kce.fgov.be/index_nl.aspx?SGREF=5265&CREF=12687
http://www.kce.fgov.be/index_fr.aspx?SGREF=3466&CREF=12688
http://www.kce.fgov.be/index_en.aspx?SGREF=5216&CREF=12689

Table 1.1: overview of the TPs interviewed

	TPs interviewed between June and September 2008		TPs interviewed between January and March 2009		Total number of TPs interviewed
	FR	NL	FR	NL	
Children and adolescents	7	7	4	5	23
Adults	14	12	5	15	46
Elderly	2	2	1	7	12
	23	21	10	27	81

An important backdrop for this research, with major implications for the research process, is that the patient monitoring (aiming at a prospective monitoring of patient characteristics) has not been implemented. This implies that we cannot report on the case mix characteristics of the TPs (see also infra).

1.2 METHODOLOGY, DATA COLLECTION AND ANALYSIS

1.2.1 Methodology

This research uses a programme evaluation approach (for details see first intermediate report pp. 15-19). This research evaluates the plan, the process and the organisational effectiveness of the TP-model, not the effectiveness of clinical psychiatric approaches neither of pharmacological interventions. An important part of the research addresses the collaboration mechanisms and the organisational model of the TP: the constitution of the partnership, the types of coordination and collaboration, the barriers and facilitating factors of collaboration.

The unit of analysis is the TP. The government's programme is the framework in which these TP develop. The government's programme is a rather open-ended tender, which means that there was no "top-down" imposed collaboration model that had to be implemented. The government's programme allowed that individual initiatives were free to propose "bottom-up" models of collaboration and partnerships, fitting within the conditions of the tender (the framework). This bottom-up approach implies that each individual project clarifies its particular ambitions and objectives as formulated in their TP-proposal ("the plan"). We initially focussed on the question on how the TPs themselves conceived their collaboration model, and tried to understand their motivations to propose a collaboration initiative as they did.

A first step of the research thus consists in describing the objectives of each individual TP (by means of document analysis and interviews) both on the level of patients and on the level of the collaboration model. The aim of this research is not to analyse and assess individual TPs, but make an aggregated analysis embedded in a cross-comparative analysis of the TPs, in order to deduct overall observations. The research pays particular attention to the "clusters" as identified in the tender. Clusters are defined by age groups (children and adolescents, adults, elderly persons) and mental health area (addictions, forensic psychiatry). The research tries to understand whether some particular patterns emerge connected to these clusters.

This report describes and analyses to what extent the different proposals (within the identified clusters) have common or diverging objectives. The future steps will focus on the facilitating and impeding factors to implement collaboration models and reach intended objectives (as far as these projects have been very specific in their aims and objectives).

Although this research pays a lot of attention to the perspectives of different actors involved in the TP, it is not conceived as a stakeholder analysis. The research will collect data on stakeholder perspectives, but does not use a method of stakeholder analysis. Neither does it focus on the patient, 'patients and family organisation' participation issues as this is the subject of another research by another research consortium.

1.2.2 Data collection

Semi-structured interviews were conducted for each TP by at least two researchers. One researcher mainly moderated the interview, while the other took fieldnotes and observations. The interviews were group interviews in which different persons of the TP were participating.

It were open-ended semi-structured interviews. The interviewers used a checklist. The interviews were tape-recorded and summarized in thematic field notes. The interviews were summarized in synthesis documents using themes such as previous experiences of collaboration, number and types of partners, catchment area, inclusion/exclusion criteria, objectives of the project, elements of coordination at the patient and partner levels, financial issues. The syntheses were cross-validated by at least two members of the research team. These syntheses were analysed based on thematic analysis. We did not aim a discourse analysis for which we decided (also for practical reasons: 81 interviews with a time variance of about 1 hour up to three hours, in two languages (French or Flemish)) not to work with formal transcripts. The tapes were used as backup and guarantee that original interview data can at all times be recalled.

1.2.3 Data analysis

We used the software Nvivo8 to code the raw qualitative data. We continued with the codes used for the analysis of the first interim report. Each researcher was allocated a series of coding themes for which he/she did the necessary coding work of all newly transcribed interviews. The coding work of each researcher was cross-validated by a second researcher in a second round (and when needed discussed with a third person). The additional information and the process of coding resulted in some adaptations of the coding schemes used for the first 41 TPs. The analysis focused more than the first intermediate report on “clusters” (children and adolescents, adults and elderly, addiction problems and forensic TPs) and –if observed- on other patterns.

A separate analysis was done for TPs that discontinued.

1.3 PATIENT DATA

The initial aim of the research was to triangulate results on patients profiles of projects from the interviews with data obtained via patient monitoring. However, the collection of data via standardised and validated registration instruments at patient level has been discontinued. Problems with the timing of making the registration operational related to delays in technical implementation of the data monitoring information system have led to the formal decision in autumn 2009 by the government to abandon the patient monitoring. This has of course a major impact on the initial purpose of this research.

Results

2 HISTORY OF TP

The first intermediate report indicated that many TPs based their TP-proposal (their 'plan') on a longer history and experiences of collaboration between partners. Of those TPs already interviewed by the end of December 2008, only a small number initiated a first time ever collaboration. The additional interviews confirm these observations

A TP collaboration without any previous collaboration at all (at least between a number of the participating partners) is occurring rarely. A complete absence of previous contacts or collaboration between any of the partners is a situation hardly met.

- For the clusters adults, elderly and children and adolescents only some projects started as a new collaboration. For the clusters addiction and forensic no information at all was mentioned concerning absence of collaboration neither for the subgroup children, nor for the subgroup adults. This conclusion holds both for French-speaking TPs and Dutch-speaking TPs .

2.1 PREVIOUS COLLABORATIONS BETWEEN PARTNERS

The first intermediate report distinguished two main forms of previous collaboration: formal and informal:

- Informal forms: These forms of collaboration are mainly based on 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 without 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 of collaboration are 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).

French-speaking TPs mainly refer to informal ways of collaboration, while in Dutch-speaking TPs both informal and formal forms of previous collaboration are mentioned.

Table 2.1 Summary table: previous collaborations between partners

	Informal collaborations	Formal collaborations
Characteristics	<p>Informal relations between individual health care professionals</p> <p>People know each other from (previous) work experiences</p> <p>Contacts in the context of individual patient needs or information needs</p>	<p>Previous collaboration on organisational level</p> <p>Formal definition of roles, operational modes, and/or funding</p> <p>Definition of common aims and purposes</p>
Regional differences	Mostly French-speaking TPs	More often Dutch-speaking TPs
Collaboration at the patient level	Individual professionals working together on patient issues	<p>Pilot projects (psychiatric home care or outreach projects)</p> <p>Collaboration initiatives at community or provincial level</p>
Collaboration on mental health care topics ‘	Often in the context of MHCCP : discussion of particular topics(general and working party meetings – e.g. addressing particular topics)	Training events

2.1.1 Informal collaboration between partners

2.1.1.1 *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 the Mental Health Care Consultation Platform (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). ‘Working parties’ within the MHCCPs focusing on a particular patient group (eg for child psychiatry, for addiction problems, forensic etc) were the setting in which mental health care organisations met or collaborated previous to the call of TPs. Dutch-speaking TPs of the cluster ‘children and adolescents’ explicitly stated that many meetings at patient level already occurred between different sectors in the framework of the “*integrale jeugdzorg*” (integrated youth care). Health care professionals know the professionals of other sectors quite well. These pre-existing collaborations functioned as a ‘breeding ground’ for TP-proposals (including the refinement of previous initiatives).

2.1.1.2 *Informal collaboration on patient level*

Previous informal collaboration on patient issues was also developed between individual professionals. Health care professionals who (had) work(ed) for different organisations (e.g. psychiatric facilities) are reported to facilitate contacts.

2.1.2 Formal collaborations between partners

2.1.2.1 *Formal collaboration on mental health care topics*

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

- Some projects refer to common training of professionals regarding mental health care 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 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). Other TPs mentioned that ambulatory and residential mental health services jointly prepared 'pilot projects' (even if for some these activities were not funded by the government).

The '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; organising psychiatric care at home), but seldom as a structural partner. Professionals at this level point at a lack of knowledge at the level of mental health care and a need to further develop this

2.1.2.2 *Formal collaboration at patient level*

As also pointed out in the first intermediate report 'pilot projects in Belgian mental health care' are the framework in which previous formalised collaboration often took place. Formal collaboration focused on patient issues (psychiatric home care (PHC) or outreach) 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 meetings about patient cases. Initially, these meetings were mostly organised to plan patients discharge from the hospital.

The role of the coordinator was, in this case, funded by a shared budget coming from organisations involved, and sometimes through additional public (a.o. provincial) funding (see innovative programmes in mental health care, circuits of care, case management and cooperation initiatives). 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).

- The great majority of TPs built partnerships with partners with which they have collaborated previously, be in formal or informal ways.
- The selection of partners is largely influenced by the perceived specificity of patients needs. If inclusion criteria for patients are defined more broadly, often partnerships become more extended.
- Dutch-speaking projects refer more to formal forms of previous collaborations than the French-speaking ones.
- Previous formal partnerships were partly formed in the context of 'pilot projects' in mental health care or funded initiatives on provincial or community level.

2.2 THE PREPARATION OF THE TP- PLAN

In quite a number of the projects the people actually implementing the TP-plan are different from those who initially developed the TP-proposal. Due to the time span between the development phase of the TP and the interviews on the preparation of the TP-plan (as already described in the first intermediate report) we have to take into account that we may be missing information on the details of the preparation process of the TP-proposals. Although the research team requested the attendance at the interviews of key people in the development of the TP, these persons were not always present. A number of TPs though made an effort to invite those people involved in the preparation and development of the plan but who were not collaborating in the TP anymore.

2.2.1 The role of MHCCPs and ISHC

Table 2.2 summary table of the role of MHCCP and ISHC

	MHCCP's	ISHC
Tasks	<ul style="list-style-type: none"> • Communication of the call to potential collaborators • Guiding and coaching role in process of TP development • Grouping proposals, comparison of similarities and putting forward proposals with high potential for funding (per province) 	<ul style="list-style-type: none"> • Communication process to (potential) individual primary care collaborators

The NIHDI note of 27th March 2006, outlining the requirements for TP-proposals, stated that the call had to be communicated via the MHCCPs and ISHC. The first intermediate report already described that the role of the MHCCPs was more than just communicating the call. The MHCCPs had a guiding and coaching role in the process of TP development, often in order to enhance the chances of obtaining funding for TP-proposals (grouping of TP-proposals, comparison of similarities in different proposals and putting forward proposals with high potential for funding (e.g. focus on a specific age group or specific patient group)). This seems especially the case in the Flemish part of the country (SPIL vzw (the MHCCP for 'Limburg'), VLABO vzw (the MHCCP for 'Vlaams Brabant'), POPOVGGZ vzw (the MHCCP for 'Oost-Vlaanderen') and the MHCCP for 'West-Vlaanderen'). We have collected far less detailed information about such a coordinating role of MHCCP in the French-speaking part of the country except for the province of 'Liège'.

A small number of TPs commented on the lack of comprehensiveness of the communication process of these ISHC for individual primary care partners (i.e. not every potential ISHC collaborator seemed to have been informed about this call).

2.2.2 The elaboration of the proposal

2.2.2.1 *Participation in the preparation of the proposal*

Some projects seem to be a continuation (and adaptation) of previous initiatives, rather than an entirely new project adapted to the tender.

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 previously. For other projects, the proposal is elaborated respectively on the initiative of a hospital or an ambulatory service.

In most projects, future core partners have actively participated in the discussions during the elaboration of the proposal, while persons from the initiating organisation edited the proposal.

Many TPs consider the project proposal as the result of a 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. In only one (resigning) TP the top management of the partners elaborated the proposal.

A lot of the interviewed TPs explicitly mentioned that they have elaborated their proposals during preparatory meetings. These meetings generally aimed at an exchange of partner viewpoints and at creating a formal consensus between all partners on the project

In some of these projects, future partners, including primary care partners (e.g. ISHC) were invited to participate. For many French-speaking projects, health care professionals themselves were mandated to the meetings, rather than the management staff of the potential partners. The content of the discussions of these the preparatory meeting was afterwards briefed to each individual participating organisation in order to guarantee support and an endorsement by all partners.

Agreement with the management was considered by many as a necessary condition to submit the TP. The final TP-proposal had at least to be agreed upon at management level. In some TPs members of the management level actively participated in preparatory meetings. For some TPs a lack of agreement with the management on the draft proposal resulted in a process of rethinking the TP.

2.2.2.2 *Content issues of preparing the proposal*

In the first intermediate report an initial listing of themes discussed during the preparatory meetings was described. Some new elements can be added :

- The choice for a specific target group and the criteria for selecting the target population was a discussion point in a number of TPs. In the cluster children and adolescents difficulties in selection of a target group according to DSM-IV criteria are mentioned. Especially French-speaking TPs in this cluster emphasize that this was an important discussion point in preparation meetings.
- Some TPs indicate that the development of a common vision on the provision of care was explicitly discussed. Other TPs agreed “to collaborate” without an explicit or elaborated model of how to do this. For these latter TPs this working model was discussed in more detail in meetings taking place once the TP-proposal had been accepted.
- Criteria for selection of partners as indicated by NIHDI: In several TPs reflections are voiced regarding the formal conditions imposed by NIHDI. TPs often indicate that the preparation phase of the TP consisted of a ‘moulding’ of the individual project into the NIHDI-format .
- The practical organisation of the TP, including following issues:
 - The individual care plan: Only a few selected TPs explicitly mentioned to have elaborated a methodology for outlining a care plan.

- The future partners to be selected as members of the partnership
- Role of partners regarding particular tasks
- Expectations about partners' commitment in the TP; e.g. the obligation for formal partners to participate in patient and steering committee meetings (this aspect influenced decisions regarding formal or informal partnership).
- The financing of the participation in meetings: In the provinces 'Limburg' and 'Oost-Vlaanderen' the administrative coordinator ISHC uses a common scheme for attendance for all projects
- The participation of the patient/ family organisations in the actual patient meetings or in the broader organisation process of the TP. Especially issues with regard to professional secrecy dominated the agenda in this respect (see also further).
- Development of tools and materials which should enhance the workings of the TP (see tools).
- Discussion of lack of experience of partners in specific problem area's and possible ways to resolve this. Especially the lack of experience in mental health care issues by primary care workers was addressed
- Implications of time allocation for meetings on clinical time and on FTE allocation to clinical work.

Many TPs mentioned that preparatory meetings drifted off in lengthy discussions on deontological or ethical issues. Some more frequently reported examples of these discussion topics are:

- rules for financing contributing partners
- the underlying value systems of different service providers e.g. the willingness to allocate a core position to the general practitioner (GP) and to reward this in financial terms, e.g. enhancing the budget for individual payment of a GP's attendance and not doing so for attendance of other practitioners.
- 'a possible danger of preferential position of patients who have been included in the TP' Some TPs actually question whether, due to existing waiting lists, partners would resist the pressure to prioritise 'TP patients' on their individual waiting lists
- Issue of shared legal responsibility (discussions about the legal position of a patient for whom the care process is overseen by a network)

2.2.2.3 *Preparation time*

The preparation time of TP-plans and proposals varies widely: from only a very few weeks up to a year or a year and a half. The small number of TPs that consulted very few people to write the proposal used far less time in general for this preparation process than those TPs with a lengthy consultation process in which most or all partners were involved.

A few TPs explicitly emphasized the importance of consensus between collaborating partners and time needed to realise this. These projects state that this contributes to a smooth running TP once it actually starts. Some even compared themselves to other TPs of which they knew they had a less intensive preparation phase but that were experiencing difficulties later on.

2.2.3 The selection of the partners

An overall comparison of the arguments of the interviews learned that some key principles guided the selection process of future partners.

Firstly partners considered for participation were often organisations previously involved in some form of collaboration: TPs often say that the choice of a partner is a 'natural' choice. This is especially the case for non-obligatory formal partners.

Secondly knowledge and expertise of a particular partner with the specific patient group influenced the involvement of this partner in the TP.

Thirdly the selection process was guided by the preset NIDHI criteria although this is often not explicitly cited as a guiding principle.

- **The MHCCP had a coaching role in the development and submission of proposals in many provinces.**
- **The level of detail with which core issues in the preparation phase were developed is limited for most TPs.**
- **The time spent on the actual preparation of the TP varies widely between projects. A limited number of TPs involved only few persons in the development of the TP proposal.**
- **Previous collaboration, knowledge and expertise about a particular patient group and NIHDI-guidelines are the key guiding principles for the selection of partners.**

3 OBJECTIVES OF THE TPS

Table 3.1 Summary table of the objectives mentioned by the TPs

Collaboration objectives	Patient and family		<ul style="list-style-type: none"> - Involving patient and family in: defining the care pathway (clusters 'children and adolescents' and cluster 'elderly') and decisions concerning the care plan - Strengthening of the existing social network around patients - Offering a place to share difficulties with professionals
	Partners	General	<ul style="list-style-type: none"> - Reinforcing and formalising the relationships between professionals/institutions/lines/sectors - Developing trust - Sharing knowledge - Guaranteeing 'consistency' and coherence between services
		Operational	<p><u>Most mentioned:</u></p> <ul style="list-style-type: none"> - Patient /ethical issues - Patients' referrals - Caregivers' expertise - Primary care workers support <p><u>Less mentioned:</u></p> <ul style="list-style-type: none"> - Identifying different roles of professionals - Coordination during acute crisis - training of professionals - Care plan with responsibilities - Shared patient file - Evaluation of the daily TP-functioning
Service delivery objectives	Transitions		<ul style="list-style-type: none"> - Continuity of care: mainly transitions and hospital discharge - Needs-based care (general statement) - Avoiding 'health-care-shopping' - Strengthening of the role of the GP - Improving patients' perception that they can rely on professionals
	Accessibility		<ul style="list-style-type: none"> - Reducing exclusion of patients from institutions - Developing access to services offering long term follow-up after an acute crisis
	Better use of care		<ul style="list-style-type: none"> - Reducing number of hospitalisations/length of stay/ redundancies of care/ 'shopping' behaviour/'revolving-door-patients'
Outcome objectives	Patient level	General (and often not specified)	<ul style="list-style-type: none"> - Improving mental health status, reintegration in the society - some isolated more specific objectives: treatment compliance, destigmatisation, return home, early detection,..
	Professional level	General and not specified	<ul style="list-style-type: none"> - Professional development and mutual support
Other	Strategic reasons		"being part of a change movement" rather than a clear cut plan for a patient group

3.1 INTRODUCTION

This section describes the aims of the TP, as described by the interviewees. We slightly changed the organisation of the topics as presented in the first intermediate report. Moreover, some additional aspects are introduced.

It is interesting to observe that the meaning given to a TP, differs between projects. Several categories of objectives are put forward:

- Objectives with regard to collaboration with patients and collaboration of (health) care providers and professionals:
 - General objectives are objectives expressed in very general terms.
 - Operational aims are related to the practical organisation of the TPs (e.g. the regular meetings between partners and patients).
- Objectives with regard to the 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 or at professional level.

In the previous intermediate report, we noticed that some projects stated that the TP-framework offers an opportunity to experiment with models of organisational and professional collaboration. For some other projects, the TP enabled to fund an existing practice of collaboration between partners. The involvement of patients and the support of families was also put forward as an important objective. Continuity of care (particularly between hospital and ambulatory care, sometimes within the sector of health care itself, or often between the health care sector and other sectors) was in general terms put forward as a motivation to elaborate the TP. For some TPs, improving accessibility of care, by reducing exclusion of patients from institutions or lack of long term follow-up, was also presented as a main purpose. Some projects underlined that the development of a network (through the TP) is necessary to leave an institution, to reduce both the number of hospitalisations and the length of stay and to maintain the patient at home. Developing a more rational and efficient use of care, chosen by the patient or family, was put forward as an important objective, in order to reduce redundancies of care or '(health)care-shopping-behaviour'.

Some of these observations can be extended on the overall analysis; others have to be nuanced (especially with regard to the patient participation).

3.2 COLLABORATION OBJECTIVES

Some of the collaboration objectives refer to the organisation of professional communication with the patient (section 3.2.1). Most of the objectives mentioned refer to the collaboration between partners (section 3.2.2).

3.2.1 Patient and family level

The involvement of patients and families in defining the care pathway is sometimes put forward as an objective, especially in the clusters 'children and adolescents' and 'elderly'. However, this objective is formulated in rather vague terms (e.g. '*offering information to the family*', '*involving them*').

Some TPs aim at involving patients and families in meetings and in decisions concerning the development of the care plan. One TP (cluster forensic) tries to realise the reintegration of the patient in his family. A very small number of TPs in the cluster 'children and adolescents' insist on supporting and strengthening the existing social network (which includes the family network), rather than to substitute for it. Some selected TPs suggest that decisions on a transfer to a residential form of support should also consider the family situation. One other project (cluster adults) stresses that one of the objectives of the TP is to offer a better visibility of the different institutions, often unknown and/or feared by patients.

A small number of French-speaking TPs stress the importance of offering patient and families a place where they can share their difficulties with professionals and where they can meet each other (co-animation of workshops aiming at patients from different institutions). This place is also an opportunity to give patients the responsibility of their own care. This needs-based approach is not aiming at offering a standard trajectory of health services, but wishes to adapt the supply to the needs thus allowing the patient to choose services or facilities in an informed way.

3.2.2 Partner level

3.2.2.1 *The general objectives*

The need to reinforce, support and formalize the inter-institutional relationships is put forward as a core objective, as well as the reduction of the distance or gaps between health care lines by means of an independent mediating coordinator and the 'integration of care delivery'. More specifically, a few TPs aim at formalizing an existing situation by 'upgrading' a link at interpersonal level to the level of a link at organisational level (i.e. to extend an established relationship between two individual persons from two different services to a more global relationship between these two services).

An explicit objective sometimes mentioned is developing trust between all actors involved and sharing knowledge about the available services and their ways of functioning (facilities, admission process, limitations of care, types of health care provision, vision on care, working habits and target groups) in order to broaden the possibilities of care for patients, to develop a better mobilisation of the available services, and to avoid stigmatisation of the patient and to help the transfer of difficult cases.

A certain number of TPs stress the necessity to function in a network and insist on the importance to '*link their worlds*': health care and welfare, social and medical, ambulatory and residential, hospital and non-hospital, prisons and non-legal care, first, second and third line, and family actors. Amongst the cluster 'addictions', most of the TPs have the objective to improve communication between mental health care and addiction services.

Some partnerships aim to develop a complementary model of care in which different professionals stay within their respective competence whilst respecting the same philosophy and deontology in a team-based-approach. One TP summarizes this idea in saying: "*bringing the partners together in order to help the patient to get better*". One of the main aims is to guarantee 'consistency' and coherence between services and to improve contacts between different actors of the network of care. One particular (resigning) TP, aimed at ensuring coherence between the care for the child and the care for the parent (parents were part of the therapeutic approach).

A minority of Dutch-speaking TPs explicitly mention "*the development of care pathways*" as the main purpose of the TP. The aim is to implement care pathways involving different organisations and services from multiple sectors.

3.2.2.2 *Operational objectives*

Many TPs have elaborated on operational objectives at the level of partners in the projects. Often meetings are explicitly put forward as a means to implement these operational objectives, especially by French-speaking TPs.

Operational objectives mentioned most often are:

- improvement of communication between partners: confronting different viewpoints of professionals on the treatment and needs of the patient or on ethical and deontological questions
- sharing information about common patient situations (e.g. to avoid similar errors in the future, to develop an overview of the patient situation and to make an inventory of the health care use of patients and the perceived difficulties)
- improvement of patients' referrals

- enriching caregivers' expertise about a precise problem area and/or about a specific patient group
- avoiding the feeling of isolation in primary care workers (they work often only with patients) and giving them a place where they can be listened to

Following operational objectives are mentioned less often:

- establishment of a personal contact between hospital services and general practitioners
- development of a clear description of the specific roles of all professionals involved in the care of an included patient
- optimisation of the coordination during an acute crisis and optimising the differences in communication strategies (especially since there is a risk that different providers set different patient objectives after a crisis)
- support for the training of professionals (see first intermediate report p. 29 for more details)
- development of a care plan (see first intermediate report p. 29 for more information)
- use of a shared patient file (in some Dutch-speaking TPs)
- 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
- handling difficult situations

Some individual TPs have other specific operational objectives. One TP aims at creating an inter-institutional link by *“investing in a common place which is managed jointly by the different partners round the patient”*.

3.3 SERVICE DELIVERY OBJECTIVES

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

Even if 'continuity of care' is often cited as a motivation to elaborate the TP (particularly between hospital and ambulatory care - sometimes within health care, or often between health care and other sectors), it is rarely mentioned explicitly, or only in very general terms.

3.3.1 The transition between organisations

Projects mainly speak about continuity of care in terms of transitions between hospital and ambulatory care or hospital discharge. The potential harmful effects of transition periods should be reduced. They refer to the 'cross-boundary' and 'information' aspects of continuity with regard to the management of transitions. They mention aims such as: assuring the post-hospital follow-up, reducing the waiting period before admission, meetings between professionals in order to avoid repetition of the same information to the family, using a shared patient file or offering a "succession of structured and coordinated therapeutic sequences" at the right moment. Most of these TPs aim at ensuring the health care delivery after the hospitalisation period (few TPs include the period before patients are admitted into hospital). A limited number of TPs consider the risks of relapse during transition periods.

The dimension 'flexible' is underlined by several TPs, often using the term 'needs-based care'. Only the care that patients' needs must be provided. Services must be offered, not imposed. Patients should not be locked up in a pathway which is imposed in a standardised manner.

For one TP, aiming at alcohol addict patients, continuity is a way to avoid 'health care shopping' by giving the GP ("better placed" and "ideal provider") a central place to build a network round the patient.

A very small number of TPs refer implicitly to the 'experienced' dimension of continuity. According to these, "*knowing that there is someone*" gives the patient the possibility to remain stable (even if the contact is not intensive and if care is not always provided by the same institution). It is also important that patients and their family know that they can count on professionals who have the same philosophy of treatment.

3.3.2 Accessibility of care

For many TPs, particularly in the clusters 'elderly' and 'adults addictions', improving accessibility of care is an important objective. These projects aim at the reduction of exclusion of patients from institutions or aim at developing access to those services offering long(er) term follow-up after an acute crisis. The projects distinguish two particular categories of patients: (a) patients who already have used mental health services but often encounter difficulties in accessing appropriate care and (b) the persons suffering of mental health disorders who did not receive appropriate care previously because of their reluctance in using these services (e.g. isolated or depressed elderly, homeless people) on the one hand or because of their ignorance of their (psychiatric) symptoms on the other hand.

According to some projects, the TP is expected to offer a solution to the exclusion of patients with co-morbidity or complexity of symptoms. Indeed, having access to services may be a problem for these patients. Therefore, TP is considered as a way to improve this situation by allowing more communication between professionals (e.g. social services are more inclined to help addicted patients with psychiatric comorbidity or socially excluded persons with budget problems if they know their psychiatric problems are treated by other professionals). One project considers that TP is a way to reduce waiting lists.

3.3.3 A better use of care

The improvement in service delivery is resumed by a small number of TPs as "*putting the patient at the right place at the right moment*".

Some projects underline that the development of a network (through the TP) is necessary to reduce both the number of hospitalisations and the length of stay, or to maintain the patient at home with the necessary support. According to them, alternatives to hospital care can be more easily found if different partners meet each other (e.g. PHC with home helpers), and seek coherence and consistency in the care process (see first intermediate report p. 31 for more details). The hospitalisation time should be used to its best advantage in getting partners round the patient, strengthening the existing network and showing patients the way to home care. In the same logic, a minority of projects promote day-hospitalisations.

A limited number of TPs aim at a more rational and efficient use of care, this in order to reduce redundancies of care and '(health) care shopping behavior'. One TP mentions it is important that patients obtain the necessary information on care provision (see also section '3.2.1 Patient and family level') in order to be able to make their own decisions regarding their own care.

Early and timely health care delivery is cited as an objective by a few TPs, this in order to prevent the worsening of patients, to increase awareness for substantial psychosocial problems in specific target populations, to be able to detect warning signs and to mobilise specialised providers (see first intermediate report p. 31 for more details).

3.4 OUTCOME OBJECTIVES

The additional interviews mainly confirmed the findings of the first intermediate report in terms of outcome objectives. We have indications that objectives at patient level are seen by a lot of the projects as an implicit and assumed result of the partners' collaboration objectives.

3.4.1 Patient level

For some TPs, and mainly in the clusters 'children and adolescents' and 'elderly', the main objectives are directly linked to the specific patient group. They mention in very general terms issues such as mental health status and reintegration or social issues (family life, employment, social integration, school life, etc.) (e.g. *"to make something for this specific population"*, *"to have a better view on the patient group"*).

Only a few isolated TPs mention:

- Improving treatment compliance in order to avoid acting-out
- De-stigmatisation of the mental illness to open the door for seeking help in psychiatry (especially in the cluster 'elderly')
- Helping the patient (cluster 'children and adolescents') to find their position back in the social network (with family, neighbourhood and overall school)
- Working for the reintegration of the patient and to give him the possibility to return home (particularly in the cluster 'adults': orientate the patient to extramural)
- Improving the recognition of the specificity of the patient group
- Some other general issues are mentioned such as: a better follow-up (e.g. to avoid acute crisis after hospitalisation), a *"more holistic approach"*, a *"supplementary expertise"* and an *"earlier detection"*

3.4.2 Professional level

A small number of projects mention rather general objectives with regard to professional development and mutual support as an aim to reach through collaboration.

Some projects submitted proposals for strategic reasons (*"We want to be a part of the movement"*). One resigning TP aims at implementing a psychiatrist peer review network, in order to support individual psychiatrists.

3.5 SPECIFIC CLUSTER-RELATED INFORMATION

In the cluster 'children and adolescents', the objective is often the formalisation of what professionals were already doing previously. In this cluster, it is sometimes mentioned that it is important to link the health care provision with psychiatry or to have a holistic approach.

TPs in the clusters 'addictions' and 'forensic' insist on the importance to better identify the needs of patients, to improve the accessibility of care and to link mental health care with other sectors (e.g. legal sector). More specifically in the cluster 'forensic', the emphasis is on giving caregivers involved support and on improving the patient referrals.

In the cluster 'elderly', most of TPs had the objective to provide support (emotional and professional) to caregivers who are working with elderly. Professional support should enable earlier detection of the mental illness' signs. The importance of accessibility of care is also stressed.

- In many cases, the TP enables to fund, reinforce, support and formalise an existing practice of collaboration between partners.
- TP is seen as a means to 'link different worlds' (e.g. health care, welfare and social care; ambulatory and residential services; prisons and non-legal care; first, second and third line; patients and family actors).
- TP is often seen as a means to reduce both the number of hospitalisations the length of hospitals stays and to maintain the patient at home
- Continuity of care (particularly between hospital and ambulatory care) is often cited as a main aim of the TP, but it is seldom elaborated upon in detail.
- TP is often regarded as a way to improve accessibility of care, by reducing the exclusion of patients with co-morbidity or complexity of symptoms.
- Developing a better use of care was put forward as an important objective, but is often not elaborated upon in practical terms.
- Objectives at patient level are seen by a lot of the projects as an implicitly assumed result of the partners' collaboration objectives.

4 SELECTION OF THE TARGET POPULATION

Many aspects observed in the first intermediate report on the selection of a target group and the observation that ‘chronic and complex’ is more an issue of multiple needs rather than one of the severity of the psychiatric disorder are confirmed. Some other additional elements are mentioned too, especially with regard to the notion of care trajectory.

4.1 MOTIVATIONS FOR SELECTION OF PATIENT GROUP

Table 4.1 Summary of main reasons and some problems for selecting a target patient population

Main reasons	Particular experience of the TP partners with a particular patient population Perceived needs of specific patient groups Service-related issues in a geographic area (e.g. current provision of mental health care services for a particular population)	
Inclusion criteria		
Age criterion	Children and adolescents	More specified age groups
	Elderly	Problem of 65 age limit
Psychiatric diagnosis	Children and adolescents	In some cases not considered needed (stigmatization)
Multiple problems		Problems in different life spheres to maintain in community
Exclusion criteria (less explicit in many cases)		
Patient diagnosis	Lack of psychiatric diagnosis	
	Elderly	Sometimes dementia
	Adults	Mental retardation
Patient needs	Sufficient social network	
	Support from less than three partners/professionals is needed	

In the first intermediate report, it was noticed that the criteria used to include patients differed between the TPs and were not always clearly defined. Reasons for selecting the patient groups were diverse, but mainly driven by three general types of motivations: patient-related issues (i.e. perceived needs of specific patient groups, considered difficult to treat), service-related issues (problems related to the coverage of mental services in the chosen catchment area) and professional expertise -related issues / particular experience of the TP partners with a specific patient group) (see first intermediate report p. 37 for more details).

The common and most pragmatic reason is that partners choose a patient-group they are already working with. But, the reasons for selecting a patient group are often formulated in very general terms. Some projects give the priority to patients who have problems with accessibility of mental health care. Particularly in the cluster elderly (especially concerning patients with early dementia) interviewees stress the lack of psychiatric service supply and the shortage of facilities in the catchment area (see also section ‘3.3.2. Accessibility of care’). These TPs mainly want to facilitate the transition between hospitals and rest homes, to reduce the waiting lists and to improve the availability of specific services. One project selected aged persons because “*in a mainly rural region, this is a population who does not easily asks for psychiatric help, because this is still considered as a taboo*”. A small number of TPs, mainly in the cluster elderly, deliberately chose to define the target group as a very broad/wide category (no specific inclusion or exclusion criteria) in order to exclude as little patients as possible. Part of the motivation for this choice is also to avoid stigmatisation of patients. Other projects use broad/wide categories for more pragmatic reasons (to reach the imposed caseload).

One TP focuses upon adolescents with adjustment disorders (“*troubles de l’adaptation*”) to create a specialised service in the hospital where they initiators of the TP work.

4.2 INCLUSION AND EXCLUSION CRITERIA

4.2.1 Inclusion criteria

Only a small number of TPs use a formal list of inclusion criteria (e.g. problems in at least N life domains; At least N years of illness; At least N admissions to a hospital,...). Only few of these TPs count these criteria in strict quantitative score (such as: at least N criteria must be met). A vast majority of TPs chose, often deliberately, broad and flexible criteria for inclusion (see section 4.1).

Additional to the NIHDI-criteria (age and disorder) many projects use one or more of the following inclusion criteria:

- Geographical place of residence (i.e. within the catchment area of TP)
- Problems in multiple life domains and/or co-morbidity (psychiatric or other disorder (sometimes indicated as different problem areas on axis IV DSM-IV TR)
- Need for support or consultation with multiple partners (some TPs will exclude the proposed patient if less than 3 partners are involved in the care process)
- Expected added value for the situation of the patient (being the first criterion for a certain number of TPs)
- (Explicit) informed consent of the patient (and of the family, for one TP aiming at elderly patients)
- Ongoing psychic problematic (the patient is for a long time in process of receiving care/help)

Some isolated TPs use more rare criteria:

- Residence of the patient (residential or ambulatory)
- Acute need implying a bad access to care
- Gender of the patient
- Language of the patient
- Possible use of antidepressants (elderly)
- Lack of a stable living situation

A very small number of TPs aiming at forensic patients, requires the risk of recidivism and the supervision by the juvenile court as a necessary inclusion criteria.

4.2.1.1 Age criterion

TPs addressing adults and aged persons generally apply the general age range set by the government's programme. For the cluster elderly, a number of TPs commented on the + 65 age limit and preferred to lower it to + 60. In the cluster adults, a small number of TPs focuses on a particular age subgroup with a higher incidence of a psychiatric problem (e.g. borderline under 45 year old).

Within the cluster children and adolescents, TPs specify more detailed age-group subcategories than the overall age clusters (e.g. 0-7 years). The motivations are often based on different needs of age-related subgroups. TPs in the cluster forensic children and adolescents point out that under the age of 12 problems are less severe, whilst especially from 15 years onwards more important and complex problems occur with this subgroup. Some remarks were made on the problems with the upper age limit of 18 for adolescents. This age limit can have major implications on the continuity of care provision. The age limit is experienced as a formalistic limit, because the maturity and development of an adolescent can be very different and may require a different approach (projects in the cluster forensic and addiction). The preset format of age clusters obliged certain TPs to opt for a subgroup in their patient population (e.g. both youngsters and young adults in age range 16- 25).

4.2.1.2 *Psychiatric disorder*

A great number of the TPs did not give explicit information on the topic of diagnosis. A small number of TPs whom were interviewed during the second round state that they do not require a specific psychiatric diagnosis to include the patient in the project. These projects mention the limited availability of psychiatrists (thus impacting on the possibility to obtain a psychiatric diagnosis), the reluctance towards stigmatising children and adolescents with a clear-cut diagnosis (because they still evolve) and the willingness to include any patient with a mental disorder (see section 4.1).

Some other projects require at least a(n indication of) psychiatric disorder. A small number of these TPs even specify other sub-criteria of inclusion such as (psychiatric) co-morbidity (e.g. personality disorders and developmental disorders; psychiatric disorders and mental retardation).

4.2.1.3 *Multiple problems*

The presence of multiple problems in different domains is regarded as more important than the diagnosis for most of the TPs aiming at patients living in the home environment (see section 4.1). Only a small number of TPs explicitly require both a psychiatric diagnosis and the presence of multiple problems before including a patient in the project.

Whilst a few TPs insist on the necessity of multiple problems without specifying the nature of the problems or the domain(s), other TPs describe the latter precisely. The most cited conditions of inclusion in terms of multiple problems are:

- Forensic status (the cluster 'children and adolescents')
- Problems in several life domains: social, relational, familial, financial, professional, accommodation
- A patient situation which requires the involvement of different services (partners)
- Downward evolution of the psychiatric condition ("Situation getting worse")

A small number of TPs consider the problematic use of care of patients as a being part of a multiplicity of problems. A TP aiming at alcoholic patients explains that it is an "evasive population that never returns to the same institution to be treated". Another TP, aiming at adolescents ("*jeunes en situation de désappartenance*"), explains that these patients "put systematically their network in a "no-win situation" and are then left on their own, isolated".

4.2.2 *Exclusion criteria*

Only a very small number of TPs clearly mentioned that no specific exclusion criteria were defined. For some, this was a deliberate choice (see section 4.1). One TP, aiming at alcoholic patients, states that "exclusion criteria would go against the objectives of their project".

Two main elements are put forward by TPs as rationale to exclude patients:

- Issues related to the patient diagnosis:
 - Only a small number of TPs stress that the absence of a formal psychiatric diagnosis is a motive for exclusion.
 - A certain number of TPs, in the cluster elderly, exclude patients for whom dementia and/or a psycho-organic disorder was the "primary" diagnosis (though, one of these TPs organises meetings for those patients outside the TP-programme).
 - A small number of TPs exclude patients with mental retardation.
 - Patients with addiction problems are not included in a very small number of projects.

- One TP excludes patients with “Antisocial personality disorder” motivated as to protect the professionals, ‘*because of the dangerousness of this population*’. Another TP excludes Antisocial and narcissistic personality disorders because of a potential high involvement with legal services.
- One TP excludes persons with “*a temporary depressive phase after a bereavement, because there are other channels for acute problems*”. In another TP, persons with depression were excluded, as the aetiology could be organic.
- Issues related to the needs of the patients:
 - A certain number of TPs agree that the patient must not be included in the project if the initial assessment shows that the network of the patient functions well or that a positive evolution is taking place (there is no real need then for regular follow-up or involvement of all obliged partners of the project). A very small number of the projects use this criterion for discharging a patient from the TP.
 - Certain TPs exclude a patient if care can be appropriately provided without involvement of 3 partners (i.e. ‘bilateral’ collaboration is sufficient).

4.3 CHRONIC AND COMPLEX

The first intermediate report indicated that the complex and chronic character of the psychiatric disorder is often not delimited in specific terms. When asked explicitly, some individual projects interviewed in the second round, develop some reflections.

Whilst most of TPs clearly distinguish the dimensions ‘chronic’ and ‘complex’ of a psychiatric disorder, a certain number describe ‘chronic and complex’ as a common intertwined characteristic.

A complex problem is identified as:

- The need for consultation and support by different partners (health care professionals and/or institutions) in different disciplines: medical, psychological, psychiatric and social support
- The presence of problems in multiple life-spheres (E.g. social, professional, financial, accommodation educational or family issues)
- A combination of a psychiatric problem with another disorder (E.g. behavioural problems or criminality) and/or co-morbidity of two psychiatric disorders

Complexity is often related to the diversity and the multiplicity of problems in different domains (and therefore the professionals needed to treat) rather than to the severity of the psychiatric disorder itself (see also section 4.2.1.3. ‘Multiple problems’). This element is especially mentioned in projects working with socially vulnerable persons or projects with a social psychiatry approach.

A very small number of TPs remarked that the ‘complexity’ or ‘severity’ depends on the setting of residence of the patient. Some behaviour may be regarded as mild in a residential setting, but as severe in a home context (see first intermediate report p. 73).

The chronic character of a psychiatric disorder refers to longer term linear and/or recurrent character of a problem:

- ‘Chronic’ is used for patients who have been diagnosed for a long time or who experience functioning problems on a long term basis. Duration is not specified. ‘The actual duration of long-term varies a lot between TPs (two years – 6 months). In a very small number of TPs, patients must have had at least two or more hospitalisations before they are considered as having a chronic problem.

- A small number of TPs state that, to be considered as 'chronic', a patient situation should require a complex (and often lifelong) care commitment by different care partners. One TP adds in this respect that there should have been an extensive and difficult "history of care provision".
- One TP sees (the risk of) relapse as an indicator of a 'chronic' situation. Another TP stresses that 'revolving door patients' are 'chronic patients'.
- A very small number of TPs state that, to be considered as 'chronic', a depression cannot only be the consequence of a particular event ('reactive depression').

4.4 CARE PATHWAY

In the first intermediate report, the concepts of 'care trajectory', 'care pathway' or 'care circuit' were not discussed. In the new 2009 data, some TPs refer to this topic but seldom in a clear operational manner. The use of the terms trajectory or pathways is often implicitly connected to the issue of continuity of care for the patient.

Some isolated TPs use terms such as 'common care circuit' (*circuit de soins commun*), 'care pathway/ trajectory' (*zorgtraject*) or 'pathway/trajectory development' (*trajectontwikkeling*) but without giving a clear definition of it.

Some individual French-speaking TPs speak explicitly about 'classic trajectory' (*trajectoire classique* or *parcours classique*) referring to the notion of care programme to describe the different stages the patient (belonging to specific patient group) goes through. Some of these TPs, aiming at forensic patients, feel that the first stage in this trajectory is the admission in a psychiatric institution (on judiciary order), whereas another TP takes the detection of the illness/ diagnosis as a starting point. The following stages are often described as transitions from one particular setting to another (E.g. from residential to ambulatory or from a psychiatric confinement to a social reinsertion) in function of the evolution of the patient situation.

- **Reasons for selecting the patient groups were mainly driven by perceived needs of specific patient groups considered difficult to treat, problems related to the coverage of mental services in the chosen catchment area and particular experience of the partners with a patient group. Projects also based their choice on more pragmatic reasons.**
- **Many projects focusing on 'elderly' refer to the shortage in specific service provision as a main reason to focus on the patient group.**
- **Inclusion criteria are not systematically used and not always strictly defined.**
- **The age limit (preset format age clusters) is experienced as a formal rather than practical limit, especially in the cluster children and adolescents.**
- **While a precise psychiatric diagnosis is rarely considered as a necessity for the inclusion of a patient, the presence of multiple problems in different life spheres is regarded as important.**
- **The notion of complexity is often defined as a combination of needs in different life-spheres rather than the severity itself of the psychiatric disorder.**
- **Chronic is on the one hand defined in terms of duration of a problem or use of care or on the other hand in terms of the recurrent character of problem.**
- **TPs provide little information on the notion 'care pathway/trajectory of care'.**

5 SELECTION OF THE PARTNERS

Table 5.1 Summary overview of the selection of the partners

Formal partners	Obligatory	Number	Only a minority of TPs are small scale and limited to the required minimum number of 3 partners		
		Type	Psychiatric hospitals/units	Main partner in most cases (exception cluster elderly): In Fr tp generally more than one hospital or unit	
			Ambulatory mental health care	<i>In Fr projects, overall</i> , a higher number of mental health care centres	
			Primary care	More limited number (usually 1 or 2) In FR TPs generally individual GP's or medical houses In Dutch TPs more collaboration with ISHC: FR TPs experience important difficulties to include a partner from primary care	
	Non-obligatory	Number	Many projects include several non-obligatory partners (at least one)		
		Type	Most projects include a mix of partners from general health care, welfare, education, legal domain		
			The involvement of family or patient organisations as formal partners is low		
			Health care partners	Large variation in number	
				Children & adolescents	-more partners from the general health care field -often inclusion of general or specialist pediatric hospital services
				Addiction	inclusion of specialised services in addiction treatment or prevention
Cluster adults	often sheltered living, rehabilitation centres, psychiatric nursing homes, day hospitals, night care units, and health care services focusing on integration in the community				
Cluster elderly	more partners from the general health care field				

		Outside_health care	Cluster addiction:	seldom
			Forensic:	most often, inclusion of PYS and penitential institutions
			Children and adolescents	Depends on patient group, inclusion of educational services, family support centres or rehabilitation institutions
			Adults	welfare services
Role		'Core partners'	managerial and strategic activities (not all partners equally involved):	
			Administrative partners	Primary care more administrative coordinator than strategic or clinical input
			'Expert' partners'	specific expertise at the level of patient meetings
Informal partners		<ul style="list-style-type: none"> - Ad hoc participation in the partnership - No role at the level of the partnership coordination - Role mainly with particular aspects of the care of the patient and participation in patient meetings if necessary Sometimes involved after the actual start of the TP -Often social care sector, welfare services or judicial sector Sometimes partners (mental) health care domain (but that do not want to commit formally) 		

As mentioned in the first intermediate report, we use the general label 'partner' to refer to an organisational entity or an individual professional or person taking part in the TP.

The NIDHI tender (27th March 2006) outlined some essential requirements regarding the partners of a TP (see first intermediate report p. 10 for more details): at least 3 separate partners had to take part in the network, of which one should be a primary care partner.

Within the category of formal partners, NIHDI distinguished obligatory partners (at least 3 from separate categories, see first intermediate report p. 10 for more details) and non-obligatory partners (see first intermediate report p. 17 for examples).

As a result of the bottom-up selection process, a wide variation of organisational configurations of these partnerships was proposed (in terms of number of partners as well as in terms of characteristics of the individual organisations). Indications are found that French-speaking projects have overall a tendency to propose configurations with more partners (in number), and more partners from different sectors than the Dutch-speaking projects.

5.1 FORMAL PARTNERS

The additional interviews confirmed that only few partnerships were proposed with a minimum number of 3 participating partners. Some partnerships have chosen deliberately to work with a small number of formal partners because of the requirements for physical attendance at meeting (number and type of formal partners). However, local or regional contextual elements (e.g. 'supply' of (health care) services) may influence the complexity of the configuration of the partnership.

- Some TPs emphasize the importance of making an overview or inventory of available services in their region (this was especially mentioned by those TPs that experience that the available services are insufficient to cover the need of particular target groups).

Most formal partners are, not surprisingly, part of the mental health care domain. Many projects also include non-obligatory partners, from general health care, welfare, education or the legal domain (juridical services) as formal partners in the projects.

During the interviews it became clear that, at least for some TPs, some misunderstandings had occurred which may have influenced the proposed configuration of the partnership. A confusion became apparent between the concepts 'obligatory partners' and 'formal partners' in the NIHDI-tender. Some TPs assumed that the formal partners could only be partners from (mental) health care services and not from welfare or social care services. Some projects complained on this lack of clarity (see also further sections).

During the interviews we focused on the difficulties and opportunities in developing an organisational configuration and the decisions about roles of potential partners. For a descriptive listing of the collaborating partners, interviewees often referred to the TP-proposal.

5.1.1 Obligatory partners

At least one psychiatric hospital or psychiatric division of a general hospital should be an obligatory partner of a TP. A majority of TPs have more than one psychiatric hospital as formal partner however. A limited number of Dutch-speaking TPs have a higher (i.e. 4-5) number of formal hospital partners. These TPs operate in a region/locality with a high concentration of hospitals (e.g. Leuven and Gent). More than half of the French-speaking TPs have up to 7 or 8 hospitals or hospital units as obligatory partners, with one TP in which 20 hospitals participate as formal partners.

Further obligatory partners had to be either Community Mental Health Services (CMHS) or pilot projects/outreach projects. French-speaking TPs opted for a higher number of CMHS as formal obligatory partners, compared to the Dutch-speaking TPs.

The number of formal partners at primary care level is generally more limited (usually one or two). Collaboration with individual GPs or medical houses as a formal partner, is far less common in the Dutch-speaking TPs. Nearly all TPs (except one) in the province of 'Oost-Vlaanderen' and 'Limburg' collaborated with ISHC ('OVOSIT' and 'LISTEL' respectively). In the province of 'Vlaams - Brabant' and 'West Vlaanderen', most TPs collaborated with and ISHC. In 'Antwerpen' the situation is more diverse (i.e. Centre Public Welfare (CPW), psycho-geriatisch network, 'Wit-Gele Kruis') rather than collaboration with ISHC.

The French-speaking TPs reported more refusals by ISHC (SISD) to participate or received no reactions from ISHC. The practical modalities of many of these ISHC (either stopping its activities, either being in a very early start phase) explains the barriers to opt for collaboration. Some of these French-speaking TPs experienced major difficulties for finding a primary care partner in order to be able to submit a proposal. These choices of primary care partners cannot be attributed to a particular cluster.

5.1.2 Non-obligatory partners

We distinguish non-obligatory partners from the health care domain and those outside the health care domain.

5.1.2.1 *Non-obligatory partners from the health care domain*

A large variation between TPs can be observed in the number of non-obligatory partners from the health care domain: some TPs did not include an additional non-obligatory partner, while most TPs include at least one.

In the cluster adults, sheltered living, rehabilitation centres, psychiatric nursing homes, day hospitals, day activity centres, night care units, and health care services focusing on integration in the community are often included as partners.

For the clusters children and adolescents and elderly, TPs include more partners from the general health care field (i.e. residential care homes or geriatric services for elderly; pediatric services for the cluster children and adolescents).

- French-speaking TPs in the cluster elderly did include additional health care partners.
- TPs concentrating on children and adolescents often include health care partners such as general or specialist (e.g. neurology, eating disorders) pediatric hospital services. Except for 2 TPs in the cluster forensic, TP do not include non-obligatory partners from the health care domain.
- TPs in the cluster addiction ('children and adolescents' and 'adults') have included quite a range of non-obligatory formal partners (belonging to the health care domain) – mostly specialised services or organisations in the field of addiction treatment or prevention. Although non-obligatory in the NIHDI-call, these are considered as key partners in the service provision for this particular cluster.

5.1.2.2 *Non-obligatory partners outside the health care domain*

Furthermore we see some cluster-related patterns in the inclusion of non-obligatory partners from outside the health care domain.

In the cluster addiction, non-obligatory partners outside the domain of health care are seldom included, except for some TPs in the cluster children and adolescents that formed a partnership with organisations in the field of youth welfare (e.g. Protective Youth Services (PYS)).

For the cluster forensic (both children and adolescents and adults), non-obligatory partners are considered as key partners though. Without these partners TPs could not be defined as forensic. Youth protection services but also penitential institutions are included most often.

For the cluster adults, a number of TPs have included welfare services (Public Municipal Social Service Department (PMSSD), CPW, 'Service d'Intégration Sociale') but these are seldom considered as strategic core partners. A small number of TPs collaborate with initiatives on re-entry in the work environment (e.g. 'Service d'intégration socio-professionnelle')

For the cluster children and adolescents, the specific patient group seems to affect the inclusion of other partners. TPs working with children of the school age often collaborate with education services (e.g. Schools Advisory Service (SAS)). Those (few) TPs focusing on very small children collaborate with family support centers. TPs working with handicapped children and adolescents include rehabilitation institutions ('MPI/IMP', 'revalidatiecentra').

Only a very limited number of TPs have chosen to have a family or patient organisation as formal partner (non-obligatory partner outside health care domain) collaborating in the TP. As already indicated in the first intermediate report, if they do participate, it is mostly at the level of steering committee meetings. Even though some family or patient organisations have requested to be able to participate in patient meetings, this request meets a lot of opposition. The lack of professional secrecy obligation is considered as a major hindrance in this respect. On some occasions it was also mentioned that participants of patient organisations may personally know some of the patients taking part in the TP, which is regarded as an even more sensitive situation.

5.1.3 The role of the formal partners

The role of partners in the network can be differentiated according to patient related activities on the one hand and management of the partnership on the other hand.

Partners who are involved in a managerial capacity are often 'core partners'. Primary care partners are often mainly taken on board of the partnership because the NIHDI-call urged to do so. In the case of lack of experience with a particular patient group ISHC takes up a more administrative coordinating role rather than providing clinical input in the partnership.

Some TPs asked some institutions or organisations with specific expertise (even outside their region) to be available (in a formal capacity) as an "expert" partner (e.g. for treatment of borderline personality disorder). This expert partner does not participate in the steering committee (management level see *infra*) but may attend patient meetings. This expert role may also extend to informal partners.

5.2 INFORMAL PARTNERS

It is difficult to develop an exhaustive overview on number, type, role or motivations of informal partners (as they did not sign the initial TP-proposal). As a general outcome of the interviews it can be observed that informal partners are invited in an ad hoc way to participate in the partnership. In some projects they were involved after the actual start of the TP (e.g. depending upon the requirements of a particular patient situation).

Informal partners are often services or professionals from the social care sector, welfare services or judicial sector (e.g. street corner workers with homeless young people, Municipal Public Social Service Department ('CPAS'/OCMW), sheltered workshop, integrated youth services, lawyers supported housing, labour rehabilitation, 'AMO', 'CSG', patient and family organisations).

Sometimes services or organisations from the (mental) health care domain which *could* actually have been involved as obligatory formal partners (psychiatric hospitals, general hospitals, additional pilot projects or individual practitioners) participate as 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.

5.3 PARTNERS NOT PARTICIPATING IN THE TP

Some initially proposed partners were excluded by the partnership or refused to participate (see first intermediate report p. 25 for more detailed information). For the latter group two main reasons play a role:

- practical and administrative issues.
 - NIHDI-regulations made some potential partners decline the proposal, this despite a genuine interest in the content and the approach of the TP. Especially smaller services sometimes declined participation as the obligatory representation in (inclusion and patient)meetings would have had important implications in terms of time investment for other (clinical) tasks.
 - Some potential partners decided not to participate in particular projects because they had been invited for participation in several TPs. They expected difficulties in handling the combined workload including the administrative requirements of each individual TP. Some did agree on 'ad hoc' / informal involvement in order to avoid administrative requirements.
 - Some organisations agreed to participate in a TP under conditions i.e; they agreed to participate but not to attend actual patient meetings thus preferring involvement from a distance (phonecalls, mail)
 - Time constraints on GP's working hours makes attendance in meetings very difficult for them. A funding scheme remunerating participation in patient meetings proved often insufficient to counter these constraints. For some GPs or GP-groups this led to refusal to participate in the TP, others agreed to participate.
- motivational/ideological reasons
 - Not being acquainted with the target population of the TP especially for first line services (ISHC). Particularly for the cluster addiction and forensic problems, primary care service providers (including GPs) point out that content-specific knowledge and experience may be lacking, reducing their 'added-value' position in the collaboration.
 - When an occasional (informal) involvement is considered useful a balancing off with practical/administrative requirements may tip over the decision to non-participation. Partners may take different positions in valuing the importance of occasional involvement versus structurally defined participation and this may influence a preference for informal or formal participation.

- **The complexity of the partnership (i.c. the number and type of partners involved) is influenced by local or regional elements, such as the availability of mental health or general health or welfare services.**
- **Some misunderstandings occurred with regard to some concepts of the TP-programme, i.c. the formal and obligatory partners. This may have influenced the constitution of the partnership in some TPs.**
- **TPs have experienced difficulties in attributing the roles of partners.**
- **Partners outside of mental health care sector are often involved as informal partners.**
- **Professional secrecy is used as an argument to exclude some services or organisations outside the health care domain.**
- **The NIDHI-requirements incited some partners not to participate in the TP-programme because of administrative, practical and ideological motivations.**
- **Only in a few TPs the 'family and patient organisation' is involved as a partner.**

6 GEOGRAPHICAL AREA OF ACTIVITY

Most TPs work in a delineated geographical area. Most of the French-speaking projects focus on the Brussels region and the provinces 'Hainaut' or 'Liège'. Most of Dutch-speaking projects are located in the province 'Oost-Vlaanderen' and 'Limburg'.

Some patterns in the choice for catchment areas will be described below.

6.1 SIZE OF THE CATCHMENT AREA^b

As mentioned in the first intermediate report (p. 44), the size of the catchment area differs between TPs:

- Almost all the TPs operate in one region (i.c. the 'Flemish', the 'Walloon' or the 'Brussels' region). Some exceptional projects cover more than one region. In these latter cases the Brussels region is always included.
- A few TPs cover more than an entire province (2 or 3), or parts of two different provinces in the same region. Some TPs cover one entire province.
- Some TPs cover several districts in the same province. Most of them cover parts of several districts. About a quarter of the TPs (mainly Dutch-speaking TPs) cover one district; a limited number of TPs cover only a part of one district.
- Some projects focus on particular areas or a city within the catchment area (e.g. in which the supply of mental health care services is concentrated or, where mental health care supply lacks).

Two kind of factors influence the choice for a specific catchment area, i.c. 'context-related factors' and motivations (which are often 'strategic factors').

Table 6.2 Summary of factors influencing the choice of the catchment area

Context-related factors	Strategic (motivational) factors
<ul style="list-style-type: none"> • Supply of mental health care services • Geographical working area of a major mental health care service • Organisational 'links' between services in a particular area • Specificities of some provinces 	<ul style="list-style-type: none"> • Feasibility of collaboration • Subdividing catchment area's from a feasibility point of view

6.2 CONTEXT-RELATED FACTORS

The choice of the catchment area is closely related to the available supply of (hospital) mental health care services. Rural or geographical extended areas often lack adapted health care supply for the target population, as opposed to other (often urban) catchment areas with higher density of services. In the French-speaking region, many health care services are provided in the provinces 'de Liège' and 'de Namur', while the geographical extended province of 'Luxembourg' has a small density of supply of medical, social and psychological services. In Flanders, many specialised, often large, services are concentrated in one district or a specific part of the province (e.g. a concentration in 'Zuid-Limburg' versus 'Noord-Limburg'; in 'Oost-Vlaanderen' a concentration in the district 'Gent', etc.).

^b Information was used of the TP-proposal documents when no information was provided during the interviews.

The chosen catchment area is mainly influenced by the geographical working area of an important mental health care service (i.e. CMHS, (psychiatric) hospital, a specialised centre), or, for a small number of projects, by several mental health care services. Some projects defined the catchment area based on previous formal collaborations (see first intermediate report). Mainly Dutch-speaking projects based their catchment area on the existing 'care region' of the ISHC. Some projects have based their selection of the catchment areas on the local context of the projects (examples given are the activity area of the legal courts (the Court of Appeal), the planning directives of MHCCP, for one project the priorities of the local council, etc.).

Some differences can be observed between the clusters. However, this does not mean that there is an unequivocal relationship between the cluster and the size of the catchment area.

- In the cluster 'elderly' and 'adults', the catchment area is most of the time smaller than a province and, for half of the projects limited to a district.
- In the cluster 'forensic', 'children and adolescents', most TPs have catchment areas of at least one province. In the cluster 'addiction', it is often connected to a legal district and most projects in this cluster have based the catchment area on the presence of partners with particular expertise about their target population. The projects cluster children and adolescents, sub cluster forensic, have based their catchment area on the legal courts (the Court of Appeal).

A few projects explicitly noticed that the partners in the catchment area (or only a part of it) have been working together for a long time and are often organisationally linked (the districts 'Brugge', 'Mechelen', 'Gent', 'Brussel/Bruxelles' or province 'Limburg' and 'Luxembourg'). In the province 'Limburg', a lot of services are structured at the provincial level.

The specificity of the provinces 'Liège' and 'Namur' have been emphasized during the interviews. These provinces have a lot of initiatives, good means of transport, many patients and health care services. Moreover, in the province 'Liège' the ideas of the antipsychiatry movement are mentioned to have penetrated more. The province 'de Namur' consists of many mental health 'networks', but these separate 'networks' lack mutual interaction.

Partners of one province are more used to work together with organisations of another province than of its own province (see the North and the West in the province 'de Luxembourg' in relation to the provinces 'de Liège' and 'de Namur').

6.3 MOTIVATIONS

Projects themselves do not think in terms of geographical-administrative boundaries (provinces, districts, etc.) to define their catchment area (see first intermediate report p. 44).

Some projects prefer operating in a small catchment area mainly inspired by reasons of feasibility and practicality (such as transport time). For some Dutch-speaking projects, the choice was influenced by the intention to show the particularities of that region to the policymakers. Some projects in the south west of Brussels deliberately aim at avoiding the concentrations of service provision in one particular part of the province (see first intermediate report p. 44 for more detailed information). A limited number of Dutch-speaking projects split the catchment area in more delineated sub-areas in which they develop activities. In some projects we heard arguments for subdividing their overall identified catchment area. The main argument for defining sub-areas are their acquaintance and knowledge of the specific needs and partners in a particular sub-area. One project motivated this choice for a sub-area to guarantee that all partners could propose patients for inclusions (as some of the partners were new to the collaboration). This latter project even used inclusion thresholds on the number of patients to be included on the level of sub-areas.

In case of an extended catchment area, more partners are involved (more expertise, etc.), which is also related to the place or residence of patients.

- **Most of the French-speaking projects focus on the Brussels region and the provinces 'Hainaut' or 'Liège'.**
- **Most of Dutch-speaking projects are located in the province 'Oost-Vlaanderen' and 'Limburg'.**
- **The geographical catchment areas of TPs differ in size: one of more provinces, a district , part of a district**
- **Projects select catchment areas in function of the localisation of partners and patients**
- **The choice of the catchment area is closely related to the available supply of (hospital) mental health care services.**

7 COORDINATION

7.1 INTRODUCTION

Coordination refers to the processes, supporting facilities and tools to align the actions of the actors in order to realise (predefined) purposes of the collaboration. It is a condition to realise better results at the level of the partnership, as well as at the level of patients.

Coordination is put into practice in different ways, by means of a variety of coordination mechanisms: meetings, tools and coordinator(s). The way these coordination mechanisms are thought through and developed in the planning of the project, varies greatly. Part of the description below is therefore already based on experience, rather than on a sole analysis of the 'plan' of the project.

Different types or levels of coordination can be distinguished.

- At the operational level, in general, each project has a small group of active persons who handle the daily coordination and administration of the TP. This operational group is differently labelled as '*dagelijks bestuur*', '*werkgroep*', '*groupe porteur*' or '*bureau*'.
- Many projects use one or more coordinators (persons) for the daily operational work (see section '7.3 The coordinators').
- The strategic coordination is generally ensured by the steering committee meetings. In this meeting, the persons who have the official power of intervening in the functioning of the TP take both operational and mostly strategic decisions.
 - Some projects use general assembly meetings gathering representatives of all partners (formal and informal) of the TP, and sometimes external professionals, obtain information on the TP. These meetings do not occur frequently and do not aim at operational decisions.

- **Three main coordination mechanisms are used by projects : meetings, support tools and coordinators.**
- **Especially aspects about meetings and coordinators have been developed and adapted along the way.**

7.2 MEETINGS

The core coordination mechanism in the TPs are meetings. Different types can be distinguished, i.c. at the partnership level and at the patient level (see Table 7.1).

7.2.1 Meetings coordinating the partnership activities

7.2.1.1 *Steering committee meetings*

Strategic and some operational partnership activities are in many projects managed during meetings labeled '*steering committee meeting*'. All formal decisions about the functioning of TP are taken during these meetings. The projects use a wide variety of labels (e.g. '*projectcomité*', '*stuurgroep*', '*raad van bestuur*', '*bureau*', '*vast bureau/bureau mensuel*', '*comité*' or '*groupe de pilotage*', '*comité d'encadrement*', '*comité de gestion*', '*groupe porteur*' or '*cellule de coordination*').

The steering committee meetings are, in many projects, prepared by a smaller core group of professionals active in the project. They prepare the agenda and collect the necessary information to ensure a smooth running of these meetings (see *infra*).

Participants

The participants are, in most projects, representatives of the formal partners, assisted by the coordinator(s). In some projects, informal partners of the project also participate in meetings.

The steering committee meeting is generally chaired by the project coordinator or an individual who is ranked highly in the hierarchy of a partner institution (e.g. the director or his representative, which is the so-called overall coordinator – see section '7.4. The coordinators'). In the French-speaking projects it is often a psychiatrist.

The participants in these meetings remain generally the same all along the project.

Patients and family organisations can participate in these meetings if they are a formal partner of the project. In reality, they rarely participate in these meetings.

Content

We obtained very little information on the content of the steering committee meetings. The topics discussed in these meetings are strategic issues on the one hand (e.g. aims and vision on the project, organisational changes, criticisms about the federal authorities, dismissing decision, etc.) and aspects related to the formal operational issues (e.g. the implementation of the patient monitoring) within the projects on the other hand (e.g. discussion about the propositions of new inclusions).

The steering committee also addresses issues such as the role and the function of the project coordinator, the perceived operational problems and suggestions for solutions (e.g. 'How to facilitate the participation of general practitioners?').

Frequency and duration

The frequency of the steering committee meetings varies between the projects from twice a year to three times a month. In the majority of the projects, such meetings are organised three or four times a year.

The frequency seems to be inversely related to the level/frequency of informal communication between participants. The more they exchange information in an informal manner, the less they organise formal meetings.

The duration of the meetings varies amongst TPs. The duration of the meetings is affected by the way it is prepared (see supra, i.c. prepared by a smaller core group of professionals) and also by the frequency of the meetings.

7.2.1.2 Other partnership meetings

In some projects, a different type of meeting, differently labeled as '*assemblée plénière*', '*séances plénières*' or '*plenaire werkgroep*', is planned. This meeting is gathering all the formal and informal partners. These 'general' meetings are mainly oriented towards general items and informing the partners involved in the projects. They do not aim at having in-depth discussions on organisational issues. The frequency of these meetings is once or twice a year. These types of meetings are more common for TPs with a large number of partners.

1.1.1 Patient-related meetings

In general, the findings on the inclusion and follow-up meetings in the first intermediate report are confirmed. The additional analysis and data-collection provides some further insights.

7.2.1.3 *Inclusion meetings*

Some projects organise pre-inclusion meetings in order to prepare the formal inclusion meeting. In some projects (especially clusters children and adolescents), the process of pre-inclusion is rather extensive, including different meetings with the professionals, the family and sometimes the patient. This is mainly the case in French-speaking projects.

In some projects, potential eligible patients are pre-assessed during the steering committee meeting, which takes place before the formal inclusion meeting.

Participants

The participants in inclusion meetings are nearly always representatives of the formal partners of TP and the project coordinator.

In the majority of the projects, the patient or family do not participate in the inclusion meeting. Two main reasons are brought forward. Firstly, the inclusion meeting is considered as an occasion to present the patient to the partners, and provide personal information about him/her. Secondly, the partners have to give their point of view on the patient, and as such the presence of the patient could be a problem.

In a minority of projects the patient and the family do participate. In this case, particular attention is paid to explain the attendance of all different partners. Since some of them may not be known to the patient (e.g. this could create a feeling of being overwhelmed by a multitude of different persons).

Content

In the majority of projects, the organisation of the inclusion meetings follows the same schedule :

- A presentation of the patient by his/her representative, based on information provided in an inclusion form (see section '7.4. Tools'). This presentation is sometimes anonymous (in order to respect professional secrecy).
- The designation of the partners that will be involved in the care process based on an (informal) 'needs-assessment' of the patient.
- After the meeting, a written report is mailed to the partners by the project coordinator.

Afterwards, the coordinator contacts the designated partners and organise the first follow-up meeting.

Frequency

The frequency of inclusion meetings varies widely between TPs: a lot of TPs have monthly inclusion meetings, some three-monthly. In some individual cases, however, TPs have more than one meeting a month.

The informed consent to be obtained from the patient

The formal requirements for obtaining the patient's informed consent of the government's tender are not experienced as unequivocally clear. As a consequence, the issue of patient's informed consent is dealt differently. The NIHDI-website states that the partners of the TP should obtain the informed consent of the patient and/or his family.

Some TPs ask the patient's informed consent during or after the inclusion meeting. Others only ask the informed consent once partners agree on the eligibility of a patient. The latter projects prefer this option in order to avoid patient disappointment in case partners would not agree upon inclusion of the patient in the TP.

Especially in the cluster 'children and adolescents', issues regarding patient's informed consent are mentioned. In the case of young patients with problems of substances abuse, an informed consent is very difficult to obtain. In the case of younger children, the oral consent is mainly asked from parents. Some situations were mentioned in which the patient is included in the TP, even though his/her parents did not agree. In this case, they are nevertheless informed about the inclusion of their child. In other situations, the child is excluded of the project as soon as the parents do not agree anymore, even though they did agree in the beginning. This information shows that the informed consent of parents is also managed very differently in the projects.

The majority of projects ask a signed informed consent and have developed a special document for this.

7.2.1.4 *The follow-up meetings*

The frequency of follow-up meetings is imposed by the NIHDI-call. The government's call also states that all partners of the TP can be involved but at least three of the formal partners have to actually participate in the meeting (to obtain funding).

Participants

The persons participating in that meeting are mainly the direct care providers involved, but this differs between projects.

In a limited number of projects, not all the direct care providers involved participate, especially in those TPs using tools to support information transfer and communication (i.c. mailbox of electronic care plan, see section 'experiences').

Patients

The presence of the patient during the follow-up meetings has been planned for only some of the projects. In other projects, its presence is not expected, or depends on some factors. Some projects mentioned that the patient is not always invited to the follow-up meeting, or only exceptionally. Some projects mention that patient participates only in a part of the meeting. The participation of patient in the follow-up meetings seems to depend on the inclusion criteria and characteristics of the target group.

The participation of patient in the follow-up meetings seems to depend on the inclusion criteria and characteristics of the target group (and may so be cluster-related). Projects in the cluster 'addiction' seem to organise more meetings without the patient being present, whilst in the cluster 'elderly' the patient is more often present in the meetings.

Frequency

Some TPs have more follow-up meetings than the required frequency (three monthly). In a limited number of TPs, the meetings take place when partners or family request for it. Some TPs organise intermediate meetings in case of a patient crisis situation.

Time

Generally, the duration of the patient meetings is not agreed upon beforehand.

Location

Some projects, cluster 'elderly', organise the follow-up meetings at the home of the patient, especially these TPs initiated by the ambulatory sector. This location is more easily accepted by the patient.

7.2.2 Separate or combined meetings

Some projects organise clearly identifiable and separate meetings for partnership activities on the one hand and patient-related activities on the other hand. Other projects combine their steering committee meeting with other patient meetings (often inclusion meetings, sometimes follow-up meetings). In the latter case, some projects distinguish the different types of meetings through changing the participants. The following mixed types of meetings are mentioned:

- One project combines the daily management committee with inclusion meetings.
- In another TP, some patient or patient group related issues are discussed during preparatory meetings.
- One TP organises a separate meeting to discuss particular issues related to patients with specific problems.

Sometimes, particularly when several projects have partially converging partners, the same steering committee coordinates the activities of more than one project.

In addition, some projects combine the steering committee meeting with the MHCCP-meeting or with the general assembly meeting.

7.2.3 Other meetings

In some TPs, support meetings are organised. These meetings concern operational issues and bring together the professionals who are the most active in the TP and sometimes also some other partners. These meetings are differently labeled as '*advisory groups*', '*réunion de travail*', '*groupe de travail*', or '*cellule méthodologique*'. These meetings generally support the project coordinator in the coordination of patient-related activities. Depending on the project, they take place every week, every month or they are organised on an ad-hoc basis. These meetings have a more informal character.

- **The complexity of the chosen coordination model differs (i.c. type and number of formal meetings). This is a.o. related to the size of the formal partnership and the use of informal communication/meetings in the project.**
- **Many projects do not separate the coordination of partnership versus coordination of patient-related activities.**
- **The use of the patient's informed consent in the TP-framework is an ethically delicate issue.**

Table 7.1.: Overview of coordination meetings (overall analysis)

	Label	Participants	Topics	Frequency ^c
partnership related activities	General meetings	Formal and informal partners	Discussion and endorsement of propositions from the steering committee	Once a year
	(informal) Workgroup meetings	Members of the core partners)	Prepare the steering committee and/or the inclusion meetings Support the project coordinator	On an 'ad hoc' basis
	Steering committee meetings	Formal partners, Coordinator(s), Chairman	- Strategic and operational topics - Functional decisions The implementation of patient monitoring	From twice a year to three times a month
patient related activities	Inclusion meetings	Formal partners	Presentation of the candidate The designation of the partners The patient consent	From monthly to three-monthly
	Follow-up meetings	Involved care providers The project coordinator/the care mediator Patients	General discussion on the evolution of the patient	Three-monthly
	Informal meetings	The coordinators	Preparation of other meetings, resolution of some problems	On an 'ad-hoc' basis

^c Many projects combine different types of meetings on one moment.

7.3 THE COORDINATORS

Most projects incorporated coordination tasks in the person of a single coordinator or more than one coordinator. The conception of the role of coordinators and the task differentiation between persons or actors varies a lot between projects however.

In the first intermediate report, different labels were introduced to identify different types of coordinators:

- The label ‘overall coordinator’ is used for the person who is both supervising the project coordinator and the overall functioning of the TP.
- The label ‘project coordinator’ is used for persons who are running the project on a day-to-day base: both partnership and patient-related issues.
- The label ‘administrative coordinator’ is used for the person(s) who perform(s) the formal administrative requirements for the external financing agencies (i.e. the NIHDI).

7.3.1 The overall coordinator

Only some projects created a function of an ‘overall coordinator’. It is mainly conceived as a support function for the project coordinator with regard to the coordination of the partnership. The role of this person incorporates operational tasks such as motivating the partners, resolving some organisational problems, ensuring that the project runs at the policy level... An overall coordinator supervises the project, but is not involved in operational tasks of patient-related issues.

For most of the projects this function of an “overall coordinator” is not differentiated in a separate function. It is taken up by the chair of the steering committee. The person with this role is generally located in one of the institutions that initiated the project. This person is generally higher in hierarchy to the project coordinator (often a responsible clinical or management function of the coordinating partner). In French-speaking projects, often psychiatrist takes up the role of the overall coordinator.

7.3.2 The project coordinator

The project coordinator takes care of the day-to-day functioning of the project. He/she is in general the contact person of the project.

7.3.2.1 *Tasks of the project coordinator*

In general, the project coordinator is the person who engages and motivates partners and facilitates the communication between them. He/she seems to act relatively autonomous with regard to the daily functioning of the TP (often under supervision of the overall coordinator).

With regard to the partnership-related activities, the core tasks of the project coordinator are communication within and outside the partnership, as well as fulfilling operational tasks (including development of tools). With regard to the patient-related activities, several operational tasks and administrative tasks can be distinguished.

In general, the project coordinator is the central contact person for proposals for inclusions. In most TPs, however, support is provided with regard to the preparatory tasks or activities related to the patient enrolment (e.g. informed consent and communication with the patient, collecting information about the patient). In some projects, the coordinator also organises and chairs the patient meetings, but in other TPs, support is provided for these tasks. Support is often provided for the communication with the patient (see section ‘7.3.2.6’).

In some TPs, the project coordinator contributes to clinical or care expertise in patient meetings. Only in a minority of projects, the project coordinator is even directly involved as health care professional in the health care delivery to the patient.

In most TPs, the project coordinator is also responsible for the completion of the administrative requirements and the transfer of this administrative information to the administrative coordinator (unless secretarial support is provided).

7.3.2.2 *The professional background of the project coordinator*

As mentioned in the first intermediate report, project coordinators have different professional backgrounds. Some similarities can be distinguished, however. In general, they have a diploma in a social or a caring disciplines (e.g. social work, psychology, criminology, sociology, nursing, occupational therapy...). Moreover, most of them have (some) relevant work experience within mental health care. They are known by at least one of the partners of the TP.

7.3.2.3 *Required competencies*

The competency needed most for a project coordinator is knowledge (acquired by experience) of available (mental health) services. Familiarity/knowledge with the patient group is certainly an advantage. A personal network with other professionals active in the mental health care of the patient population is considered as an added value. Several coordinators have said that before their recruitment they already knew “a lot of people”. This proved to be an important advantage to do this job. These elements are important element in being accepted by partners and participants in patient meetings.

Additional important competencies are good communication and motivational skills on the one hand, and administrative and organisational (logistic) skills on the other hand. Less explicitly mentioned competencies are: maturity (both personal and professional), the ability to understand the wider theoretical framework of the TPs, an interest in research and being able to keep a neutral position.

7.3.2.4 *Recruitment*

Coordinators are mainly recruited from the partnership. The majority of project coordinators have been partly exempted from their other work to take up this role, because of their relevant work experience within mental health care. (It is interesting to observe though that in this case only some of the project coordinators had participated in the writing of the project proposal).

Only a minority of TPs published a formal advertisement for the recruitment of the project coordinator. Some of these projects have experienced recruitment problems (too little or lack of candidates). If people are recruited via a formal channel, the candidates were often young and without much experience (related to the financial means of the project). A few TPs deliberately advertised a fulltime function, including a function in the TP on the one hand and a further function in the organisation on the other hand. They took this decision to make the function of TP-coordinator more attractive.

7.3.2.5 *The employment conditions of the project coordinator*

As mentioned in the first intermediate report, the employment contract of project coordinators varies in terms of percentage FTE. Work time ranges from 3 hours to 28 hours.

The majority of project coordinators combine their coordinator function with another activity in the organisation. For most projects, the project coordinator is exempted from his/her previous task for a halftime or less. In a minority of TPs, the person is not exempted from other activities in the organisation, but takes up the coordination of the project in addition to his regular work in the organisation. Some persons are project coordinators of two, exceptional three, projects.

The project coordinator is in most projects located in an institution or centre with expertise for the target population of the project (which is often the organisation who (also) applied for the TP). This is most often a hospital or a residential specialised institution; sometimes the CMHS. Only in a very limited number of projects it are services of the first line, ISHC or PHC (see first intermediate report, p. 66).

7.3.2.6 Support to project coordinator

Project coordinators are often supported by other persons for operational and administrative tasks. In comparison with the first intermediate report, -we changed the labeling of the different types of support.

A first type of support concerns partnership-related activities. The project coordinator collaborates closely with the 'overall coordinator' in most of the cases. In a limited number of Dutch-speaking projects, the ISHC provide logistic support for tasks of the steering committee meeting (e.g. writing a report; exceptionally, chairing this meeting).

A second type of support is provided for patient-related activities. The coordinator often receives support from other persons to coordinate activities around individual patients. We will use the general label 'care mediator' although these support persons receive different names in the projects ('zorgbemiddelaar', 'coach', 'spilfiguur', 'dossiercoördinator', 'casemanager', 'trajectbegeleider'...or 'réfèrent thérapeutique', 'réfèrent patient'...).

Most often, the care mediator is the person who contacts the project coordinator to propose the inclusion of the patient in the TP. This care mediator is usually also the person responsible for the follow-up of the patient. The function encompasses the supervision of the care process of the patient as well as an intermediary person, ensuring the communication between the caregivers and the patient. In some projects, this care mediator also organises and chairs the follow-up meetings and completes the required patient-related documents. In these projects, each patient has his own care mediator. The care mediator can be considered as the point of contact for the patient.

In the majority of the projects, the role of care mediator is taken up by a caregiver who is in close contact with the patient. In exceptional cases this person can be a relative, a relation of the patient, or a caregiver who is not involved in the care of that patient. In particular cases, it may be a professional from the legal sector, sometimes in collaboration with a health care professional. The care mediator may change if patients are transferred between organisations.

A difference has been observed between the French and the Dutch-speaking projects. As mentioned in the first intermediate report (p. 68), for some of the Dutch-speaking TPs, the project coordinators are supported by a separate 'consultation coordinator' (in the province 'Limburg') or 'home care coordinator' (respectively labeled as 'overlegcoördinator' and 'thuiszorgcoördinator') for patients living at home. These persons are employed by organisations outside mental health care (respectively the PMSSD and home services (HS)). This model was already in use before the TP-model was launched. The ISHC planned to integrate it within TPs to avoid two parallel, but comparable types of meetings. In the French-speaking projects, the project coordinator or the care mediator is responsible for the organisation of the follow-up meetings.

In some cases, the care mediator represents the patient if he/she does not participate at the patient meeting. This person would ideally be chosen by the patient, but most often he/she is appointed during an inclusion or first follow-up meeting. The patient could also suggest a suitable person.

In some projects, administrative support is foreseen for the project coordinator to complete the required administration for the NIHDI. This is often done by the administrative services of the organisation in which the project coordinator is employed.

In a minority of TPs, a psychologist is involved separately to provide some scientific support or clinical expertise to the project coordinator.

A third type of support is the support for the administrative tasks. This is elaborated in the following section 'The administrative coordinator'.

7.3.3 The administrative coordinator

Almost all TPs have delegated the responsibility to fulfil the administrative tasks to the ISHC or to an administrative unit of a formal partner (often an hospital). Projects in the province of 'West-Vlaanderen' delegate all the administrative tasks to one single person active at provincial level.

Nevertheless, for some French-speaking projects (and exceptionally in Dutch-speaking projects), the project coordinator is made responsible for the administrative tasks of TP too.

A number of (larger) ISHC coordinate administrative tasks of different TPs within their area of activity.

7.3.3.1 *The tasks of administrative coordinator*

The administrative coordinator performs two main tasks: collecting the required documents and transferring them to NIHDI.

As mentioned in the previous section 'support to the coordinator', in a number of TPs, the administrative coordinator supports the project coordinator in tasks at partnership level (such as chairing the steering committee meetings).

As formal partner of the TP, the administrative coordinator generally participates in the steering committee meetings. Sometimes, he/she participates in inclusion meetings.

7.3.4 Allocation of coordination tasks

Most of the projects have used the government's budget to employ one 'coordinating person' person or a number of persons. A few projects have elaborated another coordination model and did not recruited one coordinator.

The allocation of coordinating tasks is organised in distinct ways.

- The majority of the Dutch-speaking projects seem to have delegated the administrative tasks to a 'administrative coordinator' who does the communication with NIHDI and the transmission of the required documents. These are sometimes supported by one or more additional person(s).
- In some TPs, the project coordinator only performs tasks concerning the coordination of partnership related activities (i.c. the communication and the exchange of documents). The patient-related tasks (e.g. the communication with the patient, the organisation of patient meetings) are managed by the care mediators. In this kind of projects, every patient has an individual care mediator.
 - A minority of projects, have several project coordinators. Each coordinator is mandated by a different partner to perform patient-related activities for the patients included by the respective partners in the project. In this model, it is possible that one of the coordinators takes up a double role, i.c. both as project and as overall coordinator.
- In other projects, the majority of the coordination of patient-related activities is performed by the project coordinator. For some of these activities (e.g. the communication with the patient, the organisation of follow-up meetings) support is provided.
- In a number of projects (more frequently French-speaking), the same coordinator/person performs all the coordination tasks (i.c. the administrative tasks, as well as the patient-related and the partnership related tasks).
- In a minority of projects, coordination tasks have been integrated in the regular work of several professionals involved in the project. In a French-speaking project, the administrative coordination is performed by a ISHC, but the operational patient-related and partnership tasks are performed by professionals (clinicians).

- **Most projects incorporated coordination tasks into one single project coordinator. Only a minority of TPs have not recruited a person to fulfil the role of 'project coordinator'.**
- **Project coordinators are often supported by other persons for the execution of the coordination tasks, especially with regard to the coordination of patient-related activities and the administrative tasks. .**
- **The core tasks of the project coordinator on partnership level are communication within and outside the partnership, as well as operational tasks.**
- **Competencies most needed for a project coordinator are knowledge of available (mental health) services and familiarity/knowledge with the patient group (acquired by experience). Having a personal network with other professionals active in the mental health care is considered as an added value.**

7.4 TOOLS

Some tools are being used to coordinate activities, generally documents in paper or electronic form.

The structure of this section has changed compared to the first intermediate report. The classification (see Table 7.2) distinguishes now (a) tools used by the projects to support the required administrative tasks within the NIHDI-call and (b) tools used to support the operational tasks within the TP (i.e. communication on the project, coordination of partnership and patient-related activities).

Some documents, especially those related to the patient meetings are used for both purposes and can be classified in the two categories.

Table 7.2: Overview of coordination tools.

	Topics	Form
Tools to communicate on the project	<ul style="list-style-type: none"> - A general presentation of the TP (aims and means) - Functioning and practical information - Criteria of patient selection - List of partners with their coordinates 	<ul style="list-style-type: none"> - Folder - Written document - Website - Presentation slides
Tools to coordinate the partnership	<ul style="list-style-type: none"> - The decisions on the operational aspects of the functioning of the TP - The ethical and organisational settings of the TP - Communication between partners - Coordinates of the partners 	<ul style="list-style-type: none"> - Steering committee meeting report - Flow chart - Internet forum - Document to support the professional secrecy
Tools used to coordinate the patient related activities	<ul style="list-style-type: none"> - Minutes of patient meetings - Professional secrecy - Patient consent - Communication about patients - Communication about decisions taken during the follow-up meetings 	<ul style="list-style-type: none"> - Inform consent form - inclusion form - Care plan file (paper or electronic application) - Follow-up meeting report - Other tools
- Required data on patient and on partnership activities		<ul style="list-style-type: none"> - - Inclusion meeting report - Follow-up meeting report - Care plan - Yearly evaluation report

7.4.1 Tools used to support operational tasks

7.4.1.1 *Tools used to communicate information on the project*

As mentioned in the first intermediate report, some projects use specific tools to inform caregivers and patients on the aims and content of their projects. Most of these projects use a leaflet. In other cases more extended written documents, a website or presentation slides are used.

Most leaflets are addressed to professionals however. In a minority of TPs (mainly in cluster adults), a specific or additional information leaflet is created for the patient and/or family. Leaflets are used less by projects cluster 'children and adolescents', 'addiction' and 'forensic' (except for cluster 'children and adolescents', sub cluster 'addiction').

The design of such leaflets differs between the projects. In some projects leaflets are basic in a graphical sense (an A4 black and white photocopied sheet), other are very well developed (printed colored folder, containing photographs, logos...). Some leaflets use an attractive writing-style and focus on the personal added value of the needs-based approach in TP.

The content of the information differs too. Some leaflets present the general context of the 'Therapeutic Projects'. Others explain only the aims and the means of the project: a list of the partners and their coordinates, a brief description of the inclusion and follow-up process, the details of the project coordinator as the contact person of the TP.

The information leaflet is often part of a patient recruitment strategy, using an attractive argumentation (oriented towards the professionals and the patients).

7.4.1.2 *Tools used to coordinate the partnership*

In order to coordinate the partnership activities, projects use different tools. The tools most often mentioned were the minutes of steering committee meetings. Some projects have created a specific document describing the organisational flowchart and the ethical principles of networking. A few projects explicitly mentioned that they use other tools, such as: an Internet forum for the communication between partners or with the contact information of the formal partners; a document to support the professional secrecy.

7.4.1.3 *Tools used to coordinate the patient related activities*

Some projects developed tools in order to support patient meetings and to assure the circulation of patient-related information between partners. Examples are documents incorporating decisions about the patient.

These tools are partly influenced by the administrative requirements related to the general framework of the therapeutic projects (see the first intermediate report for specification on this subject).

The informed consent form

Many projects use a separate information document to obtain informed consent. In most of these documents, information is given about the general aims of TPs. It explicitly asks for consent in order to share information between several caregivers and services. In a minority of these documents, information is added on the rights and obligations if the patient is included in the project.

For most documents the patient has to sign. In some projects, it is accepted that a relative or legal representative sign. In exceptional cases, the informed consent of several persons is required (namely the patient and his legal representative).

Some projects, located in the same province use the same format of informed consent.

The inclusion form

To support the assessment for inclusion of new patients, a vast majority of TPs use a separate form, labeled as “*fiche/feuille d’inclusion*”, “*aanmeldings/inclusie formulier*”. A minority of projects used an already existing form. In one project two different forms are used because the catchment area is divided in two sub-catchment areas.

The documents differ in size based on differences in the required level of detail about the clinical situation of the patient. Most of the projects request an assessment of the caregivers proposing the patient. Only in a very limited number of projects the perspective of the patient is asked too.

This document is anonymous in a minority of TPs. Sometimes, projects located in the same province use the same or similar inclusion form.

TPs use these inclusion forms in diverging ways as described in the first intermediate report. In most projects the coordinator receives a completed registration form by email before the inclusion meeting. The project coordinator can thus examine if the inclusion criteria are respected. After that, the project coordinator invites the partners involved to the inclusion meeting. In a limited number of TPs the project coordinator sends the completed registration form to the formal partners before the inclusion meeting. In projects without a specific inclusion meeting, a pre-inclusion form is sent by email to all the partners before the first follow-up meeting in order to give their agreement.

Other documents related to the inclusion process

Exceptionally, some projects provide an additional checklist of inclusion criteria as an aid for individual caregivers to assess the eligibility of patients to be included in the project.

A minority of TPs (especially French-speaking projects) have created specific documents to present a new candidate to partners, in order to prepare the inclusion meeting.

The “care plan”

Once the patient is included in the project, projects use a care plan to support the care process. This care plan is variably labeled ‘*zorgplan*’, ‘*plan de prise en charge*’, ‘*dossier de concertation*’...

This document is generally the minutes of discussions and decisions taken during the patient meetings. The documents can either be electronic or paper. In one province a common electronic version (*webapplication*) is used by all the projects in that province. In a part of another province two projects use a common electronic patient care plan. In the latter case, all the caregivers involved and the patients have access to that electronic care plan. In a minority of French-speaking projects, it was planned to use electronic tools, but they were not elaborated (and these projects resigned meanwhile).

Some projects explicitly mentioned using previously developed documents (outside the framework of TP) to assess the care needs of the patient and do the follow-up. Part of these projects combine the use of these existing documents with TP specific care plans.

Some regional differences can be observed. The majority of Dutch-speaking projects use an adaptation of existing care plans of the ISHC to collect and communicate the administratively required TP-information for the NIHDI (see first intermediate report). This standardised tool is used to create uniformity between the TPs, and to make different health providers acquainted with one common tool. The other Dutch-speaking projects, as well as the majority of French-speaking projects, have created their project specific care plan documents.

Other documents used to coordinate the patient-related activities

Most often separate minutes of the patient meetings contain the agreements and an evaluation of the situation of the patient since the last patient meeting. These reports are sometimes anonymous, especially in the French-speaking projects.

In most TPs, these minutes of patient meetings are sent to the participants of the patient meeting. In a minority of TPs (mainly French-speaking), it was explicitly mentioned that not all the participants receive a report, but only the care givers directly involved in the care process of that specific patient (or all invited partners to the patient meeting even if they did not participate in the actual meeting). Exceptionally, the patient could also decide on the recipients of the information. The reports themselves are mainly mailed, exceptionally posted.

Exceptionally, French-speaking projects explicitly noticed not writing reports for patient meetings (besides the required report for the NIHDI).

7.4.2 Tools used to support the coordination of administrative tasks

Administrative tasks are essentially related to the communication with the NIHDI. Each project has to provide to the NIHDI some required information by the use of some more or less standardised documents as copies of inclusion and follow-up meetings reports, and a copy of the 'care plan' concerning each included patient.

For some projects, the administrative tools are the same as the operational tools. For other projects, these tools are different and there is some redundancy between the two sort of documents. At this stage however, it is yet unclear for which project this is the case and if this is related to specific patterns.

7.4.2.1 Activity reports

Projects have to send an activity report to the NIHDI. This report has to provide information on the number of patients included, the number of follow-up meetings, and an assessment of the functioning of their project.

- **Although the majority of projects have created new tools adapted to the general framework of the TPs, while some projects use tools previously elaborated in another setting.**
- **Some redundancies are observed in the tools used for the patient-related activities, namely the required TP-administration and the patient file/ care plan (with more specific information about the situation of the patient).**

8 CURRENT EXPERIENCES

8.1 INTRODUCTION

In this section, we summarise some of the initial experiences of the projects as mentioned by the interviewees. The main findings of that report still stand. The structure of this chapter has been slightly changed compared to the first intermediate report, as we integrated some sections. The experiences (process evaluation) will be elaborated upon and discussed during the next round of the interviews. So, this section only reports some preliminary findings.

When reading these preliminary findings it has to be kept in mind that the official start of the approved projects was April 2007, but that most projects were only operational from September 2007 (i.e. after summer vacation). We report on their experiences between the actual start-up and the date of the interview (up till march 2009).

8.2 GENERAL APPRECIATION OF THE TP-PROGRAMME

Overall, the projects recognize the added value and approve of the general aims of the government's programme. The TP-programme is experienced as a potential stimulus to initiate changes in the organisation of mental health care (i.e. '*creating a network*', '*needs-based care*', '*continuity of care*'). Many comments are nevertheless made on the contractual obligations. These are perceived as a "straightjacket" impeding care provision which is adapted to the needs of the patients.

As mentioned in the first intermediate report (p. 70), projects perceive the requirements of the TP-programme in different ways. Opinions differ though between projects and persons within and between projects. In general three types of approaches are observed:

- Some TPs perceive the TP-framework as 'artificial' but decided to participate anyway. They moulded their former collaboration activities in the administrative framework of the tender to be able to continue their collaborative activities. For some projects, the decision to subscribe to the requirements of the NIHDI-call was quite a difficult decision. They tend to deal with the administrative requirements in a very pragmatic manner (e.g. the collection of the required signatures after the patient meeting).
- For other projects, the TP-programme enhances the quality of the former collaboration (e.g. accelerating the involvement of different types of partners, other sectors) or reveals the weak points in collaboration (e.g. some hospitals refused specific patients).
- Some projects explicitly agree that the formal obligations help to organise and structure the project, and they see it as a means to enhance the cooperation and engagement of the partners involved.

8.2.1 Impact of the TP-programme

Projects do not spontaneously disentangle the added value for patients or for partners, although these two lines of reasoning emerge in the answers. In general projects mainly develop arguments on the added value for the partners (the provider side of care). A few projects recognize that an added value for the partners does not necessarily imply a positive impact on the functioning of the patients.

Overall, many projects stress that it would take time for caregivers to experience any added value to participate in this programme, especially because of initial difficulties in dealing with the administrative requirements of the TP (amongst other reasons, see *infra*).

In some clusters it is recognized that the launch of the TP-programme initiated the development of new operational practices in particular geographical areas (in one TP even a new function, financed by the city government). This is especially the case for sub cluster addiction for the group children and adolescents (mentioned only by Dutch-speaking projects).

8.2.2 Financing model

Comments were made on the financial model of TPs. As mentioned in the first intermediate report (p. 71), the possibility to provide funding for an individual to take up a coordination function to coordinate partners and facilitate patient meetings is well appreciated. Projects consider it as an added value that one or more identifiable persons are made responsible for the organisation and chairing of meetings, for the administration of the project, as well as for the follow-up of the care of the patient.

However, most projects perceive the provided funding as insufficient for the currently chosen coordinator model. In many projects, the organisation in which the coordinator is located has to provide additional financial and/or logistic support to make enable the function of a coordinator as smoothly running. In addition, the absence of financial means for steering committee meetings is often perceived as an emerging issue, apparently most in those projects organising separate steering committee meetings with managers rather than day-to-day practitioners.

This perception of an insufficient financing of all coordination activities is also argued on the basis that representatives of partners have to be missed in their organisation or practice while they are attending meetings, etc.

8.2.3 The patient monitoring

The patient monitoring was perceived by some partners (especially in the majority of French-speaking projects) as a reason to refuse participation in the formal partnership or guaranteeing their active involvement. In addition, it was seen as endangering the mutual trust and treatment relationship between caregiver and patient. Many French-speaking TPs stopped their participation in the TP using the argument of the patient monitoring (see chapter 'resigning projects').

8.2.4 Communication from the public agencies

Many remarks were made on the lack of clear communication from KCE, FPS and NIHDI (references are mainly made to FPS) on the actual requirements and modalities for developing the TP. Some projects used the metaphor of having signed 'a blank cheque' with regard to the TP-contract (see first intermediate report p. 96 for detailed information).

8.2.5 Other (parallel) formal collaboration initiatives

Some projects have experienced problems with the development of their TP because of other existing pilot projects or collaboration initiatives (see first intermediate report p. 96). The overlap of activities can cause competition between different services involved for each of these projects.

- In a Dutch-speaking province, a project mentioned three parallel circuits of formal meetings in the framework of different initiatives, namely 'local client meetings' ('locaal cliënt overleg'), meetings organised by ISHC (project 'home care coordinator') and the patient meetings of TP. The concern is expressed that the TP with financed meetings can involve an unwanted side-effect in reducing the motivation of care providers participating at meetings of 'local client meetings' or ISHC, which are most often not financed or only in some specific situations.

In this context, people urged to develop TP as a temporary government's programme (including evaluations) and not drawing out experiments unnecessarily as is the case for other policy initiatives.

- **Opinions about TP-programme differ between TPs: it is perceived on the one hand as a potential stimulus to initiate changes in mental health care and, on the other hand, as a source of contractual obligations.**
- **The added value of the TP-programme is recognised, especially at the level of the partners, even if many projects stress that it would take time for individual caregivers to experience this added value.**
- **In some clusters it is recognized that the launch of the TP-programme initiated the development of new operational practices in particular geographical areas.**
- **The possibility to fund a coordination function and the meetings is considered as an added value even if the provided funding is perceived as insufficient for the chosen coordinator model.**
- **The patient monitoring is perceived by some partners (especially in the French-speaking part) as endangering the mutual trust and treatment relationship between caregiver and patient.**
- **Many remarks were made on the lack of clear communication and information from the public authorities.**
- **Some projects have experienced problems with the development of their TP because of overlap with parallel experiments or collaboration initiatives.**

8.3 EXPERIENCES : PATIENT ISSUES

8.3.1 Influence of the TP-programme on patients

Some projects claim that the TP has an added value for patients, especially those with complex and evolving needs in which caregivers have to re-evaluate and adapt the care process. The TP format allows for mutual support between providers and continuous care provision in these specific situations. Particularly for aged persons with mood disorders living at home, projects report that the TP formula initiates a better detection of the patient needs. The TP-framework is also expected to have an influence on admission in residential intakes (prevention or reduction of the hospital length of stay) or on the prevention and management of crisis situations, mainly because the patient feels better supported in the TP.

Very little projects developed a spontaneous discourse on the core missions of the government's programme. Only some projects explicitly stated that the TP allows to develop 'care trajectories' and 'continuity of care' in a long-term vision. Only a small number of interviews mentioned 'needs-based care' spontaneously as an objective of the TP.

8.3.2 Experiences with the inclusion process

8.3.2.1 *informed consent*

The inclusion process of patients is reported to be strongly influenced by the obligation to obtain an informed consent of the patients (a signed form, not an opt-out procedure).

First, this formal obligation initiates potential unwanted effects on individual patients (e.g. paranoia) or patients do not consent in order to avoid inclusion in a treatment trajectory (e.g. forensic or addiction projects with people refusing treatment and follow-up, some patients are afraid of the unknown). In the cluster elderly projects were in particular confronted with a taboo on mental health care and psychiatry leading to a lot of resistance by the patients to be formally included in a "psychiatric project". Other elderly patients lacked insight in their illness, and did not want to consent, although there inclusion in a support model seemed appropriate.

Some projects experienced problems in obtaining an informed consent as individual caregivers involved were unable to provide a clear and concise explanation of the expected added value or reasons to include patients in this alternative TP approach.

Projects seem to experience less problems if consent is to be obtained from family members rather than the patient. This is particularly the case in the cluster children and adolescents. However, concerns were voiced too (mainly in some French-speaking projects) as parents feared losing control over their child when formally signing to be included in the project.

Some projects express their concerns that patients would sign for the wrong reasons i.e. Influenced by power issues (e.g. presenting TP as a part of a regular treatment) or without really understanding the aims of TP (e.g. patients with cognitive problems).

For patients with a 'forensic statute' an informed consent is often beyond the decision power of the patient (i.e. limited decision capacity/authority) which induced particular problems. For youngsters the parent or legal representative has the final decision power on issues regarding informed consent. Moreover, two 'extreme' positions in youngsters can be observed when they have to consent: either they sign, but often without realising very well what they sign, or they refuse to sign whatever is asked.

Key aspects for obtaining informed consent

Some key elements could be drawn from those projects that experienced less difficulties with obtaining this informed consent. A first element is that the person who informs the patient about the project and tries to obtain the informed consent has a mutual trust relationship with the patient. Moreover, the family and other patients can influence the decision of the patient. The communication and explanation of the objectives of the TP is a key element. It is important to use a very practical perspective directly referring to the current situation of the patient (e.g. having a house, having a perspective, financial problems).

8.3.2.2 The preset caseload

The number of included patients at the moment of the interviews ranges from 0 to 57 patients. This means that some projects stopped their participation to the TP project before including even one single patient (see section 9).

Many projects mentioned that imposing a preset caseload can have unwanted consequences with regard to the programme's objectives. Projects tend to become more concerned with administrative caseload issues rather than the intended aims of the TP-programme. It leads to situations where patients are included for which one could discuss to what extent it is a complex situation. Conversely, not many patients are excluded to ensure reaching the preset caseload of (initially) 30 patients. (see also next point)

8.3.2.3 Experiences with the predefined criteria

Inclusion criteria are applied in different ways. Some projects interpreted the inclusion criteria they proposed in a very flexible way. Others applied them very strictly, with the consequence that this can hamper reaching the caseload. Defining them too broad criteria makes it difficult to use them in practice.

Those projects applying the inclusion criteria in a flexible manner did so mainly to ensure the caseload. Some other projects broadened the inclusion criteria (or are considering it), mainly to realize more inclusions (see intermediate report p. 85 for examples); or because the criteria gave an insufficient coverage of the attempted patient group.

Most projects in the cluster children and adolescents, and particularly the clusters forensic or addiction, interpreted the age-criteria in a flexible way to guarantee the 'continuity of care' for the adolescent, i.e. keeping this patient included rather than going for a discharge because the patient's age exceeded the TPs age range.

Projects also struggle with their proper inclusion criteria in the face of a client in need. A few projects experienced it difficult to refuse a patient (who did not meet their inclusion criteria) whilst clearly being in need (but possibly having other problems than the ones described in the inclusion criteria).

The obliged use of the DSM-IV diagnostic categories is perceived by an important part of the projects as too medically oriented and emphasizing the medical diagnosis rather than the complexity of needs. Some projects fear that it can have a stigmatising effect on patients. Moreover, using a DSM-diagnosis as inclusion criterion, is difficult as non-psychiatric partners are unfamiliar with the DSM-diagnosis or do not have the authority to define the diagnosis (e.g. welfare, social and primary care services, ...). Especially TPs working outside a hospital context experienced difficulties in this respect. A few Dutch-speaking projects dealt with this in a practical manner by seeking alternative indications for a disorder category or contacting an expert to obtain the diagnosis..

8.3.2.4 *Decisions about excluding or not-including patients*

In most projects all (or almost all) of the patients whom have been considered for inclusion, actually have been included. Either it was clear for the partners (sometimes after a while) which patients could be included in the project or the preparatory work of the project coordinator enabled a smooth inclusion process.

The reasons most mentioned not to include or to exclude patients can be categorised in reasons related to:

- the inclusion criteria subscribed in the project (e.g. age, a specific DSM-diagnose).
- the formal requirements of the TP-programme a (e.g. the requirement to involve three formal partners in follow-up meetings).
- the patients condition or situation (The situation of the patient is stabilized or has improved although projects reported to give different meanings to a 'stable situation or an improvement of the situation of the patient'; the patient disappeared or was difficult to maintain in a care trajectory; death; withdrawal of informed consent, changing residence (e.g. back in prison, a long hospitalization (outside the catchment area), moving to another region).

8.3.2.5 *Patients or providers perspective*

Some individual projects struggle with situations in which the patient refuses to be included, but in which the professionals consider an inclusion as necessary. They are confronted with the dilemma of 'respecting the autonomy of the patient' versus 'a (more) paternalistic or preventive attitude'. This seems to be a particular issue in the cluster addiction

8.3.3 *Patient and/or family participation*

The aspect of patient participation is subject of a parallel research process by another research team. Some issues were mentioned though in the context of questions we raised on the experiences with patient related activities. As mentioned in the first intermediate report, several projects perceived the participation of the patient in defining the care trajectory as an added value because projects are obliged to reflect on the issue of patient participation. They also report potential advantages of the involvement of the patients. The involvement of the patient is expected to increase his/her sense of responsibility in his/her own care (other specific comments are mentioned in the first intermediate report pp. 71 and 83).

The overall analysis shows that the issue of patient involvement is a delicate one: on the level of involving patient or family organisations as partners as well as on the level of involving the individual patient in setting out and individual care trajectory.

If any, the participation of patients and/or family at the partnership level is mainly put in practice by involving the family and patients organisations as formal partners. But these are very exceptional projects.

We did not obtain much information to which extent the patient is really involved in setting out the care process at patient level. Projects consider it not always opportune to involve patients and report that in some cases patients do not want to participate at a follow-up meeting. Projects also reported on situation where caregivers prefer not to have the patient present if professionals disagree on the course of action or when partners need mutual support on issues during the meetings (e.g. in addiction).

Only a few projects have briefly touched upon their experiences with family participation. Most of them have positive experiences at the follow-up meetings. Family members are reported to experience it as an opportunity being listened. Some projects resist to the participation of family organisations at patient meetings mainly because of privacy and professional secrecy arguments. Many professionals in the projects appear to be sceptical and question whether the 'family and patient organisations' can add relevant information.

Overall, projects struggled with the question on how to incorporate patient participation in their approach. Especially those projects in which not all the partners were familiar with patient participation, seem to experience the most difficulties. Our respondents describe it as a learning process to overcome resistance, prejudice, and finding appropriate ways to deal with interests of the patients themselves. Residential institutions are reported to tend more to talk *about* a patient, whereas other sectors or services (e.g. welfare, social care, HS) talk more *with* patients. The latter are, on the whole, more familiar with family and patient participation. In addition, some tension is reported in collaborating with legal services because of its particular culture and tasks (see first intermediate report p. 92).

- **The inclusion process of patients is affected by the obligation to obtain informed consent from the patients.**
- **Less refusals from patients are experienced if there is a mutual trust relationship between the person who informs the patient about the project and the patient**
- **The imposed caseload by the NIDHI had an influence on the number of patients included. Projects tend to become very concerned with obtaining a particular caseload rather than the intended aims of the TP-programme.**
- **Inclusion criteria as defined in the TP-call have been interpreted in a very flexible way by projects. However, to broad criteria make it the more difficult to use them in daily practice.**
- **The involvement of a patient representative or the patient is a delicate issue. Some projects perceived it as an added value, other TPs do not share this point of view.**
- **The obliged use of the DSM-IV diagnostic categories is perceived by an important part of the projects as too medically oriented and emphasizing the medical diagnosis rather than the complexity of needs.**
- **Some individual projects struggle with situations in which the patient refuses to be included, but in which the professionals consider an inclusion as necessary**
- **Respondents describe the process of patient participation as a learning process to overcome resistance, prejudice and to find appropriate ways to deal with interest of the patients.**

8.4 EXPERIENCES: PARTNERS

8.4.1 The required configuration of the partnership

The required collaboration with different (subsidiary) services is in general perceived as useful. Interviewees report that different approaches, visions and information are brought together during the care process of the patient. The TP enables and facilitates the communication between those services. Only in a few (French-speaking) TPs, one professional group is said to be dominating the debate when defining the care of the patient (see first intermediate report p. 72). Other projects mentioned communication problems between services in defining the care of the patient due to their different perceptions (see first intermediate report p. 92 for some examples). The remark was made that it will take some time to decrease the distance between different services and sectors.

However, some projects comment that not all the obligatory partners, as defined by the NIHDI-tender, are always relevant for and/or familiar with the target population of the TP.

An important consideration is that different services involved in the projects are dependent upon on different policy levels (the federal (e.g. hospitals, sheltered living, psychiatric nursing home) versus the communities (e.g. CMHS)) which may render collaboration within the TP often difficult.

8.4.1.1 *Professional secrecy*

Many projects discussed the issue of professional and medical secrecy and confidentiality in an intensive manner. A main critique is that the legislation about professional secrecy is not adapted to a context of working with different professional groups. Projects perceived problems mainly with regard to the participation of caregivers whom are not obliged to a deontology or duty of professional confidentiality (e.g. schools, social care, welfare) or caregivers in the legal or security field (i.e. legal services such as protective youth services, the police or an assistance of justice).

Mainly in French-speaking projects, some partners (mainly doctors) refused to participate in the project or in patient meetings, because of their interpretation of professional and/or medical secrecy issues. Dutch-speaking projects tried to handle the problem of professional secrecy in a more pragmatic manner (see first intermediate report p. 89) they trust more that every participant at the meeting (except legal services) has the professionalism to deal with private information; or they do not mention the medical diagnosis of the patient; do not invite the assistants of justice unless there is need to;). This pragmatism does not imply that no discussions on privacy issues are taking place, though. In contrast to the principal debate on professional secrecy, some projects reported that pragmatic solutions such as discussing anonymous files (or codes or numbers) give the impression of reducing patients to objects or numbers which is not considered the objective of a needs based approach.

8.4.1.2 *Experience with the primary care services*

For many projects, the involvement of the ISHC is primarily perceived as a precious contribution to the administrative coordination of the TP. The involvement of the ISHC for the administrative coordination enhanced for some individual projects additional complications of the administrative process (mainly at the level of double administration for similar content). Some projects experience the involvement of the ISHC as theoretical and imposed rather than needed for a practical day to day collaboration. The main argument used is that primary care services are not acquainted with particularities of the content of psychiatric care. In other cases though, it is recognised that the participation of ISHC, may have an added value for the content of care in a community service, except for situations in which patients stay in a residential setting for a long time. The involvement of the ISHC seems to be appreciated most in the cluster 'elderly' for those patients living at home (because the ISHC is probably already involved).

In the cluster adults, other primary care services (such as social care of welfare services) are sometimes perceived as relevant parties. In the cluster children and adolescents social primary care services, welfare (e.g. SAS, CPW,...) or legal services (e.g. PYS) are considered more appropriate than general HS (such as nursing and support).

The participation of the general practitioner is sometimes considered important because this person has information on medication or adds and generates a medical point of view on the health status of the patient. This participation also facilitates the communication with other doctors (e.g. psychiatrists). Moreover, since the GP is a primary contact point for the patient (cf HS) he/she is generally well acquainted with the situation of the patient. The GP is often also a trusted person for the patient and recognized as a key person. The role of the GP seems not to be associated with the needs of the clusters. The involvement of the GP in the collaboration model seems mainly influenced by the habits of partners to involve the GP in discussions about the patients.

8.4.1.3 *Experience with the secondary and tertiary care services*

The obliged participation of services of second and third line is valued differently. The added-value most heard, is that the involvement of specialised services allows for a continuous exchange of expertise. Moreover it helps patients, especially elderly living at home, developing awareness about their mental disorder. It can also help this group to break down the taboo on seeking help in mental health care services .

In contrast some projects, mainly those working with children, point at the potential risk of a medicalisation of the care process and stigmatisation of the patients by including specialised (psychiatric) services.

8.4.2 **Managing the partnership**

The partnerships are generally managed by means of formal steering committee meetings, as the complement of the role of the coordinator. Very little information on the actual functioning of the steering committee meeting has been collected during the interviews at this stage (see first intermediate report p. 83). It seems that most projects do not experience much problems with regard to the participation of the formal partners at the steering committee meeting. These meetings serve to discuss the functioning of the project, and are considered as an important means to support the coordinator. In only a very small number of projects these meetings are not perceived as being meaningful. Some individual projects experience conflicts and struggles between partners in these meetings.

Some projects took the decision to include more formal partners along the way (or they are considering to do this.). These additional partners generally have particular expertise and experience with the target population or are easily accessible for the target population. Some other projects considered enlarging the formal partnership but decided not to do so, as it would have complicated the management of the project.

In a small number of projects (mainly French-speaking), some partners have withdrawn as formal partners, generally because they did not experience any added value of the project. Some of them preferred to continue participating as an informal partner mainly since it implied a release of the administrative constraints of TP. Additional reasons mentioned were: financial reasons; the role of the prison in a mental health care network is not clearly defined yet; distance and time issues; or the partner has no patients to propose for inclusion. In some individual projects the project itself stopped the collaboration with a formal partner.

Some projects changed the management of partnership related matters (or they are considering it). Some introduced a new type of preparatory meetings (eg internal coordination meeting between the persons responsible for the coordination of the project. a preparatory support meeting) (see first intermediate report p. 85). Other projects decreased the frequency of the steering committee meetings (see first intermediate report p. 83).

8.4.3 The involvement of partners

As mentioned in the first intermediate report, many projects experienced problems in activating individual partners. They experience the need to promote and inform partners and individual professionals about the aims and functioning of the TP. For most projects, the promotion of the project took a lot of time, more than they judged necessary at the beginning of the project. Some projects say that this promotion had a positive influence on the commitment of the partners and professionals, although not all were convinced that they were able to motivate these partners or professionals in an enduring manner. Projects mainly perceived problems to inform and actively involve all the individual caregivers of the primary care services operating in the framework of the ISHC as formal partner (see the first intermediate report p. 91 for more detailed information).

8.4.3.1 *Partners contributing at project level*

Projects depend to a large extent on the commitment of a core number of partners. Projects experience that partners need to be well informed about the TP, that they experience the need for (regular) inter-organisational patient meetings and that they agree with the proposed TP-approach. The preparation of the project is considered as a crucial element to develop consensus and agreement among all the partners of the project. A few projects perceived the problem that some individual partners had too high expectations of the TP or towards the contribution of some services involved to live up to (see the first intermediate report p. 90). As expectations are not fulfilled, this influences their further participation in the TP.

Direct interpersonal relationships are considered crucial to develop trust in the project coordinator. In this context, previous collaboration between partners can be a facilitating factor.

8.4.3.2 *Partners contributing at inclusion meetings*

As mentioned in the first intermediate report (p. 77) mainly formal partners who initiated the project and who are familiar with the target population, propose patients for inclusion. In some individual projects informal partners are the most active. Most proposals for inclusion come from services familiar with the target population that know and understand the problems in taking care of these patients.

Some projects experienced difficulties to organise an inclusion meeting with all the formal partners. We assume that this problem is mainly related to the number of formal partners of the project, the number of meetings and/or to the chosen coordination model (e.g. projects combining their steering committee meeting with the inclusion meeting experience less problems, but projects combining inclusion meetings with follow-up meetings had many difficulties).

Especially projects who put a lot of effort in preparatory work for inclusion meetings questioned the usefulness of meetings with all the formal partners certainly if no inclusion issues were to be discussed.

8.4.3.3 *Partners contributing at follow-up meetings*

Guaranteeing the participation of (partners or) professionals in follow-up meetings is experienced as difficult by many projects. These difficulties are related to several factors: professionals need to perceive a need or expect an added value from participation. This is more difficult for professionals not familiar with the target population of the TP or if professionals are not involved in the care process of patients or involved in a particular episode of care of the patient. Moreover, relatively small organisations may experience more difficulties in sending delegates to follow-up meetings because of workload issues (pressure on FTE). Besides the fact that some meetings cannot be financed, practical problems occur if partners (or representatives of an organisation) with decisional rights or partners with expertise remain absent (see first intermediate report p. 81 for detailed information)

The critique most heard is that the participation of three formal partners in follow-up meetings is not always considered relevant or needed, mainly because some of these partners are not involved (anymore) in the care of the patient. Many projects experienced the involvement of some partners even as inappropriate for the patient and the partners in the TP (see first intermediate report p. 94). In contrast to this, some projects made the remark though that this obligation allows to have a neutral or more independent point of view in the discussions on care process.

People report that in general the same representatives of the partners attend the follow-up meetings. This is perceived as an important element with regard to continuity.

Some problems are mentioned for obtaining the necessary signatures, often when the ISHC has signed the TP-agreement as umbrella organisation of primary care services in health care. Even if a number of primary care or HS participate in the follow-up meeting, this only counts formally as one formal signing partner. Technically these meetings cannot be financed if no other formal partner participates in this meeting. This is especially considered as a problem for projects working with patients living at home (which is often the case for 'cluster elderly').

Not having many formal partners reduces the opportunities to obtain the required signatures during follow-up meetings. It can be a problem if the formal partners of the projects are not familiar with the target population while informal partners are the relevant partners to discuss the patient's trajectory. In this case, follow-up meetings cannot be financed if the formal partners do not participate.

According to some projects, the participation of caregivers in follow-up meetings can be enhanced by freeing caregivers from administrative tasks, and focusing their activities on the actual care of the patient. Projects also experience the impact of the communication style, i.e. the importance of a more directive style (instead of a more inviting style). Time management and meeting competencies (sometimes supported by procedures) are facilitating the participation. (see first intermediate report p. 97). Specifically for general practitioners meetings are often not convenient working practices. (see first intermediate report p. 82) and projects suggest that other means of communication could be considered (e.g. calling the general practitioner during the follow-up meeting, so questions could be asked).

8.4.4 Experiences with the inclusion process

Projects organising separate inclusion meetings often decreased the frequency of inclusion meetings when the preset caseload was met. For many of those projects combining inclusion meetings with follow-up meetings, the frequency of meetings increased to more than once a trimester. For projects combining inclusion meetings with steering committee meetings, the frequency decreased after a while.

The duration of an inclusion meeting remained generally the same or shortened over time, mainly due to the number of patients considered. The time spent on discussing individual patients was affected by the number of candidates per meeting. Patients already known by the participants generally needed less time. The time allocated to discussion varies (5 to 30 minutes per patient, depending on the topics discussed).

Some projects have changed particular aspects of the inclusion meeting, such as the participants, the organisation mode of handling candidates (see first intermediate report p. 79) or the content of the issues discussed (which had an impact on the duration of the inclusion meeting). In exceptional cases, the content altered towards discussing problems in the functioning of the project rather than discussion of patient related topics.

8.4.5 Experiences with the follow-up process

8.4.5.1 *The financed follow-up meetings*

For most projects, the number of follow-up meetings per patient equals the required contractual number of follow-up meetings (namely three monthly during the first year and four monthly during the following years). Some projects did organise follow-up meetings solely for this administrative reason, even though they did not consider them as necessary. Many projects expressed that the predefined timing of meetings imposed by the TP-programme does not accord with the “pace” or evolving needs of the individual patient nor with the characteristics of the target population. Projects report that more frequent meetings are necessary in the beginning of the care process, or in specific situations (mainly crisis situations). A three-monthly meeting is often considered too frequent when a more stabilised situation has been obtained. (e.g. the patient is still on a waiting list; the patient is still functioning well).

Some TPs recognized however, that regular meetings give a feeling of comfort and security to the partners involved. The meetings are a means to get people around the table in a reflection process on the care provision. It favours quality and continuity of care and avoids that meetings are only organised in crisis situations.

Interviewees recognize that the TP and the meetings serve as a framework for social networking and learning. The collaboration and especially the meetings allow for further informal networking (or intensifying the informal contacts). People get to know whom they may contact directly for particular issues (rather than a more anonymous secretary). Moreover, people and facilities learn about the respective activities of partners and the mutual support they can offer. Even if the organisations had already heard about each other, details of functioning were often unknown to the respective partners before the TP. The mere fact that professionals of different backgrounds sit together, leads to sharing of expertise, more in-depth analysis and discussions on patient-related topics thus providing new or better insights in specific situations. This helps to fine-tune both information and care and contributes to a collective definition of responsibilities. In addition, specific support needs of partners may be better detected (e.g. when the partner lacks expertise on a mental disorder). The collaboration process also helps to avoid vagueness or misunderstandings (e.g. partners commonly define when they will consider a particular situation as a crisis situation; or caregivers do not have to rely solely on information provided by the patient). One of the projects considered a main advantage of the meetings that all the caregivers are of equal value, even those who are only involved indirectly.

Collaboration is thus more than a mere instrumental issue. The meetings are steps in a process of developing trust, feelings of reassurance and obtaining the necessary support. This is especially the case for the HS and GPs who are often working individually with a patient, without particular experience in psychiatry. The TP supports a more collective, shared approach.

Projects experienced some problems finding a common date within a trimester, especially in summer and winter time (due to holidays), leading to concerns to meet the contractual obligations of the project.

The first follow-up meeting after inclusion is often perceived as the most difficult one to organise. It seems easier to organise further follow-up meetings once people have gathered a first time, sitting together and browsing through agendas to find a common date.

There are a number of projects that organise follow-up meetings with the formal and/or informal partners of the projects, but in which direct caregivers of patients are not directly involved. These projects struggle with the issue of information transfer on individual patients in order to realise the intended governments objective of the follow-up meetings. An individual project urged to reflect on communication and information transfer mechanisms, in order to be able to set priorities in the care plan. A reference was made to the information transfer mechanisms that were used in HS (outside the mental health care context) that try to coordinate care between professionals.

Informal communication and meetings

Apart from the formal and required meetings, a lot of informal communication takes place between the caregivers (e.g. telephone calls and people organise other meetings, either in a crisis situation or in order to plan/organise practical aspects between partners (e.g. an admission of a patient). Relevant information about these informal contacts is either passed on to other partners or to the project coordinator during the next follow-up meeting or formal log-reports are made of relevant contacts.

Content of financed follow-up meetings

Based on the information collected at this stage, the follow-up meetings can be classified in three general types:

- In a first type, meetings regulate the referral of a patient. In that situation, communication is required with other (ambulatory) organisations. When discharge is not possible or necessary, internal communication within the hospital/residential service is considered sufficient for defining the care of the patient.
- In a second type, meetings aim at fine-tuning the individual care trajectory of the patient and the roles of the services involved. Based on the reported experiences this type of follow-up meeting is mainly taking form for non institutionalized patients for whom several services are involved.
- A third type, could be described as super- or intervision moments for those services that lack expertise about the target population and need some support to care for that patient (mainly non-institutionalized patients).

Some individual projects report that this follow-up meeting has no added value at all, but is just considered as a formal event within the partnership. We have indications that this perception is related to the fact that the participants in the meeting are not involved in the care of the patient or are not familiar with the target population.

Duration of financed follow-up meetings

The discussion time allocated to an individual patient depends on the situation of the patient and whether the caregivers involved consider it necessary to discuss it. The reported discussion time between projects ranges from 5 minutes up to 2 hours per patient. Most of the projects spend approximately one hour per patient. Some projects spend up to 3 hours per patient. The 5 minutes discussions generally only aim at a collecting signatures without a real discussion on the condition of the patient.

Changes in the follow-up of patients

A small number of TPs changed aspects of their follow-up meetings along the way: some grouped the individual patient meetings to decrease the workload for the partners involved; some increased the frequency of the follow-up meetings; some projects invited other participants in meetings or installed different working procedures (i.e. considering to organise separate meetings for patient and project related issues, instead of one integrated meeting combining for both issues) (see first intermediate report p. 85).

Some of these changes were put into place after an explicit evaluation process by the partners.

8.4.6 Experience with coordination tools

Projects use different types of coordination tools. The information we collected on this issue is still very limited at this stage, but some issues emerge.

What emerges from the interviews is that the notion and the use of the “care plan” as a tool seems to diverge between projects. Many projects seem to use this “tool” mainly as an administrative required activity, mainly filled out because the NIHDI requires it to obtain funding. It is not clear at this stage of the research though whether this tool is really used as a working instrument in the coordination and planning of support tasks

for individual patients. We will certainly elaborate this in the next round of data-collection

Interviewees stress the potential relevance of standardized documents and a systematic use of these document in the working processes (e.g. communication by email, using an electronic patient file, standardised form for proposing patients,...). Projects experience the use of these tools as means to increase efficiency in use of time.

However, some projects using different forms for similar purposes warn against unnecessary duplications of providing information (particularly mentioned with regard to care plans used by ISCH) leading to an unnecessary administrative workload.

Some projects report that tools were often not used as they were originally intended and that other more pragmatic solutions we used (e.g. one project reports that people did not fill out forms for considering patients for inclusion in time)

A number of projects developed a number of forms (e.g. standard candidature form, leaflet for patients,) because experience learned that the execution and coordination of activities could be smoothed.

Some projects reported that their experience learned that minutes on discussion about patients could be presented in very brief forms rather than extensive reports

The development of a web application as a common support tool for professionals is considered as very useful in these provinces using it. But it was also stressed that a common tool is not necessarily adapted to the needs of particular clusters. (e.g. a FOR K project)

- **A main critique is that the legislation about professional confidentiality and secrecy is not adapted to a context of working with different professional groups. Mainly in French-speaking projects, some partners or professionals refused to participate in the project or in patient meetings, because of professional and/or medical secrecy issues. Dutch-speaking projects tried to handle the problem of professional secrecy in a more pragmatic manner.**
- **Mixed opinions were mentioned on the obliged involvement of primary care services as a formal partner. In some cases primary care services are judged as insufficiently acquainted with the particularities of the content of psychiatric care. In other cases though, it is recognised that the participation of general primary care partners may have an added value for the content of care in a community service.**
- **The added-value most mentioned of the obliged participation of services of second and third line, is that the involvement of specialised services allows for a continuous exchange of expertise. Some projects (mainly those working with children) point at the potential risk of medicalisation and stigmatisation however.**
- **Different services involved in the projects are dependent upon on different policy levels (the federal (e.g. hospitals, sheltered living, psychiatric nursing home) versus the communities (e.g. CMHS)) which may render collaboration within the TP difficult.**
- **The partnerships are generally managed by formal steering committee meetings.**
- **Many projects experience problems in activating individual partners. They experience the need to promote and inform both partners and individual professionals about the aims and the functioning of the TP.**
- **Projects depend to a large extent on the commitment of a number of core partners.**
- **Direct interpersonal relationships are considered as crucial in order to develop trust in the project coordinator**
- **Most proposals for inclusion come from services familiar with the target population that know and understand the problems in taking care of these patients.**

- **Patients are mainly proposed for inclusion by formal partners but in some individual projects informal partners put forward proposals for inclusion.**
- **The critique most heard is that the structural participation of three formal partners in follow-up meetings is not always considered relevant or needed, mainly because some of them are not involved (anymore) in the care of the patient.**
- **Many projects expressed that the predefined timing of follow-up meetings imposed by the TP-programme does not accord with the “pace” or evolving needs of the individual patient nor with the characteristics of the target population.**
- **Regular meetings allow networking and informal contacts, they enable mutual learning and favour a reflection process on the care provision. This prevents that meetings are only organised in case of crisis situations. The meetings are important steps in a process of developing trust, feelings of reassurance and obtaining the necessary support.**
- **The participation of caregivers in follow-up meetings can be enhanced by freeing caregivers from administrative tasks, and by focusing their activities on the actual care of the patient.**
- **Specifically for general practitioners meetings are often not convenient working practices and projects suggest that other means of communication could be considered.**
- **The notion of and the use of the “care plan” seems to diverge between projects. Many projects seem to use this “tool” mainly as an administrative required activity, mainly filled out because the NIHDI requires it to obtain funding rather than a day to day working instrument.**

8.5 EXPERIENCES WITH THE COORDINATOR

8.5.1 The role of the coordinator

Many projects attribute an important role to a coordinating person. The interviews indicate that developing the role of the coordinator is a continuous learning process (both for the individual as well as for the partnership). The learning experience is closely connected with legitimacy issues (acceptance) and building trust.

Many projects experience that partners of TPs have high expectations of the coordinator. Partners expect coordinators to be both mediators and problem-solvers for partners and individual professionals as well as for patients and family. Bringing back these expectations to acceptable and workable proportions requires a lot of communication, debate and daily practice.

An important issue, mainly at the level of individual professionals but sometimes also at the level of the partnership, is the acceptance that a coordinator is taking up a particular task. A typical example is the issue of professional secrecy. In some projects fierce arguments took place about the extent to which a project coordinator could have access to patient data and under what conditions this should happen. A number of French-speaking TPs mentioned that the TP coordinator was only given a limited authority in the patient meetings.

In these projects professionals act more as members of (different) autonomous organisations. The coordinator role of the coordinator is seen more as a facilitating factor (creating the conditions for negotiations) than as an actual participant in content discussions.

The aspect of acceptance and legitimacy also emerges at the level of the partnership. One particular issue is that coordinators have to be seen by all members of the partnership as taking up a neutral position and acting independently of the interests of one particular partner. Interviewees report that this issue generally emerges in those situations in which a coordinator is recruited from the staff of a partner (in most cases a participating hospital), or when the coordinator is employed within the premises of a partner (most often a hospital).

The development of trust and legitimacy appears to be part of a learning experience. For many partners and professionals (as well as for patients) the role of an independent 'external' coordinator for organising patient meetings and managing the definition of content of care issues is new. Generally time is needed to delineate roles, to manage initial scepticism and to allow all people involved to mutually adapt to expectations.

In particular situations, some coordinators have 'two caps'. These 'two caps' refer to the management of the partnership tasks and tasks on the patient level respectively. Project coordinators have different opinions and experiences towards having 'two caps'. This problem seems to emerge particularly in those situations in which coordinators have a full time employment, of which half of it are tasks on patient matters besides the TP, and the other half is taking up both patient and partnership tasks within the TP. It can lead to situations in which the person has to talk about the patient as coordinator of the project as well as caregiver or responsible person of the patient.

8.5.2 Support for the project coordinator

Projects were talking about two different types of support, namely 'practical support' and 'emotional support'. The development of emotional support is generally a result of the organisational model for providing practical support. Some emotional support for individual coordinators is also offered through the context on the transversal meetings with other coordinators. Some project coordinators experience a sense of isolation without much emotional support.

The 'practical support' is offered in many forms when comparing the projects. Most of this practical support is at the level of patient-related activities. Some TPs provided additional (administrative) support for the project coordinator along the way. This support is experienced as a relief for the project coordinator.

However, projects report some particular problems with regard to this practical support in daily practical activities.

- Some projects that have involved a care mediator as a support to the project coordinator experienced that these persons were not taking up their roles. Tasks had to be taken up by the project coordinator anyway. In some particular cases the choice was made to allocate this task to a caregiver. Some projects remarked that the person assigned as care mediator did not have the competencies to take up the coordination of care. An individual project experienced problems to assign patients to a care mediator when the patient was discharged from the hospital.
- Projects also report that practical support tasks, initially foreseen in the organisational model of the partnership to be executed by partners, were not taken up (e.g. support for writing minutes of the follow-up meeting or serving as an external coordinator of patient activities).

8.5.3 Workload of the coordinator

Most TPs indicate that the workload of the project coordinator for running the TP is larger than initially estimated. Many coordinators refer to the administrative tasks (see first intermediate report for more detailed information). Because of the experienced workload, a few projects have employed the coordinator for more hours FTE (often at that point in time when a change of the project coordinator took place).

8.5.4 Human resources issues

During the interviews some human resource management related issues were mentioned.

One particular issues concerns the employment relationship of the coordinator. Many coordinators were assigned to a TP on a part time basis (0,5 FTE) but combined this job with another part time assignment in the same organisation. Many projects reported that it was essential to offer a full time employment to be able to recruit a coordinator for the TP.

Quite a lot of the coordinators of the TPs are recruited from the hospital staff, which means that they were already acquainted with the sector and often had a network of personal contacts with some partners. This network and experience is seen as an added value for the TP. This experience also fits with the competencies that TPs consider necessary to take up the role of a coordinator. In contrast to this advantage, coordinators mentioned difficulties in separating tasks for the TP and other tasks for the employing organisation. We already mentioned that a potential disadvantage is that coordinators are not perceived as neutral/independent actors who defend interests of the whole partnership.

Some projects had to change their coordinator. A change of coordinator does not necessarily lead to problems however. Projects with previous collaborating partners appear to experience less problems because partners continue working on the previously developed knowledge and experience. Problems seem to emerge more in projects without previous collaboration as these need more leadership and coaching to make things running. Another intermediate variable is the timing of the resignation. A coordinator quitting in the start-up phase seems less influential on the smooth running of projects than a coordinator quitting after a longer time. This is mainly because a whole new trust relationship has to be developed and as coordinators need to develop competencies and networks to keep the project running.

The first intermediate report already mentioned that a specific training for the project coordinators is considered useful or needed in order to develop the necessary knowledge and competencies to act as a coordinator.

- **Developing the role of the coordinator is experienced as a continuous learning process (both for the individual professionals as well as for the partnership).**
- **The learning experience is closely connected with legitimacy issues (acceptance) and building trust. Coordinators have to be seen by all members of the partnership as taking up a neutral position and acting independently of the interests of one particular partner.**
- **The development of emotional support for the coordinator is on the one hand generally a consequence of the providing practical support and on the other hand offered through transversal meetings. Most of practical support is at the level of patient activities.**
- **Most TPs indicate that the workload of the project coordinator for running the TP is larger than initially estimated.**
- **For most coordinators, being recruited from the network and having experiences is perceived as a facilitating factor in building trust and legitimacy.**
- **Projects without previous collaboration need more leadership and coaching from the coordinator to make things running.**

9 DISCONTINUING PROJECTS

9.1 INTRODUCTION

This section summarizes information (i.c. interviews and resigning letters) about reasons and arguments of those projects that discontinued their participation in the TP-programme of the government. 19 TPs discontinued, namely 6 Dutch-speaking and 13 French-speaking projects. Within these projects, 5 were dismissed by NIHDI.

The structure of the first intermediate report was slightly modified to provide a more comprehensive view on the reasons for discontinuing.

Table 9.1: Overview of the projects

	total started		Ongoing		Discontinuing	
	FL	FR	FL	FR	FL	FR
Children and adolescents	12	11	11	4	1	7
Adults	27	20	23	15	4	5
Elderly	9	3	8	2	1	1
Total	48	34	42	21	6	13

Of the 13 French-speaking projects that discontinued, most are part of the 'province du Hainaut' or the Brussels region and the remaining resigning projects are located in several provinces. Most French-speaking projects are located in the above-mentioned province or region as well as the province 'de Liège'. Seven of the French-speaking projects that discontinued are part of the cluster 'children and adolescents', five of the cluster 'adults' (three of them sub cluster 'forensic') and one of the cluster 'elderly'. Of these projects, 4 were dismissed by the NIHDI. The six discontinuing Dutch-speaking projects are mainly found in the provinces 'West-Vlaanderen' and 'Limburg', one TP in the Brussels region. Most Dutch-speaking projects are located in the province 'Limburg' and the province 'Oost-Vlaanderen'. Four of them were part of the cluster 'adults' (one sub cluster 'addiction'), one of cluster 'elderly' and one of cluster 'children and adolescents'. One of the discontinuing Dutch-speaking projects merged with another TP in the same cluster in the same province (i.c. 'Limburg'), and can thus be considered as a particular case of discontinuity. One Dutch-speaking project was dismissed by NIHDI.

A few French-speaking TPs (i.c. 3) discontinued during the last semester of the first work year of the programme. Most TPs (i.c. 16) stopped during the second work year.

Some of French-speaking discontinuing projects mentioned that they would continue their activities outside the scope of the contractual TP-framework with proper funding. Some projects opted for another government's programme (i.c. NIHDI-Protocol 3 for elderly and a new project for homeless).

During the interviews we focused on the reasons why TPs stopped their TP-contract. In a very small number of TPs we had an interview before the project stopped formally. One French-speaking discontinuing project refused to be interviewed.

9.2 REASONS FOR DISCONTINUING

Table 9.2 Summary of the reasons for discontinuing a TP

Administrative requirements of the TP-programme	<ul style="list-style-type: none"> -Requirements contradictory to the philosophy/vision of the partners and their existing working practices: -frequency of follow-up meetings \neq the pace of the patient -patient monitoring -workload -unclear communication about the programme -Ethical reasons (professional secrecy) -Stigmatizing effect of the TP on the patient -Preset caseload -finding patients with characteristics according to the required criteria and/or motivating patients to be included in the project
Commitment of partners	<ul style="list-style-type: none"> - Difficulties to actively involve partners that are not convinced about the added value and objectives -influence on reaching of the preset caseload - Lack of trust relationship between partners - Practical difficulties to implement the TP
Role and employment location of the project coordinator	<ul style="list-style-type: none"> -familiarity with the selected target population or with the relevant caregivers of the organisation in which the project coordinator is located -knowledge, experience and networking capabilities of the coordinator in the local context -Trust in the coordinator -description and communication on the role of the coordinator Practical issues (financial and logistical issues)

9.2.1 The administrative requirements of the TP-programme

Mainly French-speaking projects explicitly said they stopped the project because of the administrative requirements of the TP-programme. They consider the requirements contradictory to the philosophy/vision and existing (before TP) working practices of the partners. The arguments mainly dealt with the requirements of the follow-up meetings (not following the pace of the patient), the patient monitoring, the workload and the unclear communication about the programme (see first intermediate report pp. 101-102). In addition, ethical reasons (e.g. lack of anonymity) and the stigmatising effect of the TP on the patient were also mentioned.

9.2.1.1 *The preset caseload*

As mentioned in the first intermediate report, not all TPs were able to fulfill the (adapted) programme requirements for case-load. Mainly Dutch-speaking projects discontinued for this particular reason.

Projects mentioned on the one hand problems to find patients with characteristics according to the required criteria and/or to motivate patients to be included in the project (e.g. anonymity reasons, the formal engagement). One Brussels-based project experienced particular problems with Dutch-speaking patients because of the particular provision of French-speaking facilities in Brussels. One project stated that those services relevant for their particular patient population are not part of their formal partnership. This has important implications for the inclusion of patients of course. In another case, the lack of commitment of partners impeded the inclusion of patients.

9.2.2 The commitment of partners

Many of the discontinuing projects perceived difficulties to actively involve their partners as they were not really convinced about the added value and objectives of the project. This lack of commitment of these formal partners also influenced the extent to which they could obtain the preset caseload.

Furthermore the precondition of a trust relationship (between partners or in the role of the coordinator) seems to have lacked for a lot of projects. Other reasons mentioned related to the practical difficulties to implement the TP (too idealistic or because of a gap between the people preparing and those who implement it). In one project the lack of partner commitment was attributed to the late start of the project.

9.2.3 Role and employment location of the project coordinator

The familiarity with the selected target population or with the relevant caregivers of the organisation in which the project coordinator is located is assessed as an important condition in the functioning of the project.

Many projects refer to the knowledge, experience and networking capabilities of the coordinator in the local context. Trust in the coordinator is required to actively involve partners, and the coordinator should also be acquainted with all segments of care.

- Individual projects mentioned that a clear communication and description on the role of the coordinator is needed (one individual discontinuing project explicitly stated that not having a project coordinator impeded a good functioning of the project).

Besides legitimacy and trust some practical issues play a role too. Project coordinators located in a small organisation with only the limited resources of the TP-programme have less opportunities to support the coordinator in a financial or logistical manner (outside the funding by the project), which can impede the functioning of the project.

- **More French-speaking projects discontinued (i.c. 13 projects of the 19 discontinued projects) and did sooner than Dutch-speaking projects.**
- **The administrative TP-requirements (especially the frequency of the follow-up meetings, the patient monitoring, the resulting workload, and the preset caseload) are explicitly mentioned as reasons for discontinuing.**
- **The difficulty to convince partners about the added value of the TP with its requirements (and thus to actively involve them) and the lack of trust relationship played an important role in the decision of TPs to discontinue.**
- **An important condition for the functioning of the project is the familiarity of the institution in which the coordinator is situated with the selected target population or with the relevant caregivers.**

10 GENERAL DISCUSSION

In this final section, we discuss the current observations, some methodological issues, and develop some reflections on the patterns which emerge from the preliminary data. We also give indications on the topics that will be developed in-depth in the final report and on the methodology that will be used in the second round of interviews.

As already stressed in the first intermediate report, the results and reflections presented in this report do not allow for final conclusions. This second intermediate report summarises preliminary results and reflections that still have to be elaborated after a next round of data collection and analysis. The next report will be the final overall report.

- **This second intermediate report presents summarised preliminary results. It does not allow to draw final conclusions nor make definitive policy recommendations.**

10.1 METHODOLOGICAL ISSUES

This second intermediate report is limited by similar methodological considerations as already discussed in the previous report (see section 'Methodological limitations', p. 105). We add some further comments.

Compared to the first intermediate report, this report not only adds information by the fact that we analysed data from all projects. The data analysis also focused on clusters as these have been defined by the TP policy programme (children and adolescents, adults, elderly, addiction & forensic). We expect that the second round of data collection will allow to make further refinements to disentangle the factors that could potentially explain the choices for and experiences with organisational configurations of a TP.

The results section describes findings based on interviews. We started triangulating these interview data with a content analysis of the plans and with theoretical insights from the scientific literature, but we need more saturation of data before drawing conclusions.

A major and important issue with regard to the intended research methodology is related to the formal decision to stop the patient monitoring (see also 'introduction'). This patient monitoring would have allowed to get a better understanding of the case mix within projects and was initially designed to make a pre-post monitoring of patient characteristics. The discontinuation of the patient monitoring implies that this research does not encompass reflections based on standardised quantitative data on patient characteristics.

It is worthwhile mentioning that the initial research team has changed in the course of the project. All the French-speaking members and one Dutch-speaking member of the team changed. These personnel changes had implications on developing an analysis of a rather complex field of innovations. Moreover, some of the second round interviews took place at a time when the sector discussed fiercely the utility of and the conditions in which the patient monitoring would have been introduced. During those interviews it became clear that arguments about the administrative framework and the conditions to respond to, can be biased for some projects because of this debate on patient monitoring (see e.g. the results section on resigning projects).

Moreover, there is quite a relevant time gap for some projects between the time of writing of the plan (and their intentions) and the interviews on these plans. For some TPs a time gap of nearly two years exists between the actual development of their plan and the interviews. For some TPs this meant that the people who were involved in the preparation and writing of the TP were no longer part of the service at the stage of the interviews. A retrospective interpretation of the initial plans can also induce a reinterpretation of the initial meanings given to the projects based on ongoing experiences.

Although, our impression and interpretation is that the projects were not influenced by the publication of the first intermediate report, we cannot assess whether the publication of the first intermediate report has influenced the respondents of the second round.

- **The methodological considerations presented in the first intermediate report still have to be taken into consideration.**
- **The research team has changed in the course of the research process.**
- **For some TPs a time gap of nearly two years exists between the actual development of their plan and the interviews of the second round, which could induce a bias in the stories on the initial plans.**
- **Although all projects (except for one refusal) were interviewed a further triangulation with scientific literature is needed for the final report.**
- **The patient monitoring which should have provided quantitative data, has been discontinued.**

10.2 VARIETY IN PLANS

In this phase of the research we primarily focused on describing and understanding the underlying ideas of the individual proposals (plans) of the TP. As has been described in 'programme evaluation research'¹⁻³ the plan can be considered as an important step in setting the scope of a new intervention. The plan documents the theoretical conception or conceptual vision on the intervention. The plan is a form of expressing the aims, the theoretical conceived organisation of actions and partners and the outcomes aimed for. As we described in the methods section, an analysis of this plan is a crucial element to perform a 'realistic evaluation'⁴ of the implementation processes.

The most general observation on the TPs is the great variety in the way plans conceived their collaboration model. The bottom-up strategy of the government's tender, be it within a guidance framework, has led to a great variety in the theoretical description and operationalisation of the TP-plans. This variety is observed in different dimensions.

10.2.1 One TP-framework, different interpretations

The initiators of the individual TPs have given different meanings to the TP-programme.

In its most general layer, the differences are connected with the duality and the intertwined dimension "organising and coordinating the partners of a TP" and "coordinating activities around the patient". Projects seldom clearly disentangle the coordination issues of partners from the daily activities around patients, while they implicitly focus more on one of these two dimensions. Projects are generally not very explicit on elaborating on the differences between developing the "means" (the partnership model) as an intermediate objective and the final objectives of developing better needs-based care for selected patient groups. This fact seems to have an impact on the daily functioning of the TPs.

The interviews give very clear indications that the process of giving meaning to a plan of intervention is a negotiated process. Differences in meanings given to the objectives of a TP are closely connected to interests and positions taken by individual partners within the projects (see *infra*). Previous experiences of partners or partnerships with health service innovations have an impact on setting the scope of the TP. A substantial part of the TPs has developed a TP-plan that is largely inspired by previous experiences or ongoing initiatives. Some TPs commented that they moulded a (well working) previous partnership into the administrative TP format of the tender, but with the intention to continue their ongoing working practices. The interpretation of what is to be considered as a TP is thus not developed in a knowledge void, it thrives for many partners on experiential knowledge.

Besides the observation that the proportion of Dutch-speaking TP-proposals is larger than French-speaking TP-proposals, indications are found that the history of collaboration between partners differs along regional/cultural lines and thus impact on the definition and description of the collaboration model.

10.2.2 Preparation of the TP-proposal

Writing a TP-proposal can be described at different levels.

Firstly, the MHCCP have coached the projects at the strategic level as well as in some practical aspects (i.e. writing the TP-proposal and gathering the signatures of future partners). The MHCCP have essentially played this latter, practical role in the French-speaking part of Belgium. The TP-proposals reflect thus some strategic choices taken at the provincial level (since MHCCP operate at provincial level). Some ISHC have played a similar role in the elaboration of the strategic view of the project. They are positioning themselves as stakeholders/stakeholder representatives.

Secondly, the TP-proposal have been written either by a single person or a team of persons, often professionals from one or several partner institutions. When it is only one person, the latter is often a psychiatrist or a person in the management of a mental health service. We suggest the possibility that the psychiatrists played a more influential role in the French-speaking region (in the light of their participation in the writing of the TP-proposal, their role as 'overall coordinator' and their involvement in the preparation of the TP-proposal). Services at the first line are nearly never the only leader or initiator of the TP (except in a minority of TPs, mainly in the cluster elderly).

Thirdly, regarding the content of the preparation meetings, most of the TPs have touched upon core topics (E.g. the choice of the specific patient group, the choice of the partners, the development of a common point of view, the NIHDI-criteria, the practical organisation of the TP, the development of the concepts of continuity of care, care trajectory, needs-based care, etc.). They do not seem to have thought in an in-depth way about the operationalisation of these topics in the TP however. For certain issues, the TP collaborators have reflected upon the 'what' (E.g. the coordinator, the working model of the TP) but not upon the 'how'. It seems that TPs for which the duration of the preparation was longer are more the fruit of a consensus between all the partners than the others. In the same way, it seems that the more involved partners and the greater the diversity between these partners, the more difficult it is to progress towards a consensual view on the TP.

The TP-programme offered the possibility to external partners to be part of the mental health field, which was relatively closed before. Some partners have taken the occasion to enter in this field, others have been attracted by a service belonging to the mental health care field.

10.2.3 Objectives

During the interviews it became clear that the reflections on and identification of particular working objectives remained very general in most of the projects. TPs that describe very specific and focused objectives are a minority.

During the interviews respondents remained in overall terms very general in formulating their objectives. They did not analytically separate objectives on patient level or objectives in terms of the partnerships. In many TPs the objectives at partnership level are generally seen as a means to reach a patient-related goal. This accords with the earlier observation that the tender urged the projects to focus on describing their organisation model around patients.

A majority of TPs defined aims and objectives on their daily experienced difficulties and hurdles (i.e. context of their practice: patient population, health care supply of the area, practical, material problems). TPs do not tread new and undiscovered areas of the field of mental health care in order to develop a TP-proposal.

Probably there is an important pragmatic element in formulating rather vague goals and objectives too, allowing adaptation in specification later on in the process without being forced in a position to stop the TP. A small number of TPs (particularly in the French-speaking part) elaborated a too specific and idealistic plan and had difficulties to implement it (overall when the person who writes the plan is not a field worker and/or when it is written by only one person).

10.2.4 Partnership level

TP-plans vary on the definition of the structural characteristics of the collaboration model. The proposed partnerships in the TP-plans vary widely in terms of network complexity. This complexity is determined both by the number as well as the type (health care and other sectors) of partners. As a consequence we see a great diversity of partnership coordination models. Moreover, different partners fulfil different roles within and between TPs.

10.2.4.1 *The constitution of the partnership*

The NIHDI-framework imposes some criteria to which the partnership has to respond. A great diversity has been observed in the way the different health service echelons or lines, as defined in the NIHDI-call, have been involved in the partnership. In general, primary care partners, involved in the TPs, is smaller than the number of partners from second and third line. Part of the explanation is that (mainly Dutch-speaking) projects involved by means of umbrella organisations of the ISHC rather than individual primary care providers.

Although there is no clear relationship between clusters and the constitution of partnerships, the mental health care domain in terms of age groups and problem area explain partly the choice for partners involved. This is most obvious for the number and type of non-obligatory partners being involved. For example, in the cluster 'forensic', there is a necessity to work together with the legal sector, and for children the schools or education related services are often included. Many other factors explain the selection and the definition of roles of partners, such as mutual acquaintance and a trust relationship between at least a core set of partners. This is quite consistent with what is generally described in the literature on the development of organisational networks. For most projects, their partnership contains partners who already know each other (see supra). These observations are relevant on a policy level, as many projects do not necessarily select an area of activity based on population needs, but more on the informal network of providers of care.

Regional differences seem to emerge with regard to both the number and the role allocated to the partners involved. Whilst some large partnerships are also found amongst the Dutch-speaking TPs, we observe that the mean number of formally involved partners is higher in the French-speaking TPs. The specific motivations for choosing extensive partnerships remain unclear at this stage. We hypothesise that the differences between regions are connected with different perspectives on stakeholder representation or with strategic interests in the choices of partners (i.e. some partners want to be included 'to be part of the innovation movement').

Indications are found that French-speaking projects depend to a large extent on the hospital as the central actor. This shows in several factors, such as the organisation of meetings at the hospital, the localisation of the coordinator in the hospital and the involvement of several hospitals in the formal partnership. The hospital is a central actor in many Dutch-speaking projects too, but projects seem to develop more broad approaches to actively engage a broader range of partners in the actual collaborative management.

The primary care partners are often been charged of the administrative contractual tasks for NIHDI; specifically for projects in the cluster 'children and adolescents', 'forensic' and 'addiction'. It was mentioned in a number of interviews that the primary care partners often lack the background knowledge and expertise for adequately managing the care trajectories as core partners.

Beyond the distinction between formal and informal partners, we consider that it is important to distinguish the core and the peripheral partners. We define core partners as partners without whom the TP cannot continue to function. Indeed, they play a main active role in patient and/or partnership-related activities: provision of patients, initiative of the TP, preparation of the TP (writing of the TP-proposal, reflection, promotion, etc.) and daily patient or partnership-related activities.

The core partners can be both formal or informal partners. Usually these core partners are one specific institution or a combination of institutions who collaborated previously. The status of 'core partner' can change in the evolution of the TP. Some 'core' partners can disappear and new partners can be involved. This change could be related to the changes in patient needs or to the decision of the partners not to be implicated in such an intensive manner anymore.

10.2.4.2 *Modalities of coordination*

The variety in the complexity in the coordination models is showed in the mix and structuration of coordination mechanisms (E.g. differences in the number and content of meetings, in the choice of logistic tools, in the role of the coordinator, in the attribution of this role to one or more individual professionals, etc.).

Some initial (non conclusive) observations can be made in this respect.

Most projects see a coordinating person as the key coordinating mechanism. This does not necessarily imply that projects have defined a very explicit task description of this coordinator in advance. This person has to take up a wide range of tasks in the daily internal functioning of the partnership, and in many cases also for external administrative tasks concerning the tender. Often this coordinator is also the general "reference person" and key contact for all matters concerning the project.

Besides the role of the coordinator, meetings are the central coordinating mechanisms at the level of the partnership as well as at the level of the patients.

Even though the NIHDI rules oblige to organise three-monthly patient meetings, it is striking to observe how the different projects have developed different modalities for organising these meetings. In some projects the coordinator is closely involved in patient activities. In other projects the coordinator's role is more one of a facilitator. Moreover the number and ways of organising patient meetings differs to the extent in which follow-up discussions are grouped. Projects in which the coordinator takes more distant towards the patient-related activities, more differentiating arrangements seem to develop in organising the patient meetings. We will certainly elaborate on this question in the second round of the interviews.

Another important coordinating mechanism are support tools. The use of support tools varies between projects. The use of tools seems to differ between clusters, probably explained by the characteristics of the field, meaning that different collaborators with different professional backgrounds are included (e.g. for some sectors (forensic children in particular) professionals require explicitly to guarantee the anonymity of the patient when sharing/transferring patient information between partners). As mentioned in the results section in two Dutch-speaking provinces a common provincially developed tool for coordination of care is used (electronic care plan). In these provinces professionals have already experience with this tool. moreover less time was needed to negotiate on the content of the tools. A similar indication can be found for the projects in the area of 'Liège' in which projects developed common tools within the frame work of "transversal negotiations", explaining why less debate and time was probably needed within individual projects to develop patients support tools. At this stage of the research we have the impression that the use of tools is not considered in all projects as a coordination tool, but rather as an administrative requirement to answer external formal requirements. These projects have embedded to a lesser extent the use of tools as a daily coordination mechanism between partners and professionals involved, into their project.

In the next round of data collection we will have to elaborate further on the use of care plans as a coordination tool.

10.2.5 Patient level

10.2.5.1 *The selection of the target population*

Firstly, TPs make pragmatic choices to select a target population. Ensuring that the preset caseload is obtained, is an important motivation to choose the target population, even if other motivations are put forward.

The activities of the core partners involved, and generally the ones of the initiating partner, determine the choice of the target population. Projects work with patients for whom the partners have previous expertise and/or perceive problems in their regular work. These problems can be related to the health care services supply (e.g. structural problems), as well as to the specific situation of the patient: e.g. 'a dead end situation', patients whom are difficult to reach. Projects do not aim at working with a new target population.

Projects never talked about a formal needs assessment in terms of 'assessment of needs at population level' (epidemiological needs assessment) in the predefined area of activity.

Secondly, projects have different attitudes towards the importance of a psychiatric diagnosis.

Considerations about the required diagnosis

Some TPs have expressed that the inclusion of the patient requires a formal diagnosis of a mental disorder, whereas in others, the assumption that a mental disorder is present, is considered as sufficient.

The fact that TP-programme requires a diagnostic label before the patient can be included can cause difficulties. Indeed, in the case that the patient has not already been diagnosed, this diagnostic process may be speeded-up due to this requirement (only to allow that the patient be included in the TP) and go against the pace of the patient. This may be especially the case for children and adolescents that run a risk of unnecessary stigmatisation as being subject of psychiatric care.

10.2.5.2 *The position of the patient in TPs*

The TP-framework aimed at involving the patient in the definition of his care. Projects are implementing and interpreting this aspect in different ways. An influencing factor is the former collaboration and working methods with regard to the position of the patient. The more the projects have previous experiences with involving the patient in defining his care, the more the position of the patient is reflected in the defined working model or approach.

At the intentional level, the majority of projects mention the importance of patient participation. But TPs only provide very little explicit information on how to involve the patient. If any information was given, it deals with the participation of the patient in follow-up meetings. We lack information whether explicit input of the patient and patient representatives in terms of expressing their needs has taken place. It seems that most projects are working with the idea: "I think I know what you need" instead of "I'm asking you what (you think) you need". It can be said that this goes against the dimensions 'experienced' and 'flexible' of the concept of continuity of care. Indeed, the dimension 'experienced' refers to 'the experience of a coordinated and smooth progression of care from the patient's point of view' and the dimension 'flexible' stresses the importance to take into account the current needs of the patient: 'to be flexible and adjust to the needs of the individual over time'⁵.

10.2.6 Area of activity

We certainly have to elaborate more in the next round of data collection on the choice for a particular area of activity. Projects have mainly delineated their area of activity based on pragmatic reasons, closely connected to the activity area of core partners. In most TPs the catchment area of one partner institution defines the area of activity of the entire project.

In some other cases the area of activity was defined conform the activities in previous collaboration between partners. In projects of the clusters 'adults' and 'elderly' with ambulatory services initiating the TP, the area of activity is generally more limited, whereas for the clusters 'children and adolescents', 'forensic' and 'addictions' (in which the initiator is often a residential institution), the area of activity is often more extended. Of course, the choice of an area of activity can also be influenced by the level of specialised mental health care services involved in the project.

It is obvious too, that the existing geographical distribution of mental health services in Belgium influences the delineation of the catchment area for some projects.

10.2.6.1 *Strategic influences*

In some provinces the MHCCP mediated in the preparation of the TP-proposals and steered the proposals to avoid a geographical 'overlap' between TPs.

In the Dutch-speaking region, many TPs are concentrated in 2 provinces ('Oost-Vlaanderen' and 'Limburg'). At this stage, we have no clear explanation for this. It can be hypothesized however that there is an influence of the specific characteristics of that province, namely some provincially structured initiatives (e.g. the ISHC). It is possible that they try to influence the future organisation in mental health care in their province.

- **The bottom-up strategy of the government's tender, be it within a framework, has lead to a great variety in the theoretical description and operationalisation of the TP-plans.**
- **Projects seldom clearly disentangle the coordination issues of partners from the daily activities around patients.**
- **Previous experiences of partners or partnerships with health service innovations have an impact on the elaboration of the TP-plan.**
- **Services of the first line are nearly never the only leader or initiator of the TP. They are often charged with the administrative tasks for the NIHDI.**
- **Reflections on and identification of particular working objectives remained very general in most of the projects.**
- **A majority of TPs defined aims and objectives based on their daily experiences of difficulties and hurdles. The proposed partnerships in the TP-plans vary widely in terms of network complexity. This complexity is determined by the number as well as by the type (health care and other sectors) of partners.**
- **Factors explaining the selection and the definition of roles of partners are mutual acquaintance and a trust relationship between at least a core set of partners.**
- **Most French-speaking projects depend to a large extent on the hospital as the central actor (and more than Dutch-speaking projects).**
- **Most projects see the coordinator as the key coordinating mechanism. This coordinator is often the general "reference person" and key contact for all matters concerning the project.**
- **TPs make pragmatic choices to select a target population (with whom they have expertise on the one hand or with whom they perceive problems on the other hand).**
- **The fact that a TP-programme requires a diagnostic label for a mental health problem before the patient can be included, can cause difficulties.**
- **The more the projects have previous experiences with involving the patient in defining his care, the more the position of the patient is reflected in the defined working model or approach.**

10.3 EXPERIENCES

The first round of interviews brought some relevant initial findings to the forefront. The most important observation is that the introduction of new mode of working, especially focusing on the collaboration of different individual professionals working in different organisational contexts, is a learning experience. The information collected up till now is that many projects are focusing their efforts on convincing individual professionals by means of information and gradually developing a feasible working process. Important constraints for convincing individual professionals to collaborate is the time investment and the financial rewards, but more important seems to be the resistance related to the added value of the new modalities being introduced. We will discuss this issue of raising awareness, developing a common meaning and the need to promote the content of the project in one of the sections below.

Moreover, much of the resistance or reluctance to participate actively in projects has to be understood against the background of the information of the governments programme and the concerns about the accompanying research process (mainly the patient monitoring). Many projects, and members of projects struggle with the issue of convincing people about the use of a patient monitoring (and the work needed to fill out the registration tools) because the core partners of the projects themselves questioned the tool of the patient monitoring: on the one hand because they refused a tool focusing on outcome measures on patient level, on the other hand because of the workload involved.

Another recurring issue emerging as a barrier in the collaboration process is the acceptance of sharing information between different partners.

In this section we will discuss the issues which can be seen as illustrations of the learning process and the gradual development of a negotiated order between all stakeholders involved in the individual projects but also in the overall programme.

Important issues are the need to communicate and promote change processes in the sector, the notion of chronic and complex, the use of a care plan, the coordinator and the experience with primary care. We are well aware that these topics related to experiences are not exhaustive but we emphasise yet again that the focus on process evaluation should be the main objective of the second round.

10.3.1 Promotion of the TP

In the introduction of this discussion section we already made references to the necessity to communicate and promote the objectives and working practices of the projects. The reported experiences of projects learn that this promotion requires a lot of time. Promotion is needed at three different levels, i.c. promotion with regard to the partners, the individual professionals linked with that partners and promotion towards the patients.

In general, projects mainly aimed their promotion at the partners involved, based on the expectation that individual partners would inform their individual caregivers. Experiences showed that this cascade model of information-transfer was not taken up that easily. This is a problem because it is precisely these individual professionals whom are expected to discuss, propose and convince patients to be included in these new working practices. Many projects reported to depend highly on committed individual caregivers.

We have indications that TPs with (some) partners collaborating before have less problems to promote their project. Moreover, particularly projects of the cluster children and adolescents, especially in the Dutch-speaking part of Belgium, have already collaborated a lot and seem to experience less problems on this level. This serves as an additional indication for the fact that the start-up of an innovation needs a planned and well developed implementation strategy.

10.3.2 Chronic and complex

An important issue which emerges from the first findings on the implementation process relates to the patients. The government's tender is developed around the notion of "complex and chronic" psychiatric patients. The interviews on daily practice learn that the projects do not use the notion of chronic and complex as a reference term when trying to select and include patients. The results section already showed that the interpretation of this concept diverges between clusters and between projects.

Moreover, due to the formal decision to discontinue the patient monitoring, this research lacks any standardised and quantified information on individual patient characteristics and the case-mix of the patients within projects or clusters. It will be extremely difficult therefore to trace which collaboration model seems to be more effective for what patient group, and neither will it be possible to assess to what extent the projects were selective in the inclusion of patients in their daily practice. Based on the qualitative information one could discuss to what extent purposes were strictly connected to the treatment of complex and chronic psychiatric problems: namely the elderly. We have the impression at this stage of the research that quite a number of projects in the cluster elderly were aiming at tracing, treating and supporting people with behavioural and emotional problems, but it could be questioned to what extent these projects are addressing chronic and severe psychiatric issues. Some projects of the cluster elderly suggested during the interviews that they considered to stop their participation in the TP-programme and that they would submit the same approach in another NIHDl protocol (protocol 3).

Similar questions should be raised and discussed further in the cluster children and adolescents, namely to what extent do the chosen groups fit into this notion chronic and complex, and whether a similar meaning can be given to chronic and complex within the different clusters to develop a collaborative needs based community oriented approach.

10.3.3 Care plan

The government's programme requires the development of a "care plan". Care is coordinated through a common plan that must remain flexible to adjust to patients' needs. Care plans are patient specific strategies designed to address the total status of the patient and intended to ensure optimal outcomes for patients during the course of their care. Collaborative care plans explicitly and comprehensively describe interventions and expected outcomes in the treatment plan. It is also a communication tool across the continuum of care^d.

During the interviews we obtained very little information on the development and use of these care plans as a tool to plan and coordinate care. At this stage of the research we are definitely not in a position to draw any conclusions about the use of a care plan implemented and integrated in daily practice for planning and coordinating care according to the patients needs.

One possible explanation for this lack of information could be the timing of the interviews: a majority of TPs have been interviewed at a point in time at which they were mainly including patients and still not fully involved in the development of the actual care process. The indication we have on the process of including patients is rather assessing the status of the patient from the perspective whether he/she fitted in the overall scope of the projects. Very little projects made explicit references to the fact that at this stage a precise and operational care plan was to be initiated.

At this stage we only have some hypotheses to be tested further: first projects do not use or implement the care plan as a day to day working instrument in which a description of patients needs is connected to a task allocation amongst different partners or practitioners as it was an intended part of the programme.

^d Deborah Dudgeon, Managing Continuity through Collaborative Care Plans: A Study of Palliative Care Patients, CHSF June, 2004, http://www.chsrf.ca/final_research/ogc/pdf/dudgeon_final.pdf

Second, although projects did not bring it spontaneously to the fore during the interviews, we have not paid enough attention to the issue in the first round of interviews. Thirdly, the issue of the use and content of care plans was not resolved at the stage of our interviews, because some important debates we still taking form on the way patient information between partners should be shared and transferred. These discussions are closely related to opinions about privacy and professional secrecy. The second round of data-collection on the process experiences will certainly elaborate on this issue.

In this context, it is important to associate this information with the idea of care pathways. A pathway includes at least two specific components, namely a multidisciplinary character (i.e. the categories of care or activities and their interventions) and outlining the optimal sequence and timing of interventions for a well-defined group of patients. It helps in the communication with patients, as access to a clearly written summary of their expected care plan and progress over time is given to patients. Most of the projects are not working on defining pathways for a well-defined group of patients, but they are working with the specific needs of an individual patient.

10.3.4 Coordinator

The projects reported different experiences with regard to the role of the coordinator in managing the partnership and the patient related issues. The interviews learn, on an overall basis, that projects had to develop a vision on the role of the coordinator and the content of its tasks along the way. Some projects with previous experiences could have had a slight advantage, but even in those projects major efforts had to be put in place in order to define this role of the coordinator.

The interviews made clear that the role and tasks of the coordinator were not always well elaborated within the plan of the projects. Many projects did not have a clearly idea on how this “function” in the collaboration process would have to be given form. When comparing the projects, many use the notion of a coordinator, while the content of this role and the support functions of this role differed widely between projects. Based on the preliminary findings of the experiences of the projects it seems that projects are adapting and forming the role within the experienced practical constraints. This implies tasks on patients level, on partnership level, but also in the combination of the tasks.

Because of this lack of clearly elaborated governance model of the collaboration in the planning of the projects, a lot of energy and time has to be spent on identifying practical working modalities. Taking into account this part of the learning experience is quite essential, in order to understand the slow start of many projects. Moreover many projects experienced that their collaborating partners and individual professionals expect leadership from the coordinator. Partners have great expectations of the coordinator in keeping the collaboration running. It has been mentioned that the partners also negotiate on the project related tasks or responsibilities. In order to juggle different tasks, partners claim both support in patient related activities as well as at emotional level.

A particular difficulty relates to the perception of the role of the coordinator by the partners and more specifically by their individual professionals. Within the projects coordinators have to be experienced and perceived as “neutral” in order to develop legitimacy. This legitimacy is a crucial element in order to attain a smoothly running project. Especially in those case where project coordinator is located within the framework of residential partners the coordinator has to fight the prejudice of being perceived as an employee and thus only working for the interests of this particular partner.

We have been told about projects in which a project coordinator dismissed because of job strain and because of a lack of legitimacy. These dismissals have often led to setbacks and to further difficulties in the functioning of the TP. The process of building trust and giving meaning to this role had to be started all over again in these circumstances. Moreover, the development of the role of the coordinator is largely affected by the way projects use the financial means allocated by the governments programme.

We will certainly focus more in the second round of interview on this learning trajectory and (difficulties) in building legitimacy as a condition to keep the project running. The professional profile of the coordinator appears to be a core issue in this acceptance and legitimacy to take up a leadership in the collaboration process. Moreover we will dig into the question of differences and communalities between clusters.

The interviews learn that many projects also struggle with the task structure and content of the role of the coordinator, both at the level of daily executing of work as well as for the competencies required to manage such a complex of activities. Moreover, for certain tasks, people need to have or develop the necessary authority to intervene, discuss and manage the professionals involved in individual patient activities. Moreover, problematic situations may arise when the coordinator's duties are not sufficiently defined and shared between project partners, or by professionals working for projects partners.

The next round of interviews will make a more in-depth analysis of the experiences and governance models used to coordinate the network as whole and coordinate activities around patients. After three years of experiences we expect to be able to draw conclusion on barriers and facilitating factors for increasing the effectiveness of a partnership.

At this stage of the research however, we do not have enough information allowing us to identify patterns related to the different clusters.

10.3.5 Experience with primary care

Whilst we heard a lot of comments on the obligatory involvement of a GP as a primary care partner on the one hand, we obtained quite a lot of information on the other hand in which the TPs themselves, especially in the French-speaking part, expressed their appreciation of the GP involvement as an important additional value in the functioning of the TP.

At the level of patient-related activities, some projects invite individual general practitioners to participate at the meetings. Other projects have chosen a primary care organisation. The presence of GP during the TP meetings may encounter problems however, since the GP in particular and the first line in general do not share the same culture of networking which exist in the field of mental health. In addition, the GP is often an independent professional, and his presence during the TP meetings may mean a disadvantage to him, since he/she is usually paid by a fee for service system. The projects have considered various ways enable the participation of the GP in follow-up meetings. Some projects allocated a higher reimbursement to the GP in comparison to the other partners participating in the follow-up meetings. The above remarks are nevertheless not applicable to some categories of GPs who are working in 'Medical Houses' and who are more familiar with team work and the sharing of patients.

In fact, at the implementation level, most projects intending to include the GP in the TP found themselves facing a series of practical difficulties and only few projects have been able to rely on a regular participation of the GP in follow-up meetings. These difficulties may be explained by cultural, individual or regional reasons, or still by inter-professional conflicts.

If these difficulties can actually be explained by cultural and financial reasons (the GP is more familiar with a model of care based on a dyadic relationship), we can also hypothesize that some forms of resistance to change plays also a role in the GP reluctance towards collaboration work around the patient. It must be stressed that this working model brings forward some questions regarding the current position of the GP in the health system.

- The introduction of new mode of working, especially focusing on the collaboration of different individual professionals working in different organisational contexts, can be considered as a learning experience.
- Important hindering factors for convincing individual professionals to collaborate is the time investment, the financial rewards, and above all the resistance related to the added value of the new modalities being introduced.
- Much of the reluctance to participate actively in projects are related to the patient monitoring, on the one hand because partners refused a tool focusing on outcome measures on patient level, on the other hand because of the workload involved. A barrier in the collaboration process is the acceptance of sharing information between different partners.
- Concerning the promotion of TPs, experiences showed that the expected information-transfer (cascade model) from individual partners to their individual caregivers and then from the latter to the patients was not taken up easily.
- TPs with (some) partners collaborating before have less problems to promote their project.
- A majority of projects do not use the notion of chronic and complex as a reference term when trying to select and include patients.
- Especially in the cluster elderly, it could be questioned to what extent do the chosen groups fit into the notion of chronic and complex, and whether a similar meaning can be given to chronic and complex within the different clusters.
- In a majority of TPs, care plans are not use as a coordination tool but as an administrative form to answer the NIHDI requirements.
- In general, projects had to develop a vision on the role of the coordinator and the content of its tasks along the way.
- The role and tasks of the coordinator were not always well elaborated within the plan of the projects. This must be taken into account in order to understand the slow start of many projects.
- The content of the role of the coordinator and the support functions of this role differed widely between projects.
- A particular difficulty relates to the perception of the role of the coordinator by the partners and more specifically by their individual professionals (legitimacy issues).
- The development of the role of the coordinator is largely affected by the way projects use the financial means allocated by the TP- programme
- The professional profile of the coordinator appears to be a core issue in this acceptance and legitimacy to take up a leadership in the collaboration process.
- Only few projects have been able to rely on a regular participation of the GP in follow-up meetings.

10.4 FUTURE RESEARCH STEPS

The preliminary findings on initiatives for mental health care reform in Belgium give clear indications on how the development of interorganisational networks as an innovation mirror the characteristics of an organisational field that is complex and layered. The first round of interviews demonstrate that health care innovations take place in complex multi-agent environment. The implementation (adopting and sustaining) of health services innovations is influenced both by “external” and “internal” processes and barriers. The public sector context of health care includes “external” influences by multiple stakeholder through values, power plays, regulations and normative frameworks.

Authors having studied innovations distinguish mechanisms of diffusion (passive), dissemination (active and planned efforts to persuade target groups to adopt an innovation), implementation (active and planned efforts to mainstream an innovation within an organisation), and sustainability (making an innovation routine until it reaches obsolescence) as crucial elements of an innovation process. Greenhalgh et al.⁴ propose a framework to understand the diffusion and implementation of organisational innovations in a real world context. They distinguish two stages in the model: stage one considers (1) the attributes of the innovation as perceived by the intended users, (2) the characteristics of the intended adopters of the innovation and the adoption process, (3) the nature of communication and processes of influence about the innovation, (4) the organisation context and (5) the organisations readiness for the innovation (6) the nature of the outer context and how it will impact on the assimilation process (7) the implementation and maintenance process (not the adoption by individuals) (8) the nature, capacity and activities of external agencies. Stage 2 focuses on the interaction between these components.

At this stage of the research we mainly focused on the meanings given to the plans and the first implementation experiences of the projects. We did not discuss or assess the issue effectiveness yet although this would be one of the core questions. The assessment of effectiveness is a delicate issue, though as multiple perspectives are possible. Provan and colleagues⁶ proposed three levels to discuss the effectiveness: community level, the network level and the organisation/participant level. More attention needs to be paid to network functioning and more specifically to understand which network conditions lead to various network-level outcomes. Our comparative findings on the Belgian experiments offer indications that the governance models between projects differ, and we need to elaborate on that matter. But additionally we would also plead to assess the effectiveness of health services in a context-sensitive manner, meaning to consider the stage of development of certain network models within the complex and layers characteristics of the field.

The next round of data-collection and analysis will question TPs explicitly about those factors which are important to bear in mind when implementing the TPs, as well as asking for the facilitating and hindering factors for collaborating around these patients (not only related to the TP-requirements). The future stages of the process evaluation will develop a better understanding on how the issue of complexity and ‘long term support needs’ has been addressed by the projects.

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.

II PRELIMINARY LESSONS LEARNED

II.1 THE GOVERNMENT'S PROGRAMME

Although the objective of the KCE is not to assess the impact of the government's programme, it is clear that it forms the background against which the experiences of the individual TPs develop. Some indications are found on how the tender affects the functioning of the TPs.

The government's TP-programme was an open-ended tender in the form of a framework, setting objectives and general practical regulating conditions, within which individual initiatives were invited to propose "bottom-up" models of collaboration and partnerships. This bottom-up approach implies that individual initiators of projects develop different meanings and operational models of this idea of collaboration in cross-sector boundaries mental health care. Similarly the initiators were obliged to identify their target patient group with arguments on how they fitted with the notion of "chronic and complex" psychiatric problems. As expected, this latitude led to a wide variety of models proposed by the sector.

The bottom-up approach, not imposing a unique organisational model in a top-down manner, allowed to develop collaboration models between different services/partners adapted to local contexts, field characteristics and target groups, and was well appreciated by the sector. In contrast to this general positive appreciation, it appears that the sector experiences difficulties in setting up effective organisational and management practices to develop interagency collaboration. An important observation is that although the current programme initiated collaboration initiatives, it seems not to have induced real innovative thinking on interprofessional and multi-agency collaboration for most of the submitters. A substantial part of the TPs indeed has developed TP-plans largely inspired by previous experiences or ongoing initiatives. TPs commented that they moulded a (well working) previous partnership into the administrative TP format of the tender only with the intention to continue their ongoing working practices. As a result, there seems to be a growing discrepancy between those projects with previous experience and shared knowledge between partners and those with less previous collaboration experience.

Some of these preliminary observations could be picked up for future government-initiated programmes. As can be compared to other countries the government could reflect more to what extent a publicly funded programme should provide educational and management support to individual projects in order to develop innovative interagency collaborations. Interagency collaboration is a matter of coordinating both different (health care) organisations as well as the professionals involved in the care and support of individual patients. Governance models should consider both issues. The support could in particular be organised around the question of how to develop effective governance models for interagency and interprofessional collaboration. The future research steps will consider this issue.

The sector clearly experienced a lack of a clear, coherent, consistent and continuous communication on the government's framework and the intended objectives. The implementation of the programme has been affected by rumours and plenty of informal, imprecise, inconsistent information streams. A clear communication model and strategy, with a clear definition of the roles and mandates of persons, committees and government agencies is to be considered as an essential part of the support process of any health services innovation. The sector does not only need regulatory frameworks that control and try to avoid abuse of public resources, but also supportive (including communication) tools enabling the sector for the implementation of innovations. Communication and support probably needs to be professionalized and integrated into any launch of an innovation programme.

11.2 THE DESIGN OF THE TP (THE PLANS)

The bottom-up strategy of the government's tender has not surprisingly lead to a great variety in the theoretical designs of professional and interagency collaboration. It is striking though that the plans are not very clear in disentangling the aspects of collaboration around the individual patients, and the collaboration between health service agencies (the network). Moreover, many projects seemed not to be aware that these two aspects have to be managed simultaneously, while the content of what has to be managed is not the same. Projects seldom used this particular governments call to have an in depth reflection on the management and objectives of the interprofessional as well as the interagency collaboration.

The development of an health services innovation should however exceed the filling in of administrative documents to obtain funding. Health services innovations need clear, shared and well understood objectives and working practices by all persons involved, in order to streamline meanings and expectations of all people directly or indirectly involved.

The interviews give very clear indications that the process of giving meaning to an intervention is a negotiated process, during the preparation as well as during the implementation. Differences in meanings given to the objectives of a TP are closely connected to interests and positions taken by individual partners within the projects. Developing a shared language and common understanding of the activities requires bridging language, norms, values and expectations common to particular domains and professions. This requires time, but a simple process of learning by doing seems not to be the most adequate. The learning by doing needs more leadership and needs to be embedded in an explicit framework, understood and used by all people involved. Many projects would probably be helped if a more guided framework could be imposed by persons with enough legitimacy among all partners involved, within which the collaboration and governance models could get form through a learning experience. Partners and professionals probably need more guidance on how to share and discuss interests to develop a negotiated order. An purely experience-based "learning by doing" process with little active guidance is not the most efficient way to implement and diffuse innovations (using public resources).

11.3 COMPLEX INTERAGENCY COLLABORATION

The proposed partnerships in the TP-plans vary widely in terms of network complexity. This complexity is determined both by the number as well as the type of partners. As a consequence, a great diversity of partnership coordination models are put in place. The domains involved in the interagency networks per cluster and regional characteristics clearly show that interagency collaboration is very context sensitive, and that one unique organisational model of collaboration cannot be imposed.

Regional differences seem to emerge with regard to both the number and the role allocated to the partners involved. Whilst some large partnerships are also found amongst the Dutch-speaking TPs, we observe that the mean number of formally involved partners is higher in the French-speaking TPs. The specific motivations for choosing extensive partnerships remain unclear at this stage.

A clear distinction between the decision roles of specific partners emerges from the projects. We have indications that "core" and the "peripheral" partners in the management of the project can be identified. Core partners are generally taking up the leadership and management roles. In a large proportion of the projects specialised mental health care services (often hospitals) are part of the core partners. This is probably related to their particular expertise in the field but clearly also because they have an organisational overhead (staff and support function) on which they can rely to develop an innovation.

11.4 COORDINATION

Projects have assigned roles in different ways to coordinators, meetings and support tools as the coordination function of the partnership. Within this general observation, it is worth observing that similar terms or concepts (language) cover a very different content, which could hamper cross-project communication. Projects develop operational working practices that are idiosyncratic to each project or local social network, thereby often using similar terms for very different content.

Most projects see the coordinator as a person as the key coordinating agent, while the role and tasks of the coordinator(s) were not always well elaborated in the plans. This lack of an elaborated governance model resulted in many instances in a process in which a lot of energy and time had to be spent in identifying practical working modalities.

A second important indication is the acceptance of the roles assigned to the coordinator. Coordinating partners is to a large extent a matter of developing trust. Within the projects, coordinators have to be experienced and perceived as “neutral” towards the interests of different participating partners in order to develop legitimacy. A particular issue to be developed further is the question to what extent a coordinator should facilitate the collaboration between professionals (and family members) around individual patients: it is not clear to many projects to what extent the coordinator’s role is limited to that of a logistic facilitator of collaboration activities or whether he should extend his role more towards that of a case-manager.

11.5 THE CARE PLAN

The TP-programme attributes a lot of importance to the use of a care plan as a coordination tool for activities around the patient. Although at this stage the data-collection is still very limited, it seems to emerge that the notion of the care plan as a practical tool to coordinate care (and to assign roles to individual professionals) in order to serve the needs of individual patients is in many projects developed primarily as an administrative requirement rather than as an instrument for developing needs-based care, adapted to the disease and need episodes of a particular patient. However, more data-collection is needed on the use of this tool in the next rounds.

11.6 THE PATIENTS

Projects do not actively use the notion of “chronic and complex” as a reference term when trying to select and include patients. TPs make pragmatic choices to select a target population, mainly in order to ensure that the preset caseload is reached. The fact that we will not obtain patient profiles will make it impossible to detect to what extent the projects really serve the intended target populations of the government’s programme. Yet, from a government and public health perspective, the question whether the health service innovation programme serves the intended target audience is far from trivial. It needs to be clarified to what extent the TPs are actually selecting their patient group and whether the new organisational models can really serve the overall population of patients with chronic and complex psychiatric problems, and whether all projects (approaches) and the problems they address actually belong to the field of mental health/psychiatric problems.

11.7 AREA OF ACTIVITY

Projects have mainly delineated their area of activity based on pragmatic reasons, closely connected to the activity area of core partners. Projects do not use formal needs assessment methods in terms of 'assessment of needs at population level' (epidemiological needs assessment) in the predefined area of activity. The government's programme did not request this. In most TPs the catchment area of one partner institution defines the area of activity of the entire project. In some other cases the area of activity was defined so as to conform to the activities in previous collaborations between the partners. Future programmes need also to reflect on the population needs in delineated areas of activity if new community-based health service models will be diffused as a more common health service provision practice.

11.8 INVOLVING PRIMARY CARE PARTNERS

As the government's programme intends to promote more community-oriented care, it seems obvious to ask to include partners from primary care. In a historically hospital-centred and specialised care centred country, the involvement of primary care partners emerges as a particular difficulty. Most projects intending to include the GP in the TP found themselves facing a series of practical problems. Other projects mainly involve the general first line by means of the ISHC, and often as a kind of surrogate partners as only administrative tasks are assigned to this partner. In Flanders these intermediate structures are more developed than in Wallonia. But the difficulties to involve primary care partners can probably rather be explained by cultural, reasons, inter-professional resistance and the lack of a clear vision on how the general primary health care could contribute to the care process. We have some indications that TPs aiming at early detection seem to experience less problems in assigning expectations towards primary care partners. Besides this issue of assigning clear roles, more reflection is needed on managing the practical difficulties to rely on a regular participation of the GP in different types of meetings. Further reflections and debate are needed on the question how to involve primary care in a community-based mental health care model.

- **The bottom up approach is well appreciated by the sector because the sector experiences it as a means to develop locally adapted ways of collaboration between different services/partners. In contrast, the sector seems to experience difficulties in putting effective organisational and management approaches in practice to develop interagency collaboration.**
- **The sector experienced a lack of a clear, coherent, consistent and continuous communication on the government's framework and the intended objectives. A clear communication model and strategy, with a clear reflection of the roles and mandates of persons, committees and government agencies is to be considered as an essential part of the support process of any health services innovation**
- **The plans generally do not clearly disentangle the aspects of collaboration around the individual patients and the collaboration between health service agencies (the network). Many projects seemed not realize that these two aspects have to be managed simultaneously**
- **Health services innovations need clear, shared and well understood objectives and working practices by all persons involved, in order to streamline meanings and expectations of all people directly or indirectly involved**
- **Developing a shared language and common understanding of the activities requires bridging language, norms, values and expectations common to particular domains and professions. This requires time. But a simple process of learning by doing seems not to be the most adequate. The learning by doing needs more leadership and needs to be embedded in a explicit guiding framework understood and used by all people involved.**

- **A great diversity of partnership coordination models are put in place. The domains involved in the interagency networks per cluster and regional characteristics show that interagency collaboration is very context sensitive, and that one unique model of collaboration cannot be imposed.**
- **“Core partners” are generally taking up the leadership and management roles. In a large proportion of the projects, specialised mental health care services (often hospitals) are taking up this core role. This is probably related to their particular expertise in the field, but clearly also because they have an organisational overhead (staff and support function) on which they can rely to develop an innovation.**
- **Coordinating partners is to a large extent a matter of developing trust. Within the projects, coordinators have to be experienced and perceived as “neutral” towards the interests of different participating partners in order to develop legitimacy**
- **The care plan as a practical tool to coordinate care (and assign roles to individual professionals) in order to serve the needs of individual patients seem in many projects developed primarily as an administrative requirement rather than as an instrument for developing needs-based care, adapted to the disease and need episodes of a particular patient.**
- **Projects do not actively use the notion of “chronic and complex” as a reference term when trying to select and include patients. TPs generally make pragmatic choices to select a target population, mainly in order to ensure that the preset caseload is reached.**
- **Future health service innovation programmes need also to reflect on the population needs in delineated areas of activity if new community-based health service models will be diffused as a more common health service provision practice.**
- **Further reflections and debate are needed on the question how to involve primary care in a community-based mental health care model.**

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2. Studie naar de mogelijke kosten van een eventuele wijziging van de rechtsregels inzake medische aansprakelijkheid (fase I). D/2004/10.273/2.
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