

# Hervormingen in de geestelijke gezondheidszorg: evaluatieonderzoek 'therapeutische projecten'

*KCE reports 146A*

## Het Federaal Kenniscentrum voor de Gezondheidszorg

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## KCE reports I46A

**Titel:** Hervormingen in de geestelijke gezondheidszorg: evaluatieonderzoek 'therapeutische projecten'

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## VOORWOORD

In 2006 lanceerde de federaal Minister van Volksgezondheid een projectoproep in het domein van de geestelijke gezondheidszorg. De bedoeling ervan was om een betere samenwerking tussen de actoren van de geestelijke gezondheidszorg te bevorderen door aan lokale initiatieven de middelen te geven om nieuwe organisatie- en overlegmodellen uit te testen. Deze oproep kende een aanzienlijk succes aangezien er niet minder dan een zestigtal projecten gedurende drie jaar aan de slag gingen.

Van bij de start was er het de bedoeling om deze ervaringen ook te evalueren. Het was inderdaad zaak om de meest veelbelovende en werkzame formules te identificeren. Deze evaluatietaak werd aan het KCE toevertrouwd. Wij hebben de verschillende projecten over heel hun verloop opgevolgd en maakten reeds twee tussentijdse evaluatierapporten. Vandaag stellen we u het syntheserapport voor.

Het was voor het KCE een ongewone en delicate opdracht. Ongewoon, omdat het KCE eerder vertrouwd is met het synthetiseren van resultaten van studies en veldwerk van anderen eerder dan zelf het veld te betreden. Delicaat, omdat resultaatmeting in de geestelijke gezondheidszorg wellicht nog moeilijker is dan in de somatische geneeskunde.

Wij hopen toch een bijdrage te hebben geleverd aan deze collectieve inspanning en zo wat ruggesteun te bieden aan de besluitvorming voor de volgende stappen in dit proces.

Onze bijzondere dank gaat naar de equipe onderzoekers die tijdelijk in het KCE actief waren voor het uitvoeren van deze evaluatie evenals naar alle deelnemers aan de interviews en ontmoetingen die de nodige bouwstenen aanleverden voor dit werkstuk.

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## Samenvatting

### ACHTERGROND

In 2006 werd een programma voor therapeutische projecten (TP's) in de geestelijke gezondheidszorg (GGZ) gestart door de Belgische federale Minister van Volksgezondheid. Dit programma introduceerde nieuwe samenwerkingsmodellen in de GGZ. TP's 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, dat een continuïteit van zorg garandeert en de integratie van de patiënt in de maatschappij bewerkstelligt. De vooropgestelde doelgroep zijn patiënten met een "complexe en chronische" psychiatrische problematiek, binnen vooraf afgebakende clusters ('kinderen en jongeren', 'volwassenen', 'ouderen', 'verslaving' of 'forensische psychiatrie').

Het programma omschrijft een algemeen kader waarbinnen de sector 'bottom-up' voorstellen van samenwerkingsinitiatieven konden voorstellen onder de vorm van projecten. Het programma specificeerde dat elk project ten minste volgende partners moet opnemen: een psychiatrisch ziekenhuis of een psychiatrische afdeling; een Centrum voor Geestelijke Gezondheidszorg of een 'pilot project' (psychiatrische thuiszorg of outreaching) gefinancierd door de Federale OverheidsDienst (FOD VVVL); een eerstelijnsdienst (huisartsenkring, geïntegreerde dienst in de thuiszorg (GDT)).

Het RIZIV is verantwoordelijk voor de terugbetaling van zorggerelateerde activiteiten via een conventie (artikel 56). De FOD VVVL 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 patiëntenmonitoring). Voor de For-K projecten (cluster 'kinderen en jongeren' in forensische psychiatrie) financiert de FOD VVVL alle activiteiten.

### DOELSTELLING VAN ONDERZOEK

Het KCE werd door de federale Minister van Volksgezondheid gevraagd om een wetenschappelijke evaluatie te maken van de implementatie van het programma door middel van de analyse van de plannen, ervaringen en resultaten van de geselecteerde projecten. Het onderzoek is uitgevoerd in de periode 2007-2010. De onderzoekers van het project werden gefinancierd door de FOD VVVL. De coördinatie van het onderzoek gebeurde door het KCE.

In het onderzoek stonden volgende algemene vragen centraal:

- Hoe worden de doelstellingen en het samenwerkingsverband beschreven in de plannen van de TP's?
- Welke zijn de ervaringen met de implementatie van een samenwerkingsverband?
- Welk zijn de faciliterende factoren of barrières die optreden bij de implementatie van de samenwerking?
- Welke zijn de resultaten op projectniveau op het vlak van de toestand van de patiënt en de integratie van de patiënt in de samenleving?

De aanvankelijke bedoeling van het KCE was om een "kwalitatieve" onderzoeksbenadering (inhoudsanalyse plannen en inventaris van de ervaringen met de uitvoering) te combineren met een "kwantitatief" gedeelte (patiëntenmonitoring). De uitvoering van de patiëntenmonitoring werd echter stopgezet door de FOD VVVL in september 2009 (officiële communicatie in januari 2010) omwille van technische implementatieproblemen en de timing van de invoering van het systeem. Het gevolg van deze beslissing is dat het onderzoeksproject niet alle vooropgestelde doelstellingen van het project kan beantwoorden. In het bijzonder kan geen analyse gemaakt worden van patiëntenprofielen binnen de TP's, van de invloed van het nieuwe organisatie-model van zorg (TP) op de patiënt of op het zorggebruik van geïncludeerde patiënten.

## METHODEN

Door het wegvallen van de patiëntenmonitoring is het project beperkt tot een kwalitatief onderzoek dat is gebaseerd op de analyse van interviews, documenten (TP voorstellen) en focusgroepen. De documentenanalyse en de interviews werden per goedgekeurd project uitgevoerd om de plannen van het samenwerkingsmodel en de keuzes beter te begrijpen. De focusgroepen werden in 2010 georganiseerd per doelgroep en per taalgroep. De focusgroepen hadden tot doel een inventaris te maken van de ervaringen (barrières en faciliterende factoren) tijdens de uitvoering van de TP's. Deelnemers waren vertegenwoordigers van 61 nog actieve TP's in 2010 van de initieel goedgekeurde 82 projecten.

De analyse van de kwalitatieve gegevens gebeurde thematisch: de inhoudelijke thema's die relevant zijn voor het organiseren van een samenwerkingsverband worden opgesomd, geïnventariseerd en omschreven, maar niet in termen van hoe vaak ze door wie zijn geciteerd. De analyse gebeurde met software voor kwalitatieve data-analyse en gebeurde per taalgroep door minstens twee onderzoekers. De overall analyse van de thema's gebeurde door het hele onderzoeksteam.

## RESULTATEN

### INHOUD VAN DE TP-PLANNEN

Initieel werden 82 projecten geselecteerd door de overheid: 34 Franstalige en 48 Nederlandstalige (23 cluster kinderen, 47 cluster volwassenen, 12 cluster ouderen).

#### Doelstellingen van de TP's

De analyse van de plannen werd uitgebreid beschreven in eerdere tussentijdse rapporten (KCE rapport 103). TP's interpreteren het overheidprogramma op uiteenlopende manieren. De individuele projecten schuiven uiteenlopende doelstellingen naar voor zowel op het niveau van de patiënt als op het niveau van het samenwerkingsverband. De meeste TP's maken echter niet spontaan een helder onderscheid tussen doelstellingen voor patiënten en doelstellingen voor partners/netwerk. Bovendien zijn de beoogde doelstellingen doorgaans in algemene termen gedefinieerd. Elementen als 'continuïteit van zorg' en 'zorg op maat' worden vaak geciteerd als een hoofddoel, maar worden slechts zelden in detail uitgewerkt. In de clusters 'ouderen' en 'verslaving' wordt meer dan in andere clusters het verbeteren van de toegankelijkheid van (GG)zorg naar voor gebracht als een hoofddoelstelling.

De voorstellen zijn veeleer pragmatisch geschreven om te beantwoorden aan de administratieve vereisten van het programma en niet als praktische werkinstrumenten voor de uitvoering van een TP.

#### Betrokken partners

Slechts enkele TP's zijn volledig nieuwe samenwerkingsverbanden. De meerderheid van de TP's ontwikkelden voorstellen in functie van reeds eerder bestaande formele of informele samenwerkingsverbanden tussen professionals (vb artsen of psychiaters of psychologen,...) en/of organisaties (vb, ziekenhuizen, centra geestelijke gezondheidszorg,....

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

De uitwerking van projectvoorstellen werd begeleid, in bepaalde regio's soms gestuurd, door de overlegplatforms geestelijke gezondheidszorg.

De uitwerking van de projectvoorstellen gebeurde niet altijd door alle mogelijke partners actief te betrekken. Vele projectvoorstellen werden uitgewerkt en geschreven door een klein projectteam of door één persoon. Projecten die meer tijd hebben genomen om het plan voor te bereiden en daarbij overleg te plegen met alle betrokken partners, ervaren tijdens de uitvoering minder interne problemen. De uitwerking van een TP blijkt altijd een onderhandeld proces te zijn waarin een gemeenschappelijke visie en consensus of compromis moet worden ontwikkeld, zowel op het niveau van de partners als op het niveau van de professionals.

### De keuze voor een geografisch gebied

De grootte van de gebieden varieert van lokaal, over meerdere arrondissementen, tot provinciaal en uitzonderlijk provincieoverstijgend. De projecten hebben over het algemeen een geografisch werkingsgebied gekozen op basis van de activiteiten van de partnerorganisaties. Daarbij wordt niet uitgegaan van een epidemiologische behoefteeraming voor die regio of dat gebied.

### Verskillende samenwerkingsmodellen

De TP's worden gekenmerkt door grote verschillen in de organisatorische configuratie en in de voorgestelde werkwijzen. De structurele complexiteit van de projecten wordt bepaald door het aantal partners en door de mix van sectoren (vb algemene gezondheidszorg, GGZ, welzijnszorg, justitie, onderwijs,...) die in de samenwerking betrokken worden. Bovendien speelt nog het onderscheid dat de overheid maakt tussen formele en informele partners.

De keuze voor organisatorische configuraties lijkt mede beïnvloed door de clusters, (zonder dat de cluster de configuratie determineert). Het activiteitenterrein dat wordt aangeboord en de behoeften van de doelgroep bepalen de keuze voor het betrekken van actoren en sectoren. In de forensische cluster moet bijvoorbeeld justitie of justitiële diensten betrokken worden, bij de kinderen en adolescenten de scholen en in de ouderenzorg diensten uit de eerste lijn.

Er zijn ook regionale tendensen: vooral Franstalige projecten kiezen voor netwerken met een veel groter aantal partners. Dat beeld wordt in sterke mate bepaald door de projecten uit de Luikse regio die allemaal voor een meer complexe configuratie (meer partners uit een mix van meerder sectoren) hebben gekozen.

Het bestuursmodel verwijst naar de wijze waarop de partners op netwerkniveau worden aangestuurd. De entiteiten die worden ingezet voor het beheer van het netwerk verschillen en de rol van de deelnemende partners in het bestuursmodel varieert sterk. De keuze voor een bestuursmodel wordt meer bepaald door de complexiteit van het netwerk dan door kenmerken van een cluster. Ook de taakafspraken en rolverdeling met betrekking tot het administratieve en operationele werk verschillen sterk.

Zeer opvallend in alle projecten is het gebruik van vergaderingen zowel op het niveau van de netwerkactiviteiten als op het niveau van het patiëntenoverleg. De inhoud, timing, frequentie, locatie, participatie, status en mate van formalisering van deze vergaderingen variëren echter in sterke mate tussen de projecten.

## ERVARINGEN MET DE IMPLEMENTATIE

### Veranderingen in de samenwerkingsmodellen

Het samenwerkingsmodel wordt vorm gegeven tijdens de uitvoering van het project, veel meer dan op basis van een duidelijk vooraf gedefinieerd plan. Bijna alle projecten geven aan veranderingen te hebben doorgevoerd in de wijze waarop het samenwerkingsverband vorm krijgt: Die veranderingen kunnen structureel van aard zijn (aantal partners, partners uit andere maatschappelijke sectoren betrekken) of eerder slaan op werkprocessen en procedures (vergaderingen anders voorbereiden, veranderingen doorvoeren op het niveau van de deelnemers). Sommige projecten hebben ook veranderingen doorgevoerd in de bestuursstructuur (*governance*) van het netwerk. Meestal gaat het hier om aanpassingen die worden doorgevoerd omdat problemen worden ervaren die een efficiënt functioneren belemmeren.

Sommige projecten zijn opgehouden te bestaan. De projecten die gestopt zijn, zijn in absolute en relatieve cijfers overwegend Franstalig en komen uit de cluster kinderen en adolescenten. 7 stopgezette projecten komen uit het Brusselse. Een aantal projecten is uit het TP programma gestapt uit principiële bezwaren tegen de opgelegde verplichtingen.

### Interprofessionele samenwerking

Het feit dat de TP's een nieuwe manier van interprofessionele samenwerking introduceren, leidt tot nogal wat praktische problemen en weerstanden. De uitvoering van het project hield in dat werd bijgestuurd en aangepast om de werkwijze te optimaliseren. Een van de belangrijkste aandachtspunten die projecten onderschat hebben is het doorgeven van duidelijke en precieze informatie over de doelstellingen van het TP aan alle betrokkenen. Initieel bestaat er bij veel professionals een weerstand om deel te nemen omdat zij niet altijd overtuigd zijn van de meerwaarde die het extra werk zal opleveren. Ook het vraagstuk van de financiële vergoeding voor het samenwerken duikt frequent op. Ander praktische bekommernissen hebben te maken met de locatie van de bijeenkomsten, en in het bijzonder met de verplaatsingen.

De ervaring met het interprofessionele overleg heeft in alle clusters vragen doen rijzen over de efficiëntie en noodzakelijkheid van het ritme van de bijeenkomsten. Enerzijds trekt men in twijfel of het standaardiseren van de bijeenkomsten in een vast opgelegd ritme aansluit bij de behoeften in de verschillende stadia van de patiënt. Anderzijds betwijfelt men of elke professional bij elke bijeenkomst inderdaad aanwezig moet zijn. Toch wordt benadrukt dat het relevant is dat rond de patiënt regelmatig een overleg wordt georganiseerd om de status en voortgang blijvend op te volgen, zelfs als het goed gaat.

Een bijzonder probleem duikt op met betrekking tot het delen van informatie over patiënten tussen verschillende partners en professionals. In sommige projecten heeft dit geleid tot principiële weerstand tegen de werkwijze: vooral artsen en psychiaters verwijzen naar beroepsgeheim en vinden het niet gepast dat medische informatie ter beschikking wordt gesteld aan niet medische betrokken partners. Naast principiële bezwaren wordt ook verwezen naar het potentiële probleem van stigmatiseren (i.h.b. cluster jongeren en ouderen)

## De coördinator

Binnen de TP's werden middelen voorzien voor een 0,5 FTE coördinatiefunctie. De rolomschrijving en taakhoud van coördinatoren varieert sterk tussen de projecten. Aan coördinatoren worden zowel taken toebedeeld op het niveau van de coördinatie van patiëntgerelateerde taken als op het niveau van netwerkgerelateerde taken, maar de taakhoud verschilt heel sterk tussen de projecten. Er is dus geen sprake van een gestandaardiseerde rol en opdracht van de coördinator. De personen die de 0,5 FTE coördinatie taak invullen, combineren dit werk met heel uiteenlopende andere activiteiten, wat implicaties heeft voor hun beschikbaarheid voor het netwerk. Het combineren van klinisch werk met coördinatie taken wordt als potentieel moeilijk beschreven omwille van mogelijke rolconflicten.

Er bestaat algemene consensus over het feit dat een coördinator een belangrijke functie vervult binnen het netwerk. Het moet in principe een tussenpersoon zijn die de uitbouw van de samenwerking begeleidt. Een puur administratieve invulling van deze functie is onvoldoende, hoewel veel projecten de functie op die manier wel hebben vormgegeven. Deze laatste projecten, waarin het management geen sturende en faciliterende rol opnam, hebben tal van problemen ervaren bij het in de praktijk zetten van de samenwerking. Vele projecten rapporteerden in dit geval een probleem om wederzijds vertrouwen op te bouwen tussen de partners en een probleem met de aanvaarding van beslissingen van de coördinator. Coördineren betekent zo op te treden dat het wederzijds vertrouwen tussen partners en professionals groeit.

De ervaringen van de TP's tonen ook aan dat de verantwoordelijkheden voor het uitvoeren van TP-taken en het stimuleren van de partners niet mag doorgeschoven worden naar de coördinator. Een coördinator moet de morele en praktische steun krijgen van alle partners en vooral van de instelling waarin hij of zij wordt tewerkgesteld. Indien deze steun er niet is, bemoeilijkt dit de realisatie van een samenwerking.

## Het gebruik van ondersteunende instrumenten

De ervaring van de projecten toont aan dat het gebruik van ondersteunende instrumenten, zoals administratieve documenten of communicatiemiddelen het functioneren van de projecten ten goede komt. Er wordt wel op gewezen dat het gebruik van deze instrumenten moet afgestemd zijn op de GGZ, en dat het gebruik van supplementaire administratie geen aanleiding mag zijn voor dubbel werk.

## DISCUSSIE: WAT IS ER GELEERD?

### TP's over het overheidsprogramma

In het algemeen vertonen de therapeutische projecten een positieve houding ten aanzien van de algemene doelstellingen van het programma. Voor sommige TP's 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 ervaringen met de TP leveren argumenten die pleiten voor structurele overheidsprogramma's die een omkadering en inhoudelijke richting geven aan op te zetten innovaties in de GGZ om de de-institutionalisering te realiseren. De overheid zal mee de innovaties in de zorgorganisatie moeten stimuleren, maar niet onder de vorm van losstaande initiatieven waar geen verder gevolg wordt aan gegeven.

De programma's moeten de ruimte blijven creëren om samenwerkingsverbanden te laten ontwikkelen die zijn afgestemd op lokale randvoorwaarden (bottom-up). Een bottom-up strategie voor het ontwikkelen van innovatievoorstellen is zeker wenselijk, maar zou systematisch hand in hand moeten gaan met programma's die de sector inhoudelijk ondersteunen bij het ontwerp en implementatie van hun innovatie. In het kader van veranderingen in de geestelijke gezondheidszorg gaat het bij innovatie om zeer complexe interventies waarin tegelijkertijd op zeer verschillende niveau's moet gehandeld worden. Bovendien moet bij de innovatie gewerkt worden in een mengeling van culturen, visies en belangen. Niet alle competenties en kennis zijn in de sector van bij de start aanwezig binnen de projecten om met deze complexiteit om te gaan. In dit proces moet ook aandacht worden besteed aan het stimuleren van het "leren van elkaar", gefundeerd ook in evaluatieonderzoek (zie verder).

Het aanbieden van één algemeen geldend referentiekader of programma voor alle doelgroepen tezelfdertijd lijkt op basis van de ervaringen van de TP's geen optimale strategie. De behoeften van patiënten en de kenmerken van het organisatorische veld bij verschillende clusters, vraagt dat in de toekomst meer op deze context toegeschreven programma's worden uitgewerkt, zij het dat die wel moeten passen in een gemeenschappelijk beleidskader. In elk geval lijkt het belangrijk programma's te onderscheiden voor de doelgroepen "kinderen en jongeren", "volwassen" en "ouderen". Omwille van de specifieke randvoorwaarden is de werkwijze in de cluster forensisch ook anders. Zeker bij kinderen en jongeren moet vermeden worden dat problemen onnodig gemedicaliseerd worden en moet ook ingeschat worden wat het stigmatiserend effect van zorg in psychiatrische voorzieningen kan zijn.

In de toekomst moet er allicht beter over gewaakt worden dat de programma's voldoende precies de contouren aangeven waarbinnen die voorstellen moeten worden uitgewerkt. De gesprekken met de projecten leren wel dat er duidelijke behoefte is aan een strakke en heldere communicatie vanuit de overheid met betrekking tot de verwachtingen en de verplichtingen waaraan projecten moeten voldoen. De overheid zou in het uitschrijven van haar programma's preciezer moeten zijn. De overheid dient meer aandacht te besteden aan een consistente, coherente en goed getimede communicatie. Wanneer in de sector onduidelijkheid bestaat over verwachtingen en verplichtingen loopt het risico op frustratie en ontgoocheling tijdens een implementatie van een zorgvernieuwing op, en kan weerstand groeien in plaats van een motivatie tot zoeken naar nieuwe organisatievormen.

Ook bij het honoreren van voorstellen moet men strikter evalueren in welke mate het geschreven vertoog van projectvoorstellen inderdaad aansluit bij de beoogde intenties. Meer helder omschreven programma's laten ook toe de verwachtingen en de doelstellingen meer helder te communiceren.

De meeste projecten formuleren opmerkingen bij de administratieve vereisten van het TP-kader. Projecten hebben uiteenlopende meningen over de verplichte deelname van bepaalde 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 even 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.

Financieringsregels voor interprofessioneel overleg zouden daarom voldoende flexibiliteit moeten laten om het interprofessioneel overleg af te stemmen op de behoeften en situatie van de patiënt in een langdurig zorgtraject. De opgelegde verplichting om alle partners aanwezig te laten zijn op elk patiëntenoverleg kan mogelijk in vraag worden gesteld: Er is zeker behoefte om alle zorgprofessionals te verplichten te participeren in een bespreking van de doelstellingen bij de start van het zorgproces. Afhankelijk van de zorgbehoeften van de patiënt in verschillende vervolgstadia van de zorg kan echter overwogen worden om de verplichte participatie van alle professionals aan elk overleg te flexibiliseren. De financieringsregels van het interprofessioneel overleg en samenwerking zouden zo opgevat moeten worden dat een patiënt geleid wordt naar zelfredzaamheid (binnen zijn en haar mogelijkheden) en niet aangespoord wordt tot blijvende afhankelijkheid van professionele zorg. Mogelijk kan onderzocht worden hoe voor deze doelstelling financiële prikkels worden ingebouwd, zonder dat personen die zeer kwetsbaar blijven het recht op zorg wordt ontegenwoordigd.

Tot slot valt ook binnen de TP het probleem op van de institutionele randvoorwaarden van België. Het uitwerken van ge-de-institutionaliseerde zorg betekent het uitwerken van inter-organisatorische en inter-professionele samenwerking. Daarin worden noodzakelijk verschillende beleidsdomeinen betrokken, die onder de bevoegdheden vallen van federale, regionale en gemeenschapsoverheden. De beleidskaders maken het samenwerken complex. Het blijvend afstemmen en coördineren van deze bevoegdheidsdomeinen is essentieel om samenwerkingsmodellen te bestendigen.

## Het uitwerken van een samenwerkingsverband

De ervaringen van het TP programma leren dat over het algemeen de bottom-up ontwikkelde modellen in te algemene termen zijn uitgewerkt en dat het design of de architectuur van de samenwerking onvoldoende is uitgekristalliseerd voor de start. De meeste plannen van initiatiefnemers van vernieuwing zijn onvoldoende uitgewerkt. Veel barrières bij de uitwerking van projecten zijn namelijk het gevolg van een te algemene en vage beschrijving van een innovatie- of projectplan. Initiatiefnemers van projecten zouden moeten worden aangespoord om meer voorbereidingstijd te nemen, om bewust gemaakt te worden welke dimensies van een samenwerkingsverband moeten worden doordacht en er meer op gewezen worden dat het vooraf betrekken van de partners en professionals in het ontwerpen van het model ook bijdraagt tot het ontwikkelen van een echt gemeenschappelijke visie. Initiatiefnemers moeten daarin ook ondersteund worden onder de vorm van coaching of opleiding. Plannen zijn referentiedocumenten voor een innovatie. Bovendien moet de uitwerking van plannen aansluiten bij de aanwezige wetenschappelijke evidence of kennis, zowel wat betreft de begeleiding van de doelgroep als wat betreft de organisatie van samenwerking in de GGZ.

## De eerste lijn

Het betrekken van de eerste lijn is een noodzakelijke voorwaarde voor het verstrekken van zorg in een gedeïnstitutioniseerd zorgmodel.

Er moet daarom een meer helder onderscheid gemaakt worden tussen de rol die koepelorganisaties en geïntegreerde diensten thuiszorg kunnen spelen in het netwerk en de verwachte bijdrage van de individuele professionals in het overleg rond de patiënt.

Er dient onderzocht of de huidige tegemoetkoming om deel te nemen aan het overleg deze participatie van de huisarts aan het interprofessioneel overleg op langere termijn kan garanderen.

## Een leerproces

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

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 zorgen er soms voor dat bepaalde partners zich niet meer actief inzetten binnen de samenwerking. Reeds bestaande (goed functionerende) vormen van samenwerking bevorderen de ontwikkeling van vertrouwensrelaties.

## Verschillende culturen en belangen

Samenwerken is in essentie een proces waarin gestreefd moet worden naar een gemeenschappelijk begrip en definitie van doelstellingen en werkpraktijken en waarbij belangen en overtuigingen van individuele partners een cruciale rol spelen. Vooral het gegeven dat over verschillende maatschappelijke sectoren en beroepen heen moet gewerkt worden vraagt de nodige tijd, omdat de visies, waarden en normen en de belangen tussen professionals en partner-organisaties uit verschillende sectoren sterk kunnen verschillen.

## De rol van de coördinator

De ontwikkeling van een interorganisatorische samenwerking als innovatie vraagt een aansturing op het niveau van het samenwerkingsverband. Autonome partners dienen aangestuurd te worden om te werken in functie van een gedeelde opdracht door de samenwerking (betere en meer aangepaste zorg leveren voor patiënten in de GGZ). Die aansturing komt het best vanuit een functie die beschikt over de vereiste competenties om te motiveren, inspireren, veranderingsmanagement te coachen en waarin de betrokken partners vertrouwen hebben. Deze rol van coördinator kan niet gereduceerd worden tot het uitvoeren van een aantal logistiek en ondersteunende taken.

## Betrekken van patiënt en familie

Er is meer inzicht nodig in de wijze waarop de patiënt en familie op een efficiënte manier in het interprofessioneel overleg kunnen betrokken worden. Het ontwikkelen van “shared care” vraagt dat ook beter inzicht groeit in welke omstandigheden het praten over en “het praten met” patiënten en respectievelijk hun familie effectief en efficiënt is en ook beantwoordt aan de behoeften en vragen van patiënt en familie.

## Het zorgenplan

Er is behoefte aan de ontwikkeling van een gemeenschappelijk referentiekader voor de ontwikkeling van een zorgenplan dat is aangepast aan de geestelijke gezondheidszorg. Het zorgenplan ondersteunt inter-professionele samenwerking omdat het afspraken en verwachtingen verheldert. Nu wordt de uitwerking van een zorgenplan teveel overgelaten aan de individuele initiatieven. Het uitwerken van een gemeenschappelijk ICT ondersteunde zorgplan waarin op een gestandaardiseerde manier behoeften en toestand van de patiënten wordt gemeten kan meteen ook een opstap zijn naar het ontwikkelen van een accurate patiënten-monitoring.

## Evalueren

Evaluatieonderzoek naar vernieuwende projecten die inter-organisatorische en interprofessionele samenwerking stimuleren is blijvend vereist. Dit onderzoek heeft aangetoond dat er mogelijkheden zijn om te onderzoeken op welke manier de uitwerking van interprofessionele en interorganisatorische samenwerking samenhangt met de uitwerking van een plan. Het onderzoek heeft daarentegen geen inzicht gegeven in de impact van deze werkwijze op de patiënten, Door het wegvallen van de gegevensregistratie bij intake tot het einde van het traject.

## AANBEVELINGEN<sup>a</sup>

- De overheid moet organisatorische zorgvernieuwing in de GGZ blijvend stimuleren door gerichte en meer structurele strategische programma's.
- Voor het ontwikkelen van structurele programma's zal er continu een afstemming moeten gebeuren tussen de verschillende politieke bevoegdheidsniveau's. Een permanente interministeriële cel ondersteund door een vaste (wetenschappelijke) staf die strategisch en conceptueel advies kan geven en beschikt over operationele middelen, zou dit proces actief kunnen aansturen.
- Bij het uitbouwen van beleidsprogramma's moet veel meer aandacht besteed worden aan communicatie met en ondersteuning van de sector die de innovaties uitvoert.
- Binnen een algemeen gemeenschappelijk beleidskader is het opportuun om per leeftijdsgebonden doelgroep of probleemveld aparte subprogramma's te ontwikkelen.
- Op het niveau van de samenwerkingsverbanden moet afgestapt worden van een algemeen vertoog en meer aandacht besteed worden aan de concrete uitwerking van de configuratie van het samenwerkingsverband en van de onderlinge werkafspraken.
- Op het niveau van de samenwerkingsverbanden moet de rol van de coördinatoren ingevuld worden als een functie die de samenwerking stimuleert en ondersteunt en niet enkel als een uitvoerder van administratie.
- Het conditioneel financieren van interprofessioneel overleg rond de patiënt moet behouden maar verfijnd worden door meer ruimte te laten om overleg af te stemmen op de evoluerende behoeften van de patiënt.
- Het betrekken van de eerste lijn is een noodzakelijke voorwaarde voor het verstrekken van zorg in een gedeïnstitutioniseerd zorgmodel.
- Er is meer inzicht nodig in de wijze waarop de patiënt en familie op een efficiënte manier in het interprofessioneel overleg kan betrokken worden.
- Er is behoefte aan de ontwikkeling van een gemeenschappelijk referentiekader voor de ontwikkeling van een zorgenplan aangepast aan de geestelijke gezondheidszorg.
- Er is behoefte aan voldoende voorbereiding en omkadering op het vlak van de eerbiediging van het beroepsgeheim binnen de therapeutische teams.
- Innoverende projecten op het vlak van interorganisatorische en interprofessionele samenwerking moeten blijvend geëvalueerd worden, niet alleen op het vlak van bestuur- en organisatiemodaliteiten, maar ook op het vlak van de impact van die modellen op de maatschappelijke participatie en het welbevinden van de patiënt.
- Er moet in dat verband dringend verder gewerkt worden aan het implementeren van het prospectief verzamelen van patiëntengegevens en het exploiteren voor wetenschappelijke evaluatiedoelinden.

<sup>a</sup> Alleen het KCE is verantwoordelijk voor de aanbevelingen aan de overheid.



## Scientific summary

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## ABBREVIATIONS

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

# I INTRODUCTION

This is the final report on an evaluation research of the Belgian government programme on mental health care reforms known as “Therapeutic Projects” (TP). The TP programme is jointly coordinated by the National Institute for Health and Disability Insurance (NIHDI) and the Federal Public Services (FPS) for public health (mental health care unit). The aim of the TPs is to collect experiences in order to draw lessons on how to (re)organise the (mental) health care provision for selected groups. This report summarizes the findings of a process evaluation.

## I.1 BACKGROUND

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

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

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

The National advisory council on health services (NACH (NRZV/CNEH)) is closely involved in the debate on the reforms in mental health care and the introduction of the Therapeutic Projects in particular.

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

### I.1.1 Early Federal initiatives to stimulate organisational innovations

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

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<sup>a</sup> 7 ministers have discretionary decision-making power on issues related to mental health care. The federal government has mainly competencies on residential care and care aspects (FPS) and reimbursement within the public health insurance (NIHDI). Regional and community governments have political competencies on the 'non-cure' aspects of mental health care (prevention, welfare & social care). Moreover, provincial authorities can take policy initiatives too on issues of mental health care organisation.

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

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

In 2002, the “Public Health Interministerial Conference” issued a declaration on the need for a new concept in mental health care. The major objective of the reforms was to offer mental health services adapted to the individual patient’s needs, preferably in his own living environment. A number of core principles were emphasized:

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

The Minister of Social Affairs and Public Health issued in 2005 a document on mental health following the principles of this “Interministerial Conference”<sup>1</sup>. The document proposes the development of experimental “therapeutic projects”, seeking for alternative organisation models in mental health care, more particularly labelled as ‘*care circuits*’ and ‘*networks*’. The target population of these new models of organisation are patients with ‘*chronic and complex mental disorders*’.

A three year government program for experimental “therapeutic projects” was implemented by means of a royal decree of October 22 2006 on article 56 § 2 of the nomenclature<sup>b</sup>, stipulating the conditions for the creation and development of TPs:

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

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

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

### 1.1.2.1 *The practical framework for TP*

Therapeutic projects are financed by the NIHDI and the FPS of Health.

NIHDI is responsible for the reimbursement of clinical-related activities under the form of a “convention” (article 56), an agreement specifying the conditions for the reimbursement of activities.

- The TPs are funded for inclusion meetings of patients and the three-monthly follow-up meetings of patients within the projects. A yearly lump-sum of 24 000 € is paid for coordination activities. A variable sum, limited to a max of a yearly 22 500€ is reimbursed, depending on the number of patients taking part in the project.
- At least every trimester, a patient meeting should take place in which at least three formal partners should participate. If the above mentioned conditions are met, a sum of 125€ per meeting is paid by NIHDI. The first year, a maximum of four meetings is reimbursed; from the second year onwards, a maximum of three meetings. All formal partners should participate in the initial meeting to include a patient.
- Each project should include as participants at least: (a) a psychiatric hospital or a psychiatric unit (b) a CMHS or one of the “pilot projects” (home care or outreach), funded through FPS and (c) a primary care partner (an association of general practitioners, Integrated Services Home Care (ISHC) , Home Services (HS)).

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

- Each “therapeutic project” is obliged to participate in the so-called transversal consultations to share and discuss the experiences related to the organisation practices of “therapeutic projects”. The transversal consultations are organised for “therapeutic projects” addressing the same target group. For linguistic reasons, each group of transversal consultation is organised separately for the two language groups. This “transversal consultation” is intended as a support to develop a shared learning experience of TPs, based on the comparison of day-to-day experiences within the TP.
- The transversal consultations are coordinated by the MHCCP. One MHCCP coordinates all activities for Flanders. In the French speaking part, three MHCCP coordinate the transversal consultations. At the end of the governments program, the different platforms will develop a common report relative to the experiences of the TPs. The transversal consultations (and the resulting reports) will be used as input in formulating policy recommendations on the organisation of mental health services in the future.

Eventually, the therapeutic projects and transversal consultations policy program was aimed to support to the development of a future policy program for organisation of mental health care for target groups including aspects of adequate ‘care circuits’ and ‘care programs’, tailored to specific groups of patients.

### 1.1.2.2 *The selection of the TP*

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

- An expected improvement in the process of taking charge of a patient, and the implementation of a needs-based care approach.
- The expectation that a TP avoids on the one hand redundancies in care and on the other hand fills in gaps in the care provided.
- Innovative forms of caretaking through collaboration between partners and complementarities of partners.

A working group of NIHDI selected eighty-two TPs<sup>d</sup> (see Royal decree 22 october 2006). The working group assessed to what extent the bottom-up proposals met the foreseen criteria, but also considered geographic and mental health domain distributional issues<sup>e</sup>. 48 Flemish and 34 French speaking projects were selected. The vast majority of Flemish projects concentrates in Oost-Vlaanderen and Limburg (n=26). The majority of French-speaking projects concentrated in Liege, Hainault and Brussels (N= 28).

#### **Key points**

- **Therapeutic projects aim to implement an 'integrated health services model' in clearly defined catchment area's, providing services adapted to the needs of the patient, promoting his rehabilitation in the society and guaranteeing the continuity of care.**
- **Each "therapeutic project" is obliged to participate in transversal consultations to share and discuss the experiences related to the organisation practices. The transversal consultations are coordinated by the MHCCP.**
- **The TPs were proposed through a 'bottom-up' approach. A working group of NIHDI selected eighty-two TPs.**

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

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

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

## I.2 SCOPE OF THIS RESEARCH

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

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

The KCE was asked:

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

The TPs started their activities in April 2007. The evaluation process of the TPs was embedded in a programme of 3 years of TP activities. The funding for the research ended in June 2010, at the same time as the programme was ended. The research focuses on summarizing the experiences of the project concerning the development of the TP plan and the TP implementation.

This research-process only focuses on organisational questions, and not on the effect and impact of the reforms on patient level. This choice is beyond the will and initial intentions of the KCE research team. The content of the patient monitoring was developed but never implemented, by a decision of the SPF motivated by technical problems and time delays in the implementation, reducing the scientific relevance of data collected. But the decision was also inspired by the resistance in the sector on the mere fact of implementing a registration system which was not announced in the call for projects. As a consequence we cannot provide information on case mix of patients or evolution of the condition of the patients over time. Through this external decision the KCE was not able to respond to all of the initial research questions, especially the part on the patients profiles, the impact on patient level and the registration of health services use of the patients.

Because of the intended patient monitoring, the KCE research team did not foresee a qualitative analysis of patient perspectives (which would practically not be possible within the available resources). A separate research trajectory by another research consortium, focuses on the issue of patient participation within the TP.

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

### **Key points**

- **KCE was asked by the Minister of Social Affairs and Public Health to perform a scientific evaluation study of the TPs.**
- **The evaluation process of the therapeutic project is embedded in 3 years of TP activities.**
- **The research focuses on summarizing the experiences of the project concerning the development of the TP plan and the TP implementation.**
- **A patient monitoring instrument was prepared but never implemented, implying that this research offers no insight in patient outcome issues**

## 2 METHODOLOGY

### 2.1 INTRODUCTION

This is a health services research. It focuses on organisational issues in the provision of care, not on clinical, pharmaceutical or therapeutic interventions. The evaluation methodology used, is in essence a “program evaluation” embedded in the tradition of realistic evaluation.<sup>2,3</sup> Program evaluation is a formalised approach to study the goals, processes, and impacts of projects, policies and programs.<sup>3</sup> “Real world” evaluation research in mental health care<sup>4,5</sup> pays attention to the context in which organisational models are being developed.

### 2.2 AIMS

This evaluation research focuses on the one hand on the analysis of the “plan” of the interventions (the programme theory) and on the other hand on the analysis of implementation processes.

- The plan evaluation aims at describing and/or clarifying the aim of the project. The plan evaluation consists of a base line measurement at the beginning of the implementation of a program or intervention. It tries to describe the underlying vision and ideas upon which an intervention is based. We tried to describe the plans of the TP in its first year of implementation, because timing of the research process did not allow otherwise.
- The process evaluation aims at describing and analysing the implementation of the program or intervention, preferentially during the project or retrospectively at the end of the project. For pragmatic reasons and due to the number of projects, we opted for a retrospective qualitative analysis of the experiences of persons involved in the TP.
- The product evaluation (also called impact, outcome, or effect evaluation) aims at evaluating the impact of the program or intervention.

With regard to the outcome evaluation it was initially foreseen to collect general data on patients included in the TP. A literature search was performed to provide an overview of instruments that can be used to assess patient outcomes in mental health care, in order to select appropriate instruments for the target groups of the therapeutic projects i.e. clusters ‘adults’, ‘elderly’, ‘children and adolescents’, as well as ‘addictions’ and ‘forensic psychiatry’.<sup>6</sup> However, the collection of data at patient level has never been implemented, which has a major impact on the initial purpose of this research.

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

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

The report focuses on an overall analysis, and not on a detailed analysis of every individual project.

### 2.2.1 Plan evaluation of TPs

The purpose of the plan evaluation is to clarify the theoretical aims, working procedures and the strategy of each therapeutic project. We focus on the question on how the initiators and the leaders of each TP have given a meaning to the government framework. Interviews are the primary source of information, combined with an analysis of the documents. Each TP has written down a model or approach for collaboration for a selected target population in a geographical area, in formal documents submitted to NIHDI. The plans of each individual TP are written and developed within in the framework of the overall policy program..

#### **Document analysis**

We aimed at an inductive analysis in order to understand how the mental health care sector had given meaning to the notion of a TP. Besides interviews, we rely on the documents as been submitted to the NIHDI In order to identify main dimensions and characteristics of the projects. First, two researchers separately analysed in an inductive manner a randomly selected sample of TP proposals (as they were submitted to NIHDI) to understand the main concepts mobilized by the TPs in general. The analysis aimed at identifying core dimensions and concepts underlying the TP and presented the in a preliminary framework. Subsequently, the members of the research team, discussed this preliminary framework to understand the structure of concepts as identified by the content analysis. This process aims at increasing the intersubjectivity in the research process. This content analysis and the development of the framework formed the basis to structure the interview guide for the initial interviews.

#### **Interviews**

The semi-structured interview guide aimed at discussing descriptive elements as well as organisational choices:

- Descriptive component: History, Aims at a partnership and at a patient level; Target population, catchment area and partners
- Organisation and functioning of collaboration Coordination models, tools Patient coordination mechanisms and experiences with barriers and facilitating factors

The interview guide offers the framework of topics, but interviewees were given the opportunity to elaborate on particular issues or introduce themes. The interviewers were not strictly bound to a sequential use and uniform phrasing of the questions.

Each interview was conducted by at least two persons. One person moderated the discussion while at least one other person took notes and supported the moderator when issues needed further elaboration. Each interview was tape-recorded. The interviews took place in the native language of the projects, either Dutch or French.

After the interview, every researcher who participated in the interview wrote down their preliminary impressions in short debriefing notes. These debriefing notes are useful support documents to sketch the nature of the interview and to develop a first reflection on particularities of the interview.

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

## Analysis

The analysis of the raw interview data-files is conducted by means of the QSR software Nvivo 8. The data-analysis is based on an iterative cycle of coding and classification. A first level of coding focuses on identify themes and meanings of the interviewees. In a second stage this first level coding is discussed within the research team. Codes are grouped or classified, in emerging themes, into a coding tree. These themes are preliminary theoretical labels (categories) enabling the grouping of initial codings.

### 2.2.2 Process evaluation

#### Focusgroups

Considering the timing of the individual interviews, first-year experiences were already discussed to a certain extent in the first round interviews. In 2010 'focus groups' were used to collect retrospective data on the experiences with the implementation of the TP. This technique was chosen mainly for pragmatic reasons (time delays did not allow to perform a second round of project specific interviews). The interactive process allowed to share experiences sometimes leading to a better in-depth understanding of factors affecting the implementation process.

Facilitators used a predefined checklist of topics and issues that was used commonly for all focus groups.

**Table 2.1: themes discussed in the focus groups**

<b>The collaboration of individual professionals on the level of patient</b>	Effective ways to organise the care around the patient for every specific phase to meet specific events. Information who has to be involved in defining the care of the patient. Information about the use and need for a care plan. Information about the role and need for a person coordinating this collaboration. Facilitating and hindering factors. Reasons to change something in the collaboration around the patient.
<b>The collaboration between partners</b>	Effective ways to organise the collaboration between partners. Information who has to be involved. Facilitating and hindering factors. Reasons to change something in the collaboration between partners.
<b>The predefined target population</b>	Hindering and facilitating factors to work with a specific predefined target population. Reasons to change aspects of the definition of the target population.
<b>The predefined area of activity</b>	Hindering and facilitating factors to collaborate in the predefined area of activity. Reasons to change aspects with regard to the predefined area of activity.

For the focus groups, we invited individuals from all TPs. TPs could self-select the participants but were briefed that the research team expected that participants would be able to contribute relevant knowledge on experiences of the TP. We also asked to represent different perspectives within the project.

The focus groups were organised according to linguistic groups and per cluster as defined in the TP programme<sup>f</sup>. We aimed for the participation of all the active projects in each cluster still active in March 2010. If we were unable to mobilize people from all projects, at least 2/3<sup>rd</sup> of the TPs taking part of that cluster should be able to attend in order to proceed with a focusgroup. The under limit of participants for each focus group was set at 6 persons, the upper limit at 12 persons. The focus groups took place at the KCE-offices in Brussels. The planned duration of the focus group was 2 hours, with an introduction of 10 minutes.

<sup>f</sup> With the exception of one French-speaking focus group for the cluster 'children and adolescents' and 'children and adolescents – forensic' as there was only one project in the latter cluster.

One researcher facilitated the focus group, another took field notes and made observations. If possible, a third person observed the focus group. The focus groups were tape recorded<sup>g</sup>.

**Table 2.2: overview of the focus groups**

Cluster	Sub cluster	NL/ FR	TPs		Participants	
			Planned	Present	Planned	present
Children and adolescents	General	NL	4	4	12	6
		FR	4 (+1TP forensic)	4	12	8
	Addiction + Forensic	NL	7 (4+3)	5 (3+2)	7 (4+3)	6 (4+2)
Adults	General <sup>h</sup>	NL	5	5	5	7
		NL	11	10	11	9
		FR	10	8	10	10
	Addiction + Forensic	NL	6 (4+2)	6 (4+2)	12 (8+4)	8 (5+3)
		FR	5 (5+0)		10	
Elderly	General	NL	8	6	8	9
		FR	2	2	6	4

### **Data analysis**

After a team debriefing, the note-taker made a detailed raw data report of the focus group (not transcripts). The note-taker made the first preliminary analysis of that specific focus group by summarising and classifying the information given along the preset four dimensions. This 'synthesis' was validated by the moderator (and if participating also the observer). The individual focus group syntheses were afterwards analysed in a cross-comparative way.

In addition, the annual reports of the NIHDI and of the transversal consultations were used to complement the data since these documents also reported on the experiences with the implementation process.

### **Key points**

- **This research project is a health services research project using the principles of “real world” evaluation research in mental health care.**
- **The primary unit of analysis is the therapeutic project, but the analysis aims at overall (non TP specific) findings.**
- **The research evaluates the plan and implementation process.**
- **This project does not assess patient characteristics or outcomes because an intended patient monitoring was never implemented.**
- **Data sources are formal documents, interviews and focusgroups.**

<sup>g</sup> One Flemish project did not participate in the focusgroup, but was consulted via a telephonic interview to reflect on the main outcomes of the focusgroups

<sup>h</sup> We planned focus groups for 16 TPs of cluster adults. One project refused participate in the focus group as they decided to stop the project in April 2010.

## 3 SOME CORE CONCEPTS IN MENTAL HEALTH REFORM

### 3.1 INTRODUCTION

This chapter grounds some of the core concepts used in the policy reference documents orienting the TPs with existing knowledge from the literature. The formal policy documents on the therapeutic projects make reference to concepts such as continuity of care, integration of care, collaboration and networks, programmes of care and patient care. The aim of this exercise is to offer some deductive insights on concepts that are often given meaning in daily practice on an ad hoc basis. This is not an *exhaustive* literature review, but rather a stepping stone offering background information that helps to understand the conceptual perspective we used to present the results. This literature research tries to streamline some of the often confusing an generalised use of concepts in the policy debate. The review mainly relies on peer reviewed journals literature. Where possible we collected additional references through a snowballing method.

### 3.2 CONTINUITY OF CARE

#### 3.2.1 Introduction

Continuity of care has been put high on the policy agenda in health care in general<sup>7</sup> and mental health care in particular<sup>8-10</sup>. The closure of psychiatric hospitals brought about problems in the organisation of health care as patients face a complex and fragmented set of services and support within community care<sup>11-16</sup>). Continuity of care became an essential feature of community service development<sup>17</sup>. It is described as a process encompassing treatment and care episodes getting form at the crossroad of multiple services and providers<sup>8,9</sup>).

#### 3.2.2 Definitions of continuity of care

Continuity of care is a concept being 'often lauded but seldom defined'<sup>13, 18</sup>. Different meanings are often implicitly given to the concept<sup>8, 19</sup> and related terms are used as equivalents or closely related concepts: e.g. continuum of care, coordination of care, discharge planning, case management, integration of services, and seamless care.

Some definitions define continuity in a rather narrow sense. These definitions focus on discharge after an acute care episode and transfer between psychiatric facilities. Continuity is conceptualised as an absence of gap or rupture of service provision between in-patient and out-patient services<sup>8, 20-25</sup>.

Bachrach<sup>10</sup> introduced a more encompassing and multidimensional approach of continuity of care in mental health care. She suggests that continuity of care is "*the degree to which episodes of treatment are linked in a seamless, uninterrupted whole, in conformity with patients' needs*". Her approach was innovative in the sense that explicit attention was being paid on the patients' perspective and patient needs. Continuity implies that care encompasses as many services and providers as required to fit the specific needs of each individual patient.

This approach was followed by many authors in mental health care<sup>7, 8, 18, 20, 22, 23, 26-33</sup>.

Reid et al (2002)<sup>i</sup> conclude that “Continuity is the result of a combination of adequate access to care for patients, good interpersonal skills, good information flow and uptake between providers and organizations, and good care coordination between providers to maintain consistency. For patients, it is the experience of care as connected and coherent over time. For providers, it is the experience of having sufficient information and knowledge about a patient to best apply their professional competence and the confidence that their care is recognized and pursued by other providers”. Haggerty et al.<sup>7</sup> proposes a definition based on a content analysis of existing definitions: This definition adds coherence and consistency with needs and pays more explicit attention to the difference between medical and personal needs: “Continuity is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient’s medical needs and personal context”.

### 3.2.3 Dimensions

Bachrach<sup>10</sup> emphasizes seven dimensions of continuity: longitudinal nature, individuality, comprehensiveness, flexibility, relationship, accessibility and communication. To describe the dimensions of continuity of care we mainly focus on the literature review work of the research-team in which Haggerty, Reid and Freeman often participate see two core elements essential to distinguish continuity from other concepts<sup>7</sup>.

- The patients perspective should be the core domain (and thus measurement unit) of the quality of service delivery: the patients’ experience of care as smooth and uninterrupted service delivery is essential (Crawford et al. 2004). Continuity is not to be operationalised as a characteristic of providers or organizations, although integration and coordination of services is a necessary condition<sup>7</sup>
- Providing care over time is an intrinsic part of continuity. The time frame can be as short as an emergency intervention or be extended to all aspects of long term care. The time dimension is to be analytically distinguished<sup>7,33</sup> into:
  - “informational continuity” : meaning information transfer and accumulating knowledge,
  - “Relational continuity”: a sustained contact between patient and a provider by means of an ongoing relationship and consistency and coherence of care
  - management continuity: including consistency and coherence of care and flexibility adapted to the needs of patients.

Two models are worth quoting because they illustrate on how continuity of care is a multi-dimensional issue: Freemans<sup>13,14</sup> eight facets model of continuity of care and Burns<sup>20</sup> seven-factor model built on Freemans initial model. Although not integrated individual dimensions can also be found in<sup>7, 10, 17, 18, 22, 24, 28, 29, 31-33</sup>.

The authors focus on the relevance of the experienced continuity; flexible and adapted care and support to needs; guaranteeing smooth cross boundary managed transitions; reducing the number of contacts with different professionals but with intensive follow-up and maintaining relationship with primary care; guaranteeing information transfer; care that should sustain a person’s preferred social and personal relationship in the community and that enhances quality of life

#### Key points

- **Continuity of care is a complex concept and multidimensional in nature.**
- **“Continuity is the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient’s medical needs and personal context”<sup>7</sup>**

<sup>i</sup> [http://www.chsrf.ca/final\\_research/commissioned\\_research/programs/pdf/cr\\_contcare\\_e.pdf](http://www.chsrf.ca/final_research/commissioned_research/programs/pdf/cr_contcare_e.pdf)  
consulted July 2009)

(last

## 3.3 INTEGRATED CARE

### 3.3.1 Introduction

Often discussed in close connection to continuity of care is the aspect of integration (for mental health care see Goldmans<sup>34</sup> conceptual paper on evidence and systems integration). Continuity of care and integrated care are discussed to make the shift from fragmented episodic treatment towards a well coordinated provision of multi-disciplinary services to support people with chronic conditions. The Belgian policy documents on Therapeutic projects refer to the integration of services in the context of a programme of care or care trajectory. We briefly refer to some literature mainly to show that the concept of integration is used on different levels of the health care provision. Some strategies consider to overcome professional and departmental boundaries and aim towards the development of multi-professional teams while others aim to integrate different sectors of care, namely to link primary, secondary and tertiary care.<sup>35</sup> Leutz<sup>36</sup> says that integration can signify *“anything from the close coordination of clinical care for individuals to the formation of managed care organisations that either own or contract for a wide range and social support services”*. Integrated care refers particularly to the means used to realise continuity of care. The concept of integrated care also connects to literature focussing on developing networks. Mur-Veeman et al<sup>37</sup> describe integrated care as an organizational process of coordination that seeks to achieve seamless and continuous care, tailored to the patient’s needs, and based on a holistic view of the patient. Fleury and Mercier (2002)<sup>38</sup> use the concept of integrated service networks. *“A Network is an organisational model or configuration of health service organisations connecting different types of providers (compare<sup>39-41</sup>*

### 3.3.2 Definitions of integrated care

Leutz<sup>36</sup> defines integration as *“the mechanisms used to connect health care providers with each other and with other human services in order to improve outcomes (clinical, satisfaction and efficiency)”*.

Kodner and Kyriacou (2000) define integration as *“a discrete set of techniques and organizational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors at the funding, administrative and/or provider levels.”*

Grone & Garcia-Barbero:<sup>35</sup> define it as a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency:

Kodner & Spreeuwenberg:<sup>42</sup> *“[Integrated care] is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors. The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings”*

### 3.3.3 Dimensions of integration

Leutz <sup>36</sup> distinguishes linkage, coordination and integration:

- *Linkage of providers* allows individuals with mild to moderate health care needs to be cared for in connected systems that serve the whole population without requiring any special arrangements.
- *Coordination* requires that explicit mechanisms or structures are put in place to coordinate care across acute and other health care sectors. While coordination is a more structured form of integration than linkage, it still operates through separate structures of current systems.
- *Full integration* creates new programs or entities where resources from multiple systems are pooled.

Furthermore there are a number of authors disentangling the different levels to be distinguished when discussing integrated care

Edwards and Miller, 2003 distinguish

- *System integration* includes activities such as strategic planning, financing, and purchasing systems, program eligibility and service coverage, within a geographical area or across a country or province.
- *Organizational integration* refers to the coordination and management of activities among acute, rehabilitation, community care and primary care provider agencies or individuals.
- *Clinical integration* concerns the direct care and support provided by direct caregivers.

At micro-level (the individual patient) the term integration may be used interchangeably with coordination to describe the close collaboration between different professionals and teams required to deliver timely, efficient and high quality interventions.

At a meso-level, integration may describe organisational or clinical structures and processes designed to enable teams and/or organisations to work collaboratively towards common goals. Examples include clinical pathways that cross primary and secondary care, integrated health and social care teams and may include shared IT, administration and data systems that support timely and efficient sharing of processes (such as booking appointments) or information.

At a macro-level, integration will typically describe structures and processes that link organisations and support shared strategic planning and development. Examples include merged provider organisations that span health and social care services (such as care trusts); integrated payer and providers organisations; or the virtual integration achieved through joint strategic planning processes linking health and social care.

Armitage et al <sup>43, 44</sup> categorise models of integrated care in three major groups: system levels models (most of them focus on organisational change processes including issues of leadership, structure and culture), programme/services level (focussing on coordination of services by tools such as case management, collocation of services and information, development of teams) and progressive of sequential models" (focussing on the means for better care by distinguishing different stages from less to more integrated care).

Delnoj (2001) mentions that integration can occur at different levels:

- Functional integration occurs at the macro level of the care system, i.e. through the mainstreaming of the financing and regulation of cure, care, prevention, and social services.
- Organisational integration acts at the meso level of systems, e.g. in the form of mergers, contracting or strategic alliances between health and social care institutions.
- Professional integration is also at the meso level, e.g. in the form of mergers (e.g. group practices), contracting or strategic alliances between health care professionals.
- Clinical integration acts at the micro level, i.e. by providing continuity, co-operation and coherence in the primary process of care delivery – integration is thus at the individual level of care.

Mowlan and Fulop et al (2005) base their work on Contandriopoulos and Denis (2001) to develop a typology with the key requirements for effective integration

- *Organisational integration* (or how the organisation is formally structured) – for example, by mergers and/or structural change or virtually through contracts between separate organisations.
- *Functional integration* – how are non-clinical support and back-office functions integrated?
- *Service integration* – at the organisational level, how are the clinical services offered by the organisation integrated with each other?
- *Clinical integration* – at the clinical team level, is care for patients integrated in a single process both intra and inter-professionally through, for example, the use of shared guidelines along the whole pathway of care?
- *Normative integration* – the role of shared values in co-ordinating work and securing collaboration in the delivery of healthcare.
- *Systemic integration* – the coherence of rules and policies at the various levels of organisation

An overview report<sup>45</sup> provides a summary of eight models or different ways of integrating and coordinating primary care and mental other care facilities across a continuum—from minimal collaboration to partial integration to full integration.

- *Minimal collaboration.* Mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
- *Basic collaboration at a distance.* Primary care and behavioral health providers have separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter. Improved coordination is a step forward compared to completely disconnected systems.
- *Basic collaboration on-site.* Mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture.
- *Close collaboration in a partly integrated system.* Mental health professionals and primary care providers share the same facility and have some systems in common, such as scheduling appointments or medical records. Physical proximity allows for regular face-to-face communication among behavioral health and physical health providers. There is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient.

- *Close collaboration in a fully integrated system.* The mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care.

A common distinction made in organisational sciences (and which will be discussed later) is the difference between vertical and horizontal integration. *vertical integration* pertains strategies linking different levels of care (e.g. linking primary, secondary and tertiary care) Vertical integration takes place between organisations (or units) on different levels in a hierarchical sector: *horizontal integration* refers to strategies linking similar levels of care (e.g. overcoming professional and departmental boundaries; linking hospitals providing similar services) (compare <sup>46</sup>).

### Key points

- **Continuity of care and integrated care are discussed to make the shift from fragmented episodic treatment towards a well coordinated provision of multi-disciplinary services to support people with chronic conditions.**
- **Integrated care is an organizational process of coordination that seeks to achieve continuous care, tailored to the patient's needs**
- **Different levels have to be distinguished when discussing integrated care**

## 3.4

### CARE PROGRAMMES AND PATHWAYS

The policy documents supporting the TP programmes make reference to the notion of care programmes (*zorgprogramma/programme de soins*) for target groups in mental health, in order to organise and streamline the provision of care. The Belgian legal hospital framework uses the concept of care programmes as a complement to the financing in terms of functions and departments, also with the ambition to promote inter-professional collaboration and integration of care. A care programme is conceptualised as a coherent set of services for a well defined patient group. A distinction is made between basic programmes for regular conditions and specialised programmes for more rare conditions. Regular programmes can be provided by all types of hospitals, specialised programmes not. A programme holds the identification of norms with regard to infrastructure, personnel, activity level etc. However, for the mental health care sector no care programmes have been developed yet.

Although a care programme is clearly not intended to be used in the same way as clinical pathways, there is a relationship. In the USA, care pathways have been applied to health care in the 1980s as a management tool to improve the efficiency of care and reduce hospitalization costs. In the UK, care pathways are used to promote well-organized and evidence based care (achieving a continuum of care across care settings; streamlining the care given based on the latest evidence and research).<sup>47</sup>

In the literature related terms are used interchangeably. Sermeus and de Bleser <sup>47</sup>quote de Luc et al. (2001) who found 17 different terms encompassing the concept of clinical pathways. The most common terms were, "care pathway", "critical pathway", "integrated care pathway" and "care map". The terminology 'clinical pathway' or 'critical pathway' is used worldwide. Integrated Care Pathway (ICP) is mainly used in the United Kingdom. The network clinical pathways ('netwerk van klinische paden') found more than 90 different international definitions<sup>1</sup>.

### 3.4.1 Definitions

A clinical pathway is a means to plan and follow a needs-based program in a systematic manner<sup>k</sup>. For mental health care, the World Health Organization<sup>48</sup> says: *‘The pathways to care are the routes whereby people with mental disorders gain access to providers of mental health services. These pathways influence the organization of services. Established pathways to care and treatment may hinder access to services and lead to poor outcomes, due to several reasons (e.g. low awareness of available services, inadequate links between services...)’*.

Clinical pathways are primarily designed to reflect the patient care activities of the entire multidisciplinary team. It incorporates all aspects of patient care (i.e. including prospective plans for all disciplines involved in patient care) and 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. De Bleser et al.<sup>47</sup> define ‘clinical pathway’ as: *“A method for the patient-care management of a well-defined group of patients during a well-defined period of time. A clinical pathway explicitly states the goals and key elements of care based on Evidence Based Medicine (EBM) guidelines, best practice, and patient expectations by facilitating the communication, coordinating roles and sequencing the activities of the multidisciplinary care team, patients and their relatives; by documenting, monitoring, and evaluating variances; and by providing the necessary resources and outcomes. The aim of a clinical pathway is to improve the quality of care, reduce risks, increase patient satisfaction and increase the efficiency in the use of resources.”*

Integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem. An integrated care pathway (ICP) is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes ICPs are ‘patient-focused’ as they view the delivery of care in terms of the patients’ journey and seek to improve both the coordination and the consistency of care. Emphasis is placed on the provision of appropriate care that is, what is suitable for each individual patient in relation to the clinical evidence base and/or consensus of best practice.<sup>l</sup>

### 3.4.2 Dimensions

Most definitions of ‘clinical pathways’ include at least two specific components, namely the type of services/interventions that are provided and the timeline over which this happens. De Bleser<sup>47</sup> identifies the following core dimensions: (a) The multidisciplinary character, (b) The content: outlining the optimal sequence and timing of interventions (c) The goals, namely in particular aiming at achieving optimal efficiency and improving quality of care (the continuity and co-ordination of care across different disciplines and sectors)

Hill, 1994, 1998<sup>m</sup> identify four main components: (a) A timeline (b) The categories of care or activities and their interventions, (c) Intermediate and long term outcome criteria (d) The variance record which allow deviations to be documented and analysed

#### Key points

- **A care programme is conceptualised as a coherent set of services for a well defined patient group**
- **the World Health Organization<sup>48</sup> says: ‘The pathways to care are the routes whereby people with mental disorders gain access to providers of mental health services. These pathways influence the organization of services.’**

k <http://www.nkp.be/00000095de07fde01/00000095de0ed732a/index.html>

l <http://www.medicines.ox.ac.uk/bandolier/booth/glossary/ICP.html>

m <http://www.openclinical.org/clinicalpathways.html#benefits>

### 3.5 COLLABORATIVE CARE PLANS (ZORGPLAN/PLAN DE SOINS)

Another core instrument mentioned in the governments' programme is the use of care plans, and a tool to coordinate the activities of the professionals around the patient.

Care is coordinated by means of a plan to be used in a flexible way to adjust to patients' needs<sup>7</sup>. 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 provide standardized care management guidelines throughout all stages of an illness course as well as a communication tool across the continuum of care. It is generally conceived as a case management tool assuming that it will support health service quality improvement. Collaborative care plans explicitly and comprehensively describe interventions and expected outcomes in the treatment plan. Collaborative care plans, and symptom management guidelines provide a common "language" across the continuum of care.<sup>n</sup>

#### Key points

- **Collaborative care plans explicitly and comprehensively describe interventions and expected outcomes in the treatment plan**

### 3.6 INTERORGANIZATIONAL NETWORK

#### 3.6.1 Introduction

The main underlying idea of the government reforms of the TP is that multiple agents and professionals collaborate to provide adequate care as much as possible in the community. However, once again the concept of network is used to describe very different things: social networks, governance mechanisms, organizational forms, informational systems,... We focus on one particular type of network usually referred into the literature as Interorganizational networks (ION). In the literature ION are considered as an organizational remedy for the fragmentation of mental health care delivery. The research and theorizing focuses on the characteristics, dimensions, properties and patterns in relationships between organisations pursuing mutual interests or goals, while the constituent parts remain autonomous agencies.

#### 3.6.2 Defining Interorganizational networks

Literature provides only few explicit definitions of inter-organisational networks partly because scholars are more concerned with the understanding of inter-organisational relationships than with identifying a network as such. Provan et al.<sup>49</sup> observed that nearly all existing definitions refer to common themes, including social interaction (of individuals acting on behalf of their organizations) and forms of relationships (under the form of connectedness, collaboration, collective action, trust, and cooperation).

Ebers<sup>50, 51</sup> defines ION as "a particular form of organizing or governing recurring exchange relationships among a limited number of organizations that retain residual control of their individual resources yet periodically jointly decide over their use". Networks are constellations of organizations that come together through the establishment of social contracts or agreements (such as the provision of health services through referral systems), rather than legally binding contracts. Legally binding contracts may exist within a network, but the organization of the relationship is primarily based on social contracts.

Provan et al.<sup>49</sup> say that an ION consists of multiple organizations linked through multilateral ties. This network can be defined as "a group of three or more organizations linked through multilateral ties in ways that facilitates achievement of a

<sup>n</sup> 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](http://www.chsrf.ca/final_research/ogc/pdf/dudgeon_final.pdf)

common goal". The main feature of ION is that they are goal-directed in contrast to other forms of networks emerging "serendipously".

### 3.6.3 Dimensions of ION

Organisations and relationships are two core issues to be considered when trying to describe and understand the processes characterising the nature of ION. ION can be characterized as an identifiable agency in which individual organisations maintain relationships for the functioning of the network as a whole<sup>52</sup>

- Individual organisations being members of the network. It describe and explains the motivations and forms of individual organisations to involve in interorganisational networks.
- The network as a whole: it studies issues such as the number of members involved, the spatial distribution of members, the density of the relations, etc: In this latter perspective one can focus on structural an interaction components

An additional dimension would be the field or domain in which the networks evolves. In our particular example it is the public domain of mental health care.

When focussing on the level of the organisations, Structural network dimensions consider the position of member organisations<sup>49</sup>:

- *Centrality* identifies the most prominent actors in the network, that is those who are extensively involved in relationships with other network members. Studies showed a strong association between organizations' network centrality and their influence in the domain of activity.
- *Relational Complexity*, the number of types of links or types of exchanges between an individual organization an others in the network;
- *Broker relationships*. some organizations play the role of *Broker* spanning gaps or structural holes in a network

Structural dimension at the level of the entire network are<sup>53</sup>:

- *Complexity*: this is defined by the number of organisations involved, but also by the mix of sectors from which individual agencies come (welfare, mental health care, acute hospital care, primary care, justice, etc) and the types of activities offered through the network
- *Cohesion* describes the interconnectedness of actors in a network. It can be expressed by means of the *Distance* between two actors in a network (or nodes) "degrees of separation" the *reachability* (whether actors within a network are directly or indirectly related to all other actors) and the *Density* (the total number of relational ties divided by the total possible number of relational ties) Density is one of the most basic measures in network analysis. *Fragmentation* of the network indicates where "structural holes" between organizations can exist in a network. The lack of relationships between network partners can be caused by "Interorganizational barriers": eg. Cultural or philosophical, geographical.
- A *clique* is a subgroup of actors who are all directly connected to one another and no additional network member exists who is also connected to all members of the subgroup. This structural aspect has been particularly enlightened by researches conducted recently in health and human services. In this domain, some mental health delivery agencies may be part of a broad system and also be tightly connected to a small group that deliver services to a particular clientele. The network outcomes for this clientele are thus likely to be more affected by the activities of these members of the clique than by the activities of the complete network. In such "cliquish" system integration often occurs between cliques, "when organizations that provide services to a particular client group work together to coordinate the services these clients need".

- *Centrality* is also used as a characteristic of a network as a whole and expressed (or better measured) using the subdimensions: *Degree centrality* (the sum of all other actors who are directly connected to one particular actor) *Closeness centrality* (based on the notion of distance between network members) and *Betweenness centrality* is the number of times an actor connects pairs of other actors, who otherwise would not be able to reach one another.

ION are not just formalised structures though; they are characterised by interactions between network members. The mere nature of an interorganisational network are relationships between different parts of the health and other sectors in order to achieve health outcomes in a more efficient and effective way than could be achieved by the health sector working alone. This aspect of research will try to connect issues of sense making, giving meaning and enactment, as aspects of cultural issues in engaging in relationships. It also focuses on how power relations and interests of individual members affect the structuration of a network.

### **Key points**

- **an ION is a group of three or more organizations linked through multilateral ties in ways that facilitates achievement of a common goal**
- **ION are goal-directed in contrast to other forms of networks emerging “serendipously”.**
- **The mere nature of an interorganisational network are relationships between different parts of the health and other sectors in order to achieve health outcomes in a more efficient and effective way than could be achieved by the health sector working alone.**

## 4 PLANS OF THE TP

### 4.1 INTRODUCTION

This chapter summarizes the findings of the plan-evaluations as discussed more extensively in two intermediate reports (in particular KCE-report 103). The “plan” of each TP offers information on the design of the intervention. It offers relevant baseline information in order to understand and assess the objectives of each project. Our aim is to develop an overall understanding of the choices and intentions of the selected projects not to evaluate the plans of each individual TP.

As a general observation, TP-proposals were in most cases not developed as practical guideline for the daily implementation of the TP. Moreover, the plans propose quite diverging structural models as well as interactional and governance rules. Much of the variance can be explained by the historical and social networking context of partners involved in individual projects, the complexity of the partnership, the influence of the MHCCP and the role of the ISCH. This section briefly recapitulates.

#### 4.1.1 Preparation of TP-proposal

The governments call offers a framework in which the TP-plans had to be developed in a bottom-up manner. This implies that projects did not need to be standardized collaboration configurations: projects were allowed to develop their proper meaning to a project as far as it would fit within the framework. This latter explains the wide variety in approaches and collaboration models in the proposals.

##### 4.1.1.1 Previous collaboration

Many TP submitted proposals based on their historical involvement in networks and collaborations developed within longer lasting mental health reform policy initiatives since the 1990's. These “preexisting” collaborations have certainly affected the “bottom-up” design: much of the partnership modeling, selection of target groups and setting of objectives mirror aspects of previous collaboration. During the interviews it was often confirmed that previous experiences with and knowledge about other partners facilitated the development of the TP proposal. Far less time had to be spent on negotiations and developing a mutual understanding on objectives and structural form of the collaboration. Historical collaborations were far more dominant than a geographical needs based approach and pillarization (*verzuiling/pilarisation*) does still affect the choices for partnerships. The interviews also learned that the TP programme offered a mechanism to fund, reinforce, support and formalise pre-existing collaborations. Only few TP plans propose a partnership not relying on already established partnerships between organizations or professionals. This could be informal collaborations or formalized partnerships

- Compared to French speaking projects Flemish projects seem to rely much more on already established formalized partnerships, rather than ad hoc and informal previous collaboration.
- In the cluster children and adolescents-(general) projects relied on broad previous formal as well as informal collaborations within and between sectors,. In the sub-cluster addictions and forensic psychiatry this seems far less the case
- Some partnerships previous experience on the level of *interprofessional* collaboration only while others also with *interorganisational* collaboration.
- Formalized partnership in French speaking projects were mainly established on the level of professionals, while in the Flemish projects formalized partnerships were already established between organizations

The data give plenty of indications that this difference has an impact on the meaning given to a TP. TPs focus on other “levels” in the collaboration depending on their experiences: many projects with experience on interprofessional collaboration mainly focus on the question of coordinating the care of professionals, while other plans pay more attention on the question on how to embed this interprofessional collaboration in a partnership collaboration model.

#### 4.1.1.2 *Including primary care*

The governments’ program obligation to collaborate with primary care is new for many projects. It is especially perceived as a challenge in the design of the TP in the cluster adults and the cluster children and adolescents (including forensic and addictions), and most particularly in case where the collaboration is constructed with ISHC.

#### 4.1.2 The content of the proposals

The bottom-up strategy of the government’s tender has led to a great variability in interpreting different dimensions in the proposal.

##### 4.1.2.1 *Objectives of the TPs*

The interview and document analysis learn that objectives in the plans remain very general. Objectives are defined in very broad terms mainly rephrasing the core topics of the TP-programme such as providing continuity of care (often transitions and hospital discharge), needs-based care, accessibility and reducing length of stay in residential settings. More specific objectives with regard to the collaboration between partners (both at patient/family level and at partners level) as well as within and between sectors are mentioned but seldom elaborated upon in practical details:

- Especially in the French-speaking part, initiators of the TPs defined objectives more in a theoretical or conceptual way than in operational terms (particularly in those TPs where the author of the plan writes alone and/or is not a field worker).

No analytical distinction is made between objectives on the one hand with regard to patients and the collaboration of professionals around patients and on the other hand objectives in terms of partnership development.

- Plans of TPs in the clusters addictions and forensic strongly insist on the importance to better identify the needs of patients and connect mental health care with other sectors (e.g. legal sector). Plans in the cluster ‘forensic’ put more emphasis on the provider side, on supporting caregivers to improve patient referrals.
- Also in the cluster ‘elderly’ the provider side is emphasised, e.g. providing support (emotional and professional) to caregivers who are working with elderly in order to enable earlier detection of the mental illness’ signs.

##### 4.1.2.2 *Selection of the target population*

The TP programme obliged every project to select a target patient population. TPs mainly made pragmatic choices essentially with the aim to ensure that the preset caseload of the government programme is to be reached. Within this general approach, patient groups were selected for whom partnership members experience particular problems (e.g. structural problems with health care services supply, problems with patients in ‘a dead end situation’ or difficult to reach).

No formal epidemiological needs assessment (at population level) was used in the predefined area of activity to select a patient population. The selection of a target population is mainly based on current experiences of providers with target groups.

Inclusion and exclusion criteria of patients are set in broad terms, mainly driven by pragmatic reasons to reach the imposed caseload.

- Especially in the cluster elderly, often focusing on early detection, TPs made a deliberate choice to exclude as little patients as possible and to avoid stigmatisation.

Additional criteria to the NIHDI-criteria are mentioned (Table 4.1) but seldom seen as a formal list leading to quantitative score (e.g. at least N criteria must be met).

Firstly, the age criterion is experienced as a formal rather than practical limit, especially in the clusters children and adolescents and elderly. In the cluster Children and adolescents it is mainly the upper age limit of 18 that is a difficult issue, in the cluster elderly persons the under age limit.

Secondly, a precise psychiatric diagnosis is rarely considered as a necessity to include a patient. The assumption that a mental disorder is present is often considered as sufficient. Remarks were made during the interview on the need for a diagnosis, because the formal need to have a psychiatric diagnosis is not congruent with the needs of a patient, especially for children and adolescents that run a risk of unnecessary stigmatisation as being subject of psychiatric care. Yet, if a psychiatric diagnosis is often not considered needed, the presence of multiple problems in different life spheres is regarded as important. (see also chapter experiences)

**Table 4.1: Summary of inclusion/exclusion criteria and problems for selecting a target patient population**

<b>Inclusion criteria</b>		
<i>NIHDI-criteria</i>		
Age criterion	Children and adolescents	More specified age groups
	Elderly	Problem of 65 age limit
Psychiatric diagnosis	Often not considered needed (against the pace of the patient)	
	Children and adolescents	Risk of stigmatisation
<i>Main other criteria</i>		
Multiple problems	Problems in different life spheres to maintain in community/ Co-morbidity (psychiatric or other disorder)/Need for support or consultation with multiple partners	
Geographical place of residence	Living within the catchment area of TP	
Added-value	TP has an added value for the situation of the patient	
Informed consent	Patient has given his explicit informed consent to participate in the TP	
Ongoing psychic problematic	The patient is for a long time in process of receiving care/help	
<b>Exclusion criteria (less explicit in many cases)</b>		
Patient diagnosis	Lack of psychiatric diagnosis	
	Elderly	Sometimes dementia
	Adults	Mental retardation
	Other (rare)	"Antisocial personality disorder"/Certain forms of depression
Patient needs	Sufficient social network (no real need then for regular follow-up)	
	Support from less than three partners/professionals is needed	

The notion of complexity is often defined as a combination of problems in different life-spheres (and the need for consultation and support by multiple different partners) 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.

Based on the qualitative information it could be questioned to what extent certain projects address chronic and complex psychiatric issues, especially in the cluster elderly. Within this cluster, projects aim at treating and supporting people with behavioural and emotional problems but one could discuss if these projects are addressing chronic and severe psychiatric issues in particular. Not surprisingly some of the projects considered submitting a proposal under "protocol 3" a NIHDI reform initiative for elderly care and withdraw from the TP framework.

### 4.1.3 Composition of the TP- partnership

For composing the TP-partnership the governments call allowed to differentiate between formal and informal partners. The latter were partners that did not sign the collaboration agreement holding a number of obligations, but collaborated outside the contractual framework. These partners participate on an ad hoc basis.

The governments call also differentiates between required and non-required partners. Required partners are defined as 3 types of providers from mental health care or psychiatry (or experimental “pilot projects” outreach or psychiatric home care) and partners from primary care (general practice, ISHC, home care) As a consequence some partners had to take up the role of formal partners. Non required partners are partners outside mental health care: these can be differentiated as providers within health care and outside health care (schools, welfare, local social policy, ...) Many of these latter partners became informal partners within the TP (but not in all TPs).

#### 4.1.3.1 *Complexity of the partnership*

##### ***Number of partners involved***

Table 4.2 classifies the projects according to the number and types of partners. French speaking projects tend to include more partners (some include more than 40 partners). Apparently there is a clear bias in this choice as it are mainly the partnerships in Liege (guided by the local MHCCP) that includes more partners. Only one Flemish TP includes up to 40 partners, which is a forensic project.

The number of informal partners per project is almost impossible to trace as they are only in exceptional cases mentioned in project documents. The interviews learned that informal partners are very often not structurally involved in the activities of the TP but often solicited on an ad hoc basis, which complicates the process.

Besides the historical natural ties between partners, the interviews learned that TPs choose for a number of partners because of pragmatic reasons meaning securing manageability and controlling administrative obligations rather than providing an overall service model (except for the province of Liège)

Table 4.2: Discontinued projects

Cluster (number TPs)	Sub clusters (number TPs)	TPs with small number of formal partners (3-8)		TPs with medium number of formal partners (9-19)		TPs with large number of formal partners(20-39)		TPs with very large number of formal partners (40 and more)	
		NL	FR	NL	FR	NL	FR	NL	FR
'Children and adolescents' (15TPs)									
	General (7TPs)	2	1	2	1	/	/	/	1
	Forensic (5TPs)	2	/	1	1	1	/	/	/
	Addiction (3TPs)	3	/	/	/	/	/	/	/
'Adults' (38TPs)									
	General (27TPs)	10	4	7	3	/	1	/	2
	Forensic (2TPs)	1	/	1	/	/	/	/	/
	Addiction (9TPs)	2	1	2	/	/	1	/	3
'Elderly' (10TPs)		NL							
	General (10TPs)	3	/	5	1	/	1	/	/
<b>Total</b>	<b>63 TPs</b>	NL							
		<b>23</b>	<b>6</b>	<b>18</b>	<b>6</b>	<b>1</b>	<b>3</b>	<b>/</b>	<b>6</b>

Cluster (number TPs)	Sub clusters (number TPs)	TPs with small number of formal partners (3-8)		TPs with medium number of formal partners (9-19)		TPs with large number of formal partners (20-39)		TPs with very large number of formal partners (40 and more)	
		NL	FR	NL	FR	NL	FR	NL	FR
'Children and adolescents' (8TPs)									
	General (8TPs)	1	1	/	3	/	3	/	/
'Adults' (9TPs)		NL							
	General (5TPs)	/	1	3	1	/	/	/	/
	Forensic (3TPs)	/	/	/	2	/	1	/	/
	Addiction (1TP)	1	/	/	/	/	/	/	/
'Elderly' (2TPs)		NL							
	General (2TPs)	/	1	1	/	/	/	/	/
<b>Total</b>	<b>19 TPs</b>	NL							
		<b>2</b>	<b>3</b>	<b>4</b>	<b>6</b>	<b>/</b>	<b>4</b>	<b>/</b>	<b>/</b>

### **Diversity of partners involved**

TP have included partners from a mix of domains: psychiatric hospitals, services from general hospitals, mental health care, primary care: general practice home care and home nursing, welfare, justice ... formal partners are generally partners from the broad mental health care domain and primary health care (because of the formal obligations). Informal partners are very often partners offering services outside the health care domain.

- In Flemish projects more ISHC participate as a formal partners while in French speaking TPs it are more individual general practices (probably to be explained because ISHC is more developed in Flanders)
- Flemish projects include more tertiary service providers as formal partners in geographical areas with a high density of hospitals (eg Gent en Leuven). This aspect is often interacting with existing previous collaborations between partners.
- The cluster children and adolescents include more than other clusters obligatory second and tertiary care providers

Logically connected to the particular needs of different age groups or problems, different types of non-obligatory partners are included (Table 4.3)

- The cluster elderly shows the least complex partnerships, and seldom includes partners outside the general health care domain.
- Projects in the cluster 'adults' are often more complex than other clusters because the often include non-obligatory partners outside health care.
- Within the cluster 'children and adolescents-general" many non obligatory partners are being involved outside the mental health care domain.
- The complexity of the partnership in the cluster addiction is strongly affected by the treatment and support model used and the addiction problem (Legal versus illegal).
- The complexity of the partnership in de cluster 'forensic psychiatry' is also affected by the judicial partners that have to be included, especially by those TPs covering more than one judicial administrative area (cfr juvenile court)

**Table 4.3: overview non-obligatory partners**

Cluster	Formal non obligatory partner in health care: binnen gezondheidszorg	Formal non obligatory partner outside health care:
'children and adolescents'	General hospitals, paediatric services,	-school - family help -rehabilitation centres (handicap sector)
'adults'	Brede waaier aan voorzieningen	welfare
'forensic psychiatry'	/	Justice and judicial services
addiction  'children and adolescents'  'adults'	Specialised addiction treatment and drug prevention centres	Judicial sector  Partners depend on care approach used
'elderly'	-nursing homes -Geriatric units	

Maybe it is worth mentioning that people submitting proposals have developed different understandings: some projects had understood that partners outside mental health care could never be included as formal partners (mainly heard in Flanders, which could explain why these projects have a less mixed model of formal partners).

In some TPs certain partners were identified as formal partner in the written text of the proposal, but were approached as informal partners in the daily activities

### ***The governance of the partnership***

Overall, governance models of TPs are adapted to the complexity of the partnership. TPs with a large number of partners generally differentiate between “core” and “peripheric” formal partners, meaning that not all formal partners on paper are included in the same way in decision making processes: a smaller core of partners becomes responsible for strategic and operational management decisions (on the network level). Projects with a smaller number of partners include all partners in the governance meetings, although it is said that in daily practice one could identify more core partners and more peripheric partners too.

- Quite specific are the Liege proposals, that are all centrally coordinated from a psychiatric hospital, but in which each project is managed by another hospital

#### **4.1.4 Coordination**

Coordination refers to the way projects planned the alignment of activities of several actors with regard to patient activities, as well as partnership activities.

- The coordination of the patient-related activities refers to the mechanisms used to coordinate the administrative and clinical activities of professionals into the care process around the patient, including the inclusion, the follow-up and eventually the end of care within TP. A distinction has to be made between operational tasks and administrative ones.
- Coordination on partnership level is closely related to issue over network governance

The daily operational coordination mechanisms are meetings, support tools and the coordinator.

- The notion of meetings is clear itself: different types of meetings are planned for in the TP design, each focussing on other topics and composed differently
- The coordinator is a person coaching the day-to-day activities aiming at the alignment of persons and activities on patient level and/or partnership level. The role and tasks were not very elaborated in the plans, often resulting in vague function and tasks descriptions
  - A small number of French speaking projects have not worked with coordinators, but integrated operational coordination tasks around the patient in the daily work of the care givers.
- The support tools refer to (technological) instruments and facilities used to support the activities of the partners and professionals involved

Projects developed different ways and modalities to implement these operational coordination mechanism resulting in a great variety of coordination models between the TPs.

This section makes an analytical classification of the coordination activities, although one had to remain aware that in the TPs this analytical distinction is often difficult to observe, especially since most project plans are not very precise and implicitly focus on the level of interprofessional collaboration.

#### 4.1.4.1 *Partnership level*

##### **Meetings**

On the partnership level two types of meetings have to be differentiated: the management committee and a steering group committee: as mentioned before, the choice to implement a mixed governance meeting model is largely affected by the complexity of the partnership.

The role of these mechanisms is essentially to provide support and to make decisions around matters about which the other professionals active at the patient level have a limited intervening and decision power: the overall vision and missions of the TP, financial issues, dismissing decision, changes in the role and function of the coordinator, organisational arrangements, etc. Projects differentiate between steering groups meetings and/or management meetings and in some exceptional projects annual member meetings.

In some projects the management meeting and steering group meetings are the same. Other projects created a daily management committee group (and meetings) composed of directors or management staff from core formal partners, besides the other types of meetings. These meetings are chaired by a member of the head staff of a core partner (this is essentially the case in the Dutch-speaking projects) The coordinator of the project participates in these meetings. As we will see further, some projects implemented also preparatory meetings for the steering and/or management group of the network (a kind of “bureau”).

Some individual projects also added an annual membership meeting in which the activities of the TP were reported to all members (formal, informal partners and patient organisations).

##### **Coordinator**

There is a clear difference between the projects on how the role of the coordinator is defined: on the one hand the more operational coordinator, made responsible of tasks relevant for the daily functioning of the partnership (cf. supporting of agenda, taking minutes, informing all partners about content of meetings) and on the other hand a more strategic and motivation role of coordinators as a kind of change managers (such as motivating the partners, resolving some organisational problems, ensuring that the project runs at the policy level.

Moreover, the description of the role of the coordinator at the partnership level can not be disentangled from the role of the coordinators at the level of the health care professionals and patients, as most coordinators have to fulfil tasks at both levels. In the proposals the role at partnership level is seldom explicitly developed.

#### 4.1.4.2 *Patient-related activities*

In the following section we organised the coordination mechanisms used along the general lines of the patients trajectory: namely inclusion follow-up and exclusion/end of care.

##### **Inclusion**

###### **MEETINGS**

The inclusion process is mainly coordinated through meetings labelled ‘inclusion meetings’ (with the particular exception of Liege, where no meetings were organised on this matter). The organisation of inclusion meetings varies greatly between projects: some projects grouped patient inclusion meetings within the obliged three or four monthly meetings with all (formal) partners. This implies that inclusion files were discussed “in bulk” at each of these moments. Inclusion meetings were than often combined or integrated in the steering committee meetings (inclusion became an agenda point of the steering or management committee). As a result of this model it is rarely the case that patients and/or their family are involved in this decision moment. Moreover, many projects disentangled the decision to include from the first meeting at patient level in which the care needs and the care plan would be developed

- In some French speaking projects 'inclusion meetings' are sometimes prepared by a pre-inclusion meeting gathering the professionals, the patient referent, the family and sometimes the patient. This pre-inclusion meeting sometimes replaces the formalised meeting in projects without such a one.

### **COORDINATOR**

The coordinator receives the candidatures for inclusion (and prepares the meeting); S/he organises the inclusion meeting and collects the signatures, writes the minutes of the meeting, completes the administrative documents and transfers them to the concerned persons after the meeting (the administrative coordinator, the care givers involved).

### **TOOLS**

The majority of TPs use a separate inclusion form in order to support the assessment of the candidature. The documents used differ in size and content (extensive or limited presentation of the candidate; anonymous or not), In TPs without a specific inclusion meeting (as in the Province of Liège), this inclusion form is send by e-mail to all the formal partners who are asked to electronically agree or disagree.

### ***Follow-up***

#### **MEETINGS**

Very few TPs have been explicit on the follow-up issue. Respondents and documents stick in general to the imposed (and financed) three or four monthly frequency imposed by the NIDHI-call. Some TPs though, envisaged to organise intermediate meetings when partners or family request for it, in case of a patient crisis situation, for instance.

From the plans it is not clear however to what extent these patients meetings are grouped (in which all included patients are discussed "in bulk") or to what extent these meetings have been planned adapted to the patient.

The participants of the follow-up meetings are mainly the care providers directly involved in the shared care process, assisted by the coordinator. The participation of the patient and the family differs between TPs. Only a part of projects have explicitly planned the participation of the patient during the follow-up process.

In the majority of the TPs, the follow-up meetings are organised by the coordinator. In those TPs with a more case-management oriented approach this can be done by the reference person (care-mediator) who is often a caregiver in close contact with the patient, a relative or a professional from sectors outside the mental health sector.

### **COORDINATOR**

For patient follow-up activities, the coordinator interacts most with the care mediator, who supervises the overall care process of individual patients. ensures the communication between the caregivers and the patient, and represents the patient at the follow-up meeting in case of absence of the patient. The main tasks of the coordinator are facilitating the organisation of patient meetings and fulfilling administrative tasks. For this latter, some coordinators can rely on support to complete administration for NIDHI. The collecting of these documents and their transfer to the NIDHI is often fulfilled by the administrative service of the organisation in which the coordinator is employed. In almost all Dutch-speaking TPs, the responsibility to fulfil the administrative tasks is delegated to the ISHC or to an administrative service or a formal TP-partner (often an hospital). Only in some French-speaking projects, this responsibility is a part of the tasks of the coordinator.

## TOOLS

Different documents are used to coordinate the patient-related activities. The core instruments should be related to the development of a care plan. The interviews made clear though that it are separate minutes of the meeting containing the agreements and the evaluation of the situation of the patient. These minutes are mainly sent by the coordinator to the participants of the meeting (often the caregivers involved in the shared care process). It are generally the Flemish TPs with a longer tradition that implement care plans, mirrored in methods used outside mental health care reforms (in particular ISHC).

### 4.1.5 Geographical area of activity

About two thirds of the projects proposed a geographical area of activity on the level of the province, a mixture of two or more districts (arrondissement/S/en) within a province or one particular district. Only a minority defined its area of activity on a larger scale; more than one province or administrative region (e.g Brussels and Walloon region) French speaking projects tend to choose for larger geographical area's than the Flemish.

The choice for a geographical area seems to be very much affected by the catchment area of one or two key players in the partnership (often a hospital), or by the area of activity of the partners that already collaborated before submitting the TP (the proposal tries to consolidate previous activities). This choice is often motivated because people have experience based knowledge with the key players in this area.

The choice of an area is also inspired by the "feasibility" criterion on the hand for practical and logistic reasons, but also to not interfere with preexisting domains of the key players in mental health care, or to start serving historically underserved areas.

Specifically for the forensic projects, the area of activity was aligned with the zone for which courts were active.

#### Key points

- **TP-proposals were in most cases not developed as practical guideline for the daily implementation of the TP.**
- **Objectives in the plans remain very general. Objectives are defined in very broad terms mainly rephrasing the core topics of the TP-programme**
- **No analytical distinction is made between objectives on the one hand with regard to patients and the collaboration of professionals around patients and on the other hand objectives in terms of partnership development.**
- **The plans propose quite diverging structural models as well as interactional and governance rules.**
- **Much of the variance of tp proposals can be explained by the historical and social networking context of partners involved in individual projects, the complexity of the partnership, the influence of the MHCCP and the role of the ISCH**
- **Inclusion and exclusion criteria for patients in the projects are set in broad terms, mainly driven by pragmatic reasons to reach the imposed caseload.**
- **The daily operational coordination mechanisms are meetings, support tools and the coordinator. Projects developed different ways and modalities to implement these operational coordination mechanisms, resulting in a great variety of coordination models between the TPs.**
- **The choice for a geographical area seems to be very much affected by the catchment area of one or two key players in the partnership (often a hospital), or by the area of activity of the partners that already collaborated before submitting the TP (the proposal tries to consolidate previous activities).**

## 5 IMPLEMENTING THE TP

### 5.1 INTRODUCTION

This section summarizes the experiences of the projects during the implementation. Information is collected on the hindering and facilitating factors potentially impacting on the effectiveness of the projects. In order to discuss the effectiveness of a network, three different levels can be distinguished:

- The effectiveness at the level of the interorganisational network, mainly referring to survival chances, viability and sustainability, and creating an added value through the collaboration, which cannot be offered by activities of organizations acting independently
- Effectiveness at the level of the collaboration between professionals providing care for the patient: aiming at coordinating and integrating care approaches. There are no gaps in the care provision or double provision of care is avoided. This is particularly relevant in cross-boundary areas, where different sectors and providers meet: Professionals experience a smooth and sufficient transfer of information between each other along the longer term process of care
- Effectiveness the level of the patient (and their peers) which should be measured by means of outcomes in their daily functioning, quality of life, experiences continuity of care, to what extent the support and care is adapted to (developing) needs etc. We already discussed that unfortunately the foreseen patient monitoring using validated instruments was never implemented, which also means that effectiveness on population level cannot be addressed

This section discusses experiences with the preparation of the proposal, experiences on the level of developing the network and finally experiences on the level of interprofessional collaboration.

### 5.2 DEVELOPING THE PROPOSAL: EXPERIENCES

The interviews learned that developing the proposal, and thus to a certain extent the design of the TP including identifying the aims and working practices has been challenging by itself. The mere process and procedures of writing of the proposal has an impact on “how shared” the views are on the scope and working practices in the project.

The preparation and actual development of the proposals was seldom an entirely shared process of all partners: an individual or a small working group, very often from the residential care sector, was the lead partner to develop the proposal. These texts were discussed, amended and eventually endorsed by the partners involved. However, projects stressed the importance of a real mutual understanding and shared meanings about the project facilitating a smooth implementation. Many projects experience that this interprofessional and interorganisational collaboration had to develop these meanings along the way.

A typical barrier is experienced in those cases where one individual (one staff or direction member from one institution or one health care professional from one partner organization) or a very small committee was designing the TP, but in which partners were not really involved or had not enough time to contribute to the preparation process. In the case in which only one partner developed the plan, this plan was often perceived as the project of one particular institute, rather than a shared partnership approach.

Convincing partners to participate in a TP shows to be an issue of showing the added value to collaborate with other partners. The most convincing arguments appear to be demonstrating the shared interest to handle the problems of individual participants in providing adequate care for patient groups. Partners expecting an added value both for the patient group and the functioning of the proper organisation are most keen and open to engage in a partnership. This general perspective has to be balanced with perceived interests and financing issues. One particular recurrent issue mentioned was that many partners also participated for strategic reasons: namely being involved in the overall movement of mental health care reform from the beginning. Partners want to engage in these reform initiatives in order to increase the future legitimacy of their proper organization in the mental health care sector. The lack of adequate provision of mental health care in some regions is also mentioned as a reason to engage in formalized partnerships

A second impeding factor mentioned was that the proposal was being developed and discussed on the level of management but that the “workfloor” was not being involved, with many consequences afterwards on the implementation because people on the workfloor were not aware or did not understand the purpose of the initiative.

- Projects in the cluster elderly focusing on the issue of “early detection of mental health problems” stressed the importance of actively involving primary care partners in the preparation of the TP design.

Some other problems were mentioned too:

Including “new” partners was often difficult and time consuming in order to develop a common understanding and to build trust. Particular difficulties were reported in those TPs adding formal partners to the partnership that had not participated in the design of the plan. This eventually lead to disagreements between formal partners on the scope of the TP plan.

Projects that had not paid enough attention to this process often experienced problems in the latter implementation phases.

Including partners from sectors outside psychiatry or mental health care, introduced particular challenges because regulatory frameworks of other sectors (both with regard to financing, manpower, development of activities as well as concerning professional secrecy) require the necessary efforts to mutually adapt partners to each other. A recurrent issue, both during the development of the plan as well as during the actual implementation is the aspect of sharing of information on patients.

- The formal obligation to include partners from primary care in the partnership is perceived by many as not very obvious. During the interviews project mentioned that they would not have included primary care in the partnership if they would not have been obliged by the governments call.
- Especially in French speaking projects rather fierce discussions developed on issues of professional secrecy, in which mainly the psychiatric profession resisted sharing medical information with other partners.

The coaching, involvement and support of the MHCCP was considered as a substantial support in orienting the TP proposals on two levels: first on the level of the success rate to obtain financing for a project, as the platforms set priorities to submit proposals within the provinces. A number of Flemish projects also relied on the expertise in collaboration and networking developed within the GDT and for coordination administrative tasks.

### Key points

- The preparation and actual development of the proposals was seldom an entirely shared process of all partners. The process and procedures of writing of the proposal has an impact on “how shared” the views are on the scope and working practices in the project between the partners.
- Including “new” partners in a partnership is often difficult and time consuming in order to develop a common understanding about the collaboration and in order to build trust.
- Convincing partners to participate in a TP shows to be an issue of showing the added value to collaborate with other partners. Partners expecting an added value both for the patient group and the functioning of the proper organisation are most keen and open to engage in a partnership. This general perspective has to be balanced with perceived interests and financing issues.
- An crucial barrier occurs in those TPs where the proposal was being developed and discussed on the level of management but that the “workfloor” was not being involved. However it is the latter that becomes responsible for implementing.
- Including partners from sectors outside psychiatry or mental health care raise particular challenges because regulatory frameworks of other sectors (both with regard to financing, manpower, development of activities as well as concerning professional secrecy) require the necessary efforts to mutually adapt partners to each other.

## 5.3 DEVELOPING THE PARTNERSHIP

In this section we will focus on the issues mentioned on the level of the partnership, potentially impeding the effectiveness and efficiency of a TP. First we discuss aspects related to the discontinuation of projects. Then we will describe the changes some projects went through and summarize some of the motivations for these changes along the way.

### 5.3.1 Discontinued TPs

A first indicator of a “failure” to maintain partnerships is the number of projects that discontinued. Table 5.1 shows that both in absolute and relative numbers mainly French speaking projects discontinued collaboration within the TP framework. The majority of these projects are part of the cluster Children and adolescents, and it has to be mentioned that 7 projects operate the Brussels capital area.

**Table 5.1: overview of the projects**

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

The motivations to discontinue the projects are both internal to the project or concern external obligations (Table 5.2):

- projects stopped because they were unable to meet the NIHDI criteria: In these case external conditions written in the call imposed the decision to stop the project. For these projects it was mainly a NIHDI decision imposing to stop the project
- projects took the “internal” decision to stop working within the NIHDI framework. A number of French speaking projects from the cluster Children and Adolescents, particularly in Brussels stepped out of the TP framework because of a disagreement with the conditions imposed (among which data-registrations and sharing of information) by the governments framework.
- Some of the TPs stepped out of the TP framework but continued to collaborate with (some of) the partners. In these cases it was mainly the conditions of the government framework that urged to stop, rather than intrinsic characteristics of the partnership.

The motivation to stop projects overlap to a large extent with barriers mentioned by all TPs.

Table 5.3 summarizes the external barriers.

**Table 5.2 the barriers internal to the partnership for all projects.**

<b>External Barrier</b>	<b>Argument</b>
Government rules with regard to the number of meetings were considered as contradictory to the culture of collaboration of partners	Some projects could not include enough patients because partners did not propose, or deliberately refused to propose patients for inclusion
	Imposed frequency of meetings is considered artificial and not adapted to needs of patients
The need for a psychiatric DSM diagnosis	The obligation to have a psychiatric diagnosis as a necessary condition is considered as a barrier because potentially stigmatizing the patient (cluster elderly and cluster children and adolescents)
Obliged sharing of information between professionals (also written form)	Collaboration is seen as a threat to the therapeutic relationship (trust relationship) of individual professionals with individual patients
	Professional secrecy is for some professionals an absolute value hampering the collaboration
Patient monitoring	remarks both on content of scales as well as (expected) administrative workload
Administration	the obligation to collect and report administrative data is a burden
Financial	Financing of the project is considered as not proportional to the obligations, especially if partners did not want to invest resources outside the (financial) resources made available for the TP activities
Communication and support from the government	Projects experienced a lack of clear communication by the government for implementing their project: many projects mentioned that it was not always clear what the government expected
	Projects experienced that concerns and remarks expressed towards the government were not always heard or considered

**Table 5.3: external barriers hampering the smooth implementation of TP**

<b>Internal barrier</b>	<b>Argument</b>	<b>details</b>
The TP plan-proposal	People who have written the plan are not those who have to implement: result a lack of (shared) understanding	
	Not all partners were involved in preparation of plan: result not enough awareness about TP	
	The proposal is too theoretical and vague and cannot be used as a support tool for practical implementation of the TP and management of the partnership:	Target population mentioned in proposal cannot be reached in practice
		area of activity mentioned does not have providers in that regions needed for adequate care
		Unclear conceptualization of the role and tasks of coordinator within partnership
		Partners foreseen to participate in meetings have no mandate to take decisions during meetings
Commitment of partners	Not all partners are committed enough to make the partnership “work”	Sometimes related to a lack of involvement in preparation of TP
		Partners are not convinced of the added value of the approach
		Partners rely on the coordinator to keep partners committed:
		not all coordinators are seen by all partners as trustworthy and legitimate representative for the purpose of the project
		Replacement of coordinator during project
	Regulatory and financial constraints of particular sectors (cited example Flemish CGG-rules require 60% of the time clinical activities which impedes using time for TP)	
	a lack of tangible results	Late start of the TP Feeling that people only talk with no real initiatives or actions
Trust	Partners have different sectoral and professional backgrounds sometimes hampering the development of a shared approach and priorities in defining activities.	Fundamental distrust between partners has been a cause for discontinuation of projects

### 5.3.2 Changes during implementation

Many projects changed their operational modus during implementation. We identified three “types” referring to the pervasion of changes in the initial TP model: stable TPs, soft changers and hard changers. Changes occur in the configuration of the partnership and/or in the working procedures on different operational levels.

#### 5.3.2.1 *Changing the governance*

Structural complexity raises particular governance and collaboration issues within the TPs. The complexity (number of partners, sectors involved and types of services provided) explains to a certain extent the differences we observed in the management of the operational and strategic issues and how the TPs developed their governance model. Projects have paid a lot more attention to issues related to interprofessional collaboration and involvement of partners concerning activities around the patient and far less attention is being paid to the interorganisational network form in which this interprofessional collaboration takes form.

Data do not provide much detailed information about the changes in the organisation of steering committee meetings. The major argument made for changing or reorganizing management and steering group meetings is efficiency. Projects introduced support steps or mechanisms in order to prepare general meetings (E.g. internal coordination meeting between the persons responsible for the coordination of the project). Other projects decreased the frequency of the steering committee meetings (e.g. initially every two weeks, but every month later on) (French focus groups).

#### **Partnership configuration and governance**

The data learn that if the number of network participants increases it is likely that brokered forms of governance (meaning that key players obtain delegated power to take decisions and become a centralized junction (node) between partners) rather than participative forms (in which all partners are involved in all types of decisions) are needed. The choice for a governance model is mainly an experiential process aiming at increasing (perceived) efficiency (the time needed to discuss, the number of meetings, the related costs) and effectiveness (being able to take decisions and act anyway).

An intermediate variable having impact on the network efficiency and effectiveness shows to be the geographical distribution of partners: in a complex network characterized by a large geographical distribution of partners the burden on resources needed to meet is a lot higher. Experiences of the TPs indicate that in these cases network governance models structuring their activities around a central “broker” organization appear as more efficient and effective, because tasks can be delegated. However, it is only more effective if all partners accept and trust the core group of partners playing the “brokers”. A breakdown of legitimacy and trust can have detrimental impact in the network as whole. e.g Trust easily breaks down in the case where partners have the feeling or observe that their individual interests are not served. Especially in those cases where the brokering role develops around hospitals (only) concerns are a lot higher by the non-hospital partners to what extent interests, visions and perspectives of other members of the network would be safeguarded. In all clusters concerns were express with regard to a too much hospitallo-centred approach.

Smaller and less complex networks seem to a certain extent to be able to rely on direct interaction between all partners. This requires high commitment of the individual partners to keep involved in a wide range of activities (on different levels of the network). These network governance models rely to a large extent on informal and personal interaction.

Projects argue that communication and information transfer between all partners is a crucial element to make the network function as a whole: many projects have learned that different tools and mechanism have to be implemented in order to share and distribute information on the different network activity levels. Smaller networks, who generally rely on participative governance models, are able to rely on more interactive and informal information sharing mechanisms, although many projects stated that some formal back-up (minutes, documents,...) are needed too as a binding mechanism between partners.

### 5.3.2.2 *Structural changes*

Projects introduced changes in the structural configuration of the network meaning the number of partners or the range of sectors involved in the partnership. Furthermore roles of partners in the network can change too during implementation (e.g. shift from formal to informal partners):

Three types of structural changes in the network configuration can be identified:

- partners initially signing the collaboration agreement withdrew or were excluded from the partnership.
- partners who change from formal to informal partner
- partners were added (mostly as informal partners), sometimes for substituting withdrawing partners.

In the first case partners did not experience an added value of their collaboration or left the partnership because initial expectations were not met within the collaboration activities. For many partners practical/administrative issues (NIHDI-regulations implying time constraints and insufficient remuneration for participation in meetings, especially for GP's; expected workload due to participation in other TP) and motivational/ideological issues (no acquaintance with the target population of the TP, especially occurring for first line services (ISHC) in the clusters 'addiction' and 'forensic') played an important role. Sometimes organisations initially choosing not to sign the collaboration agreement did however agree to collaborate on 'ad hoc' / informal involvement in order to avoid administrative requirements.

Some particular reasons were mentioned in individual projects:

- In the cluster 'adults', one TP mentioned they had to stop collaborating with a general practice federation (Fédération de médecins généralistes) because they refused to come to meetings for patients they were not treating themselves. The TP substituted this partner by another primary care organisation but focusing on nursing care.
- One general practice organisation in a TP (cluster 'adults addictions') withdrew for ethical concerns with regard to the (intended) patient monitoring. After the formal answer of the commission for privacy protection the partner re-entered the partnership.
- In one project in the cluster elderly some partners withdrew, mainly because of the workload related to the number of meetings. These partners continued participating and referring patients though within another framework with less obligatory meetings and tasks.

A second type of changes is related to the level of formal involvement of partners: during the projects partners shifted from the status of formal to informal partner, in order to be released of the administrative obligations; for financial reasons or the input of resources (distance and time issues); in forensic projects because the lack of a clear definition of the role of prison in a mental health care network; or because the partner realised during implementation that he has no patients to propose for inclusion.

The third type of changes is this where TPs include new partners (who did not sign the initial TP-proposal) along the way. The latter can be involved as a formal or informal partner. New *formal* partners generally have particular expertise and experience with the target population or are easily accessible for the target population. New *informal* partners are often services from the social care sector, welfare services or judicial sector, and are invited in an ad hoc way to participate in the partnership (e.g. depending upon the requirements of a particular patient situation). We were unable to make an exhaustive overview on number, type, role or motivations of these partners (as they did not sign the initial TP-proposal). Overall projects largely jumped at the opportunity to occasionally invite informal partners to answer particular needs of patients included. Particularly in the cluster children and adolescents partnerships were extended in order to develop a support network for the family of the patient. Other partnerships included new partners (cfr cluster adults addictions) in order to include a new group of patients.

The mere fact of a change in composition of the partnership also implies an adaptation in the collaboration model of the partnership (sometimes formal, sometimes purely interactional).

Respondents mentioned that a withdrawal of “core” partners (taking initiatives, providing patients,...) could become a crucial challenge for the viability: not only because of the required administrative obligations, but also because for functional reasons (eg. Potential to offer adequate services, potential to recruit patients,...).

- Only Flemish speaking TPs in the clusters ‘addiction’ and ‘adults forensic’ have not changed the structural configuration (and connected collaboration agreement) along the road.

In a number of projects the partnership configuration was gradually adapted towards the experienced needs that emerged along the care process of their target population. These projects changed the formal collaborations agreements (Table 5.4). In absolute terms more changes occurred in the clusters ‘children and adolescents’, ‘children and adolescents forensic’, ‘adults’ and ‘elderly’, and particularly in the Flemish speaking projects.

**Table 5.4: Changes in the formal collaboration agreements**

	<b>Dutch-speaking TPs</b>	<b>French – speaking TPs</b>
<b>Children and adolescents</b>	N=4 active 2 TPs have made changes to the collaboration agreement	Of the 4 remaining TPs 1 changed the collaboration agreement
<b>Children and adolescents forensic</b>	2 out of 4 projects have made changes in the collaboration agreements during the second year.	/
<b>Children and adolescents addiction</b>	<b>No changes</b> in the collaboration agreements	/
<b>Adults</b>	3 out of 19 projects changed the collaboration agreement	<b>changes</b> in collaboration agreements took place in order to incorporate new partners and to adjust the agreement to difficulties with existing partners
<b>Adults forensic</b>	<b>No changes</b> in the collaboration agreements have been mentioned	/
<b>Adults addiction</b>	<b>No changes</b> in the collaboration agreements	<b>No important changes</b> in the collaboration agreements
<b>Elderly</b>	2 TPs have made changes in their collaboration agreements	(information lacking)

Source: Rapport de concertation transversale 2010

We have not seen any project that reoriented the design of the collaboration in a fundamental way. This can probably be explained because the TPs are experimental and need to fit within conditions defined by a government framework.

### 5.3.2.3 *Procedural changes*

Many projects made changes in the procedures used to coordinate and manage the partnership, on the level of daily operational matters as more strategic matters. TPs generally made soft changes in the way they organised their projects at partnership level often inspired by questions of efficiency (cfr changes in procedures to keep partners informed, changes in decision making procedures (and partners participating) role and function of steering committee. These procedural changes were often needed because projects experienced that not enough preparation time of the proposal was spent on operational matters and partnership relationships: so the design of the procedures in the initial plans proved to be non-efficient in the daily practice of the functioning of the partnership. Moreover, the lack of preparation time and involvement of all partners in the writing and design of the TP resulted in a lack of shared meanings on the working procedures and objectives of the projects once implemented.

### 5.3.3 Resources and interests

A main organizational issue emerging for the individual organizations was the pressure on resources. Partners expressed their concern on the resources needed (time for meetings and administrative tasks on top of patient activities) to invest in all TP activities. They often raise questions on the viability from an economic point of view. Managers expressed their concern on the efficiency of the TP working practices and the demands imposed by the government on the TP model.

Professionals recognize in general that time and meetings are needed in order to coordinate and develop shared approaches around patients. In particular cases respondents also stressed the importance of the TP as a tool to install a model of *shared responsibility* for the patients (instead of a sum of individual responsibilities), which is considered of utmost importance to develop continuity of care. At the same time they refer to plenty of practical constraints, such as the need to participate in the discussion on all patients included, the vast number of meetings etc. Especially hospital partners tend to see the added value in participating in projects but mainly for strategic reasons: it offers them an opportunity to communicate about and extend their competencies beyond the walls of their proper facility, and in some cases even as a tool to surpass the constraints imposed by the regulations in the hospital sector (cfr limitations on number of beds etc). Being a partner of a network allows to transfer patients to other settings outside the hospital facilities (or the inverse: taking charge of patients that normally are handled outside the hospital).

During the focus-groups some professionals saw an added value on the level of the expected potential benefits of TPs for a regional (local) approach, enabling a better coordinated provision of care within the local circumstances. Although it requires to invest time and energy in a TP, some indirect benefits are expected on the local or regional level making it worth to invest in the project. It must be clear though that these comments do not necessarily reflect “evidence” on the TP: it could also be a more general and theoretical reflection or even expectation.

#### 5.3.4 Intersectorial and interprofessional collaboration

The development of shared meaning plays at the level of professionals (with a different training background and working environment (see *infra*)) and at the level of care domains (health, mental health, psychiatry, police, justice, welfare home care, hospital care, ...). Projects reported on difficult discussion between professionals within and between sectors on core issues for the collaboration. Differences in values, norms, preferences and even procedures to set priorities plays on setting objectives with patients as well as on the level of defining working procedures and practices. Going through a mutual adaptation process goes hand in hand with tensions or even conflicts. But if mutual adaptations cannot be reached this will hamper the viability of a collaboration model. In order to overcome or support these potential differences tools such as “charters” or documents committing partners to professional secrecy is considered as a support for developing “trust”.

#### 5.3.5 Management support

The support of the management/directors of the individual partners towards the TP-activities has been raised frequently as a facilitating matter in the functioning of the professionals and partners within the partnership. This support takes form on two levels: (a) the will to invest own resources (by assigning support staff for preparation of the projects or for administrative task) of the organization, and (b) moral support: stimulating their departments and professionals to contribute to the TP. It was mentioned that only subscribing to the TP call, without developing internal support is a hampering factor for the functioning of the TP. One does not expect that the management of an individual partner organization should take up daily operational tasks in the functioning and activities of the TP, but a minimal support is needed. Moreover, support of the management to develop co-responsibilities with other partners on both the functioning of the network as well as activities around the patient is needed. A lack of interest or a negative attitude towards collaboration activities is to detriment of the TP.

The support has to be offered at all levels. A strict differentiation between the management tasks of individual partners in the TP (e.g. participating in steering group or management committee) and the activities of the coordinator and professionals, will also hamper the smooth functioning of the TP because discrepancies could develop between daily activities and strategic decisions.

#### 5.3.6 Geographical distribution of partners

The spatial (geographical) distribution of the partnerships is an issue to be considered, even to the extent that it can hamper efficiency. There is the practical level of distance (require additional time and resources) in order to contribute to the (often many) meetings and the level of practical decisions on where to organize meetings. But there is an aspect of “knowing each other” too: on smaller geographical scales partners tend to know each other better which facilitates becoming acquainted with the working processes of individual partners. However, we cannot conclude there is a linear relationship between distance, knowing each other and developing a collaborative approach.

### Key points

- The motivations to discontinue projects are both internal to the project or concern external obligations. The motivation to stop projects overlap to a large extent with barriers mentioned by all TPs
- Many projects changed their operational modus during implementation. Changes occur in the configuration of the partnership and/or in the working procedures on different operational levels.
- Changes in the composition of the partnership imply an adaptation in the collaboration model of the partnership (sometimes formal, sometimes purely interactional)
- Projects have paid a lot more attention to issues related to interprofessional collaboration and involvement of partners concerning activities around the patient and far less attention is being paid to the interorganisational network form in which this interprofessional collaboration takes form. They experience though that both are important
- In complex networks brokered forms of governance (meaning that key players obtain delegated power to take decisions and become a centralized junction (node) between partners) rather than participative forms (in which all partners are involved in all types of decisions) are needed
- Partners expressed their concern on the resources needed (time for meetings and administrative tasks on top of patient activities) to invest in all TP activities. In a complex network characterized by a large geographical distribution of partners the burden on resources is a lot higher.
- Implementing collaboration is related to the development of mutual understanding and shared meanings. The development of shared meaning plays at the level of professionals (with a different training background and working environment (see infra)) and at the level of care domains (health, mental health, psychiatry, police, justice, welfare home care, hospital care ...).
- A breakdown of legitimacy and trust can have detrimental impact in the network as whole. Especially in those cases where the brokering role develops around hospitals (only) concerns are a lot higher by the non-hospital partners to what extent interests, visions and perspectives of other members of the network would be safeguarded.
- communication and information transfer between all partners is a crucial element to make the network function as a whole: many projects have learned that different tools and mechanism have to be implemented in order to share and distribute information on the different network activity levels
- a withdrawal of “core” partners (taking initiatives, providing patients,...) could become a crucial challenge for the viability of the network, not only because of the required administrative obligations, but also because for functional reasons
- The support of the management/directors of the individual partners towards the TP-activities plays a facilitating role in the functioning of the professionals and partners within the partnership.

## 5.4 INTERPROFESSIONAL COLLABORATION

Working processes around patients vary considerably between projects. Projects were also quite different in the number of professionals from individual partner organizations involved in the TP. Moreover, the focus groups clearly indicate that projects evolved and changed their working processes around the patients inspired by their experiences along the way: changes were introduced on the nature of the meetings (face-to-face or not), procedures to share information (ICT-supported or not), location of meetings, professionals involved per stage of the care process and content discussed. The division of labour was adapted in many projects too. The changes mainly aimed to improve efficiency and guarantee or develop commitment of the professionals involved.

In this section we organize our findings within a framework of the different stages of the care trajectory: we respectively discuss aspects of interprofessional collaboration in the stage of the inclusion, follow-up, end of care trajectory and in crisis situations

### 5.4.1 Inclusion process

The inclusion process is the decision making process using TP eligibility criteria to include a patient in a TP. The examination of the patient candidatures occurs mainly during meetings gathering the professionals from the *formal* partners and who are familiar with the target population.

Especially after the first year of experiences of the TP (in which a lot of effort has to be put in including patients and realising the caseload of 30 patients for the projects) the inclusion of new patients became less of a strain. But, inclusion processes were in many projects changed in order to “smoothen” (read speed up) the activities. Projects introduced preparatory activities, a pre-assessment of potential candidates by the coordinator (with or without a small team) who informally contacted some of partners proposing patients for inclusion. This can be an advice that only is endorsed in the partner meetings without much discussion. Some interviewees recognised that the formal inclusion meeting became as such less a meeting on what the care process and care trajectory for a patient would be, but became a technical aspect of the partner meeting.

Many projects reported that the decision making process on including or excluding patients has to a large extent been affected by the external formal obligation to attain a caseload of 30 (adapted for some clusters in the second year). As projects experienced difficulties to recruit and include patients, the need to respond to this external obligation made that patients were included primarily to answer the external obligation rather than because they really fitted in the intended approach of the TP or governments' program.

It is reported that the development and the efforts to obtain a mutual understanding of partners –especially in the start-up phase of the project- impeded a smooth development of the inclusion process. Not all partners involved proposed (a) patients for inclusion or (b) patients that fitted in the profile of “complex and severe”. Although we have no formal data on the case mix, we have plenty of indications that many projects included patients for which questions can be raised whether these are the “chronic and complex” target audience.

In the next sections we will discuss some particular issues.

#### 5.4.1.1 *Involving professionals and formal partners*

Formally a mutual agreement between formal partners is needed to include a patient. In daily practice though projects experienced some difficulties to organize inclusion meetings with all the formal partners involved, particularly for big partnerships. Moreover the individual professionals of these partners taking care of the patient are not always participating in the inclusion meeting.

Additional to this and especially in larger partnerships the professionals consider that only an agreement is needed between the professionals that will be actually involved in the support and treatment of the patient, rather than a signature of all partners involved.

### 5.4.1.2 The use of predefined inclusion criteria

Overall interviewees are convinced of the relevance to explicitly use inclusion and exclusion criteria. While initially the comments on the obliged use of criteria were primarily negative (see previous interim reports), daily experiences showed that the mechanism helped internal working processes and avoided unnecessary discussions (especially mentioned in the cluster adults). The use of inclusion and exclusion criteria offers a basis to set the activity scope within the TP and consequently a useful mechanism to select, or better to reduce or to control the number of partners in the partnership design.

The comparison of projects learns that projects developed quite different practices concerning the use of preset inclusion criteria (as described in the project plans): first there are TPs who (report to) apply preset inclusion criteria in a strict way. Other projects indicated that preset criteria were a frame of reference to used in a very flexible way (also to ensure the required preset caseload). In other cases, TPs broadened preset inclusion criteria mainly to realize more inclusions or because the criteria were insufficiently defined in the initial plan to reach the attempted patient group.

Reflecting on their experience, respondents recognized that too broadly defined criteria makes it difficult to use them in practice and often hampers the smooth running of inclusion meetings. A too bureaucratic approach is of no use either. Criteria should be used as a frame of reference rather than a decisive technical list.

Professionals in particular, often mention the relevance of assessing the condition and needs of the patient as more important than the mere application of criteria, because many patients do not fit exactly in certain boxes: This argument came particularly to the fore in the cluster children and adolescents.

Other issues concern the difference between “theoretical preset criteria” and applying criteria in practice. Interviewees mentioned that it was difficult to refuse a patient who did not meet their inclusion criteria although clearly being in need (but for other problems than the ones described in the inclusion criteria).

- Most projects in the cluster children and adolescents, and particularly the subclusters forensic or addiction, applied preset 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.
- In the cluster elderly similar difficulties were experienced with the age-limit set at 65 which is considered as not always practical to use. The argument was made during the focusgroups to lower this age limit to 60 as this is also the age limit for entrance in a rest home.
- Projects in the cluster children and adolescents working around early detection of potential mental health problems mention the difficulty to develop precise assessments of needs and identify action strategies fitting into this needs analysis. Early detection of problems is an issue that in daily nature is considered as initially vague. Moreover in this process diagnoses are not set. Because of this aspect it is very difficult to use formal inclusion and exclusion criteria as a closed frame of reference.
- Some French speaking projects in the cluster children and adolescents have applied strict inclusion criteria adapted to very narrowly defined target groups, and as a result experienced problems in recruiting patients
  - A particular project working with children with parents having mental health problems, mentioned that the parents themselves refused to include their children while the needs of the children were clear.

- In the cluster children and adolescents difficulties were reported to motivate parents to include their child in a “psychiatric” project. The psychiatric label seems to be a source of resistance for some parents. Other parents are not that keen to set their child in an “experimental” approach, especially if their children are supported already in other facilities. Thirdly it is reported that some parents see the process of being involved in a longer term process with regular meetings with different professionals as very interfering in their personal/educational life. It has been reported too that many of these parents learn over time that the process can be supportive.
- Some particular comments emerged in the project from the cluster adolescents with an addiction. Here many comments were made on the specific age limits that were used in order to “belong” to a certain cluster. The strict application of the age criterion means that care process cannot be continued, while an assessment shows that patients in these “border-aged” tend to fall between two stools

### ***The use of DSM IV***

The obliged use of the DSM IV diagnosis was criticized by many, particularly in the cluster children and adolescents (and particularly very young children) and elderly for those projects choosing a target population with no *psychiatric* indication.. This because of the stigmatizing effect but also because for some projects in this cluster (early detection in particular) the diagnosis is not known at the stage of consideration for inclusion. A potential implication is that one excludes a priori eligible patients with a complex spectrum of needs that can easily be addressed in a collaborative model such as TP.

- For children and adolescents child psychiatrists mentioned a potential confusion between “symptoms” and diagnostics which can have major impact on the future life of the child. Not all symptoms (e.g. hyperactivity) lead to a condition of complex needs, which makes that the care should not necessarily be organised in a TP approach.
- In the cluster elderly it was mentioned that the obligatory use of the DSM IV favours elderly patients coming from hospital settings to be considered for inclusion. Through this mechanism a potentially relevant group of elderly in need of care can be missed

A diagnostic can also induce potential discussions between psychiatrists as for the one a diagnostics goes hand in hand with a pharmaceutical treatment and for another psychotherapy in combination with family counselling is seen as a sufficient approach.

The use a psychiatric diagnosis can be perceived as stigmatizing and as such increase the reluctance of potential patients to participate. The use of the psychiatric diagnostics can potentially induce a (potential unnecessary) medicalisation of mental health problems, including becoming dependent on psychiatric professionals (to obtain the diagnostic label).

- Some interviewees of the cluster children and adolescents suggested to develop instruments identifying the needs of children rather than the use of diagnostics.
- In the cluster elderly many interviewees asked to focus more on the complexity of needs in different life domains as far as they are related to a mental health problem, than on diagnostic labels at least for the inclusion. It is recognised though that if a diagnostic is available it can offer very relevant information to understand the needs of a patient.

### **Chronic and complex'**

Most interviewees recognized that collaboration models such as TP primarily address persons with complex needs that last over longer time. Implicitly some of the interviewees recognized that (certainly initially) they did not include patients with this profile.

- Interviewees in the cluster children and adolescents stressed the difficulties to assess to what extent mental health problems of this group were indeed chronic and complex. These interviewees said it was almost impossible to assess and predict this aspect. There is also an important ethical aspect to be considered when a child or adolescent is being labeled as a chronic patient. Moreover, complexity could also be attributed to the personal context of the child (family, school, etc than to the condition of the child or adolescent as such.
- In the cluster adults it was reported that the notion of “chronicity” was made operational in different ways (example identifying a chronic depression by the number of hospitalizations or the period that a person is under medication, rather than just defining a time slot

An aspect –mainly heard in the cluster adults- is that complexity is not defined from the perspective of the needs of the patients but rather from the perspective of the providers (“*the number of disciplines and partners needed to provide adequate services*”). Of course there is a relation between both the needs of the patients and the providers, but the discourse illustrates that complexity is primarily seen from the perspective of the provider.

- In the cluster elderly it was mentioned that elderly patients have almost always multiple needs (not mental health specific) and that it is sometimes difficult to assess whether the complex needs are related to the mental health or psychiatric condition or to other reasons. Therefore some projects in this cluster focused more on the severity of the mental health problems than on the multiplicity of needs.

### **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).

- 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 their inclusion in a support model seemed appropriate.
- Particularly in the cluster addiction. 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’.

Problems are reported for obtaining an informed consent because 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.

- Based on internal discussions and after discussions with the administration some projects developed a separate document including information about the general aims of TPs, on the rights and obligations of the patient and caregivers concerned, as a support tool to inform patients and their families.

Projects seem to experience less problems if consent is to be obtained from family members rather than the patient. (particularly in the cluster children and adolescents). However, mainly in some French-speaking projects, concerns were voiced as parents feared losing control (the autonomy to decide) 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.c. 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.

Although many problems were reported on obtaining this informed consent, some key elements could be drawn from those projects that experienced less difficulties. A first element is that the person who informs the patient about the project and tries to obtain the informed consent has a 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) rather than explaining in abstract theoretical ways.

#### 5.4.2 The follow-up of the patient after inclusion

There is an overall consensus on the principle that bringing together all professionals involved in the care process of a patient is necessary and useful: it helps to develop knowledge about activities of other sectors and professionals; it helps developing mutual understanding and trust, it helps to better understand the situation of the patient.

However, especially the focus-groups clarified that respondents had multi-layered opinions on the efficiency (in terms of use of time) of the imposed three- or four monthly meetings. Some respondents questioned the need for the imposed three-monthly frequency as this might not necessarily be adapted to the needs of the patients, especially in the phases where the condition of the patient is stable. In contrast, other respondents recognised that a regular follow-up of patients is needed in order to not lose track of the patient. The rhythm of three or four monthly meetings urges to do an active follow-up of the situation of the patient and allows for an early detection of potential problems (and as such preventing crisis situations or fundamental problems). Moreover, there is also an added value for the professions as the meetings can serve as (emotional) support and a model of intervention.

- Individual French speaking projects with a large number of partners have introduced a follow-up model of patients based on distance communication using phone, mail or teleconferences. It was mentioned though that this is a practical solution but one that holds the risk that the follow-up becomes a purely technical matter rather than an issue of reflection and interactive communication on the needs of patients.

### 5.4.2.1 *Professionals involved*

Related to the issue of the number of meetings many projects also experienced practical problems to decide on places and dates for meetings with participants (from the 3 obligatory partners). It was considered as quite a difficult logistic process to organize the meetings, especially in those cases where the coordinator participated in the follow-up meetings. Remarks were also made on who should participate in order to increase the efficiency of follow-up processes. Opinions on this matter diverged.

In general terms respondents say that only those professionals should be involved that have to play a support role adapted to the identified needs in particular stages of the trajectory of the patient. Some consider it inefficient to involve professionals that do not have to contribute care in particular stages (with particular needs). With regard to a needs based approach the choice for involving professionals in the regular meetings should also be adapted to the different informal social support network a patient can rely on.

- In the French speaking focus group -cluster addictions it was argued that a participation of three partners was not necessary, because most discussions on patients focused whether on the situation in which the person was staying (residential setting) or the setting to where s/he would be transferred. Professionals from the legal sector should not always be implied in all meetings in the different stages/ Sometimes it would suffice that they provide information on legal constraints and conditions (if they apply). But these partners seldom contribute to the content of the care trajectory of patients
- Although the involvement of representatives from schools is generally considered useful or necessary in the cluster children and adolescents, this principle was questioned in individual projects, (in French speaking projects) mainly by the psychiatrists. Here arguments are made that communicating about the condition of the patient is considered difficult, because certain partners fear that information on diagnostics could be wrongly used within a school context.

The requirement to involve professionals from primary care is assessed differently. Many remarks were made on the practical –financial- constraints for primary care and in particular general practitioners to be involved. Moreover some respondents even question the usefulness of involving general practitioners (not in those clusters in which the GP is considered as a key person (especially cluster elderly), and except for those situations in which the patient has a trust relationship with the GP). Most comments developed on the fact that more flexible models have to be developed in order to involve general practice in the follow-up activities of the patients. Suggestions were made such as:

- Only invite GP to those meetings where their contribution is really needed
- Contact them beforehand by phone in order to assess if their presence is needed and whether necessary information cannot be collected by phone.
- Give priority to the agendas of general practitioners for setting dates and moments to organize meetings

### 5.4.2.2 *A reference person for the patient*

It was mentioned by some that the use of a reference person (labeled 'réfèrent', 'thérapeute réfèrent', 'vertrouwenspersoon' ou 'spilfiguur') who knows the patient very well and has an overall image of the patient, facilitates the follow-up. It was accepted that a reference person could change in the course of the health care trajectory. In daily practice this person becomes the go-between of the different professionals as well as families. Moreover, this person can also take up the responsibility to explain decisions to patients or families if these did not understand during patient meetings. However it is also mentioned that the time investment for being the "reference person" over the whole trajectory of a patient is vast, and that it should be considered whether it is possible to change the reference persons within the partnership over the trajectory of the patient. Reference persons could e.g. be chosen from partners most involved in the support and care in the different phases of a trajectory of the patient.

#### 5.4.2.3 *Fixed or changing professional team*

The interviews and focus groups also revealed the impact of a changing team of professions for working processes around the patient. TPs made different choices with regard to this matter: some TP work with fixed teams of professionals, other (by choice or forced by the situation) work with teams constituted differently over time. For this latter one has to consider the following: A variable team can be the result of adapting the type of professionals needed considering the needs of the patients. Many projects indicated (compare also supra) that it is efficient if professionals are only involved if the needs of the patient and family require it. Over time, as the condition of the patient evolves it would be seen as a logical result that the constitution of the team changes, and it would be more logical to meet with the professionals needed in that stage.

Certain TP mention that that fixed teams have their particular advantages too for the daily working processes, especially in those meetings where both patient issues (content and needs) and organisational issues (how to practically coordinate care between professionals) are discussed.

#### 5.4.2.4 *Different types of follow-up meetings*

The organisation of patient follow-meetings varies between projects:

Some projects grouped the follow-up meetings of all patients included in the same rhythm, holding that different professionals were attending meetings were patients were discussed with whom they had no professional relationship. This grouping was a management decision in those projects where the coordinators also participated in the follow-up meetings (to guarantee the external requirement to provide follow-up reports) and used as a technique to respond to the formal obligation of having four or three meetings on the patients condition..

Other projects organised patient-specific individual patient meetings, in which a team of professionals together with the patients and their families decided (and judged it necessary) to meet. This implies that in projects where the same professionals were involved in the care of a number of patients that their time investment for meetings also increases.

Certain projects differentiated between “types” of follow-up meetings which means that not the same professionals were participating: Some of these meetings were introduced outside the formal requirements of the government programme.

#### 5.4.2.5 *Location*

Tps choose to organise their follow-up meetings in a fixed or changing location. The vast majority estimate it necessary though that the location of meetings should be flexible, both for the patient as well as for the professionals.

- For the cluster elderly many French and Dutch speaking projects emphasized the importance to meet at the living place of the patients, also because it facilitated the participation of the general practitioner.

Especially for projects covering larger geographical areas, professionals also appreciated if their travelling time could be reduced by means of changing locations (and by means of this balancing travel times for all). In contrast, it has been mentioned that having meetings in the hospital facilitated the participation of hospital psychiatrists. Often these psychiatrists resist or have difficulties to participate in meetings outside the hospital.

- One project said that the first meeting after inclusion deliberately was organised in the hospital, because the involvement of the psychiatrist increased the credibility of the approach.

There are practical and logistic consequences for choosing for changing locations for the coordinator and the partners. Many coordinators warned that this was not always easy and that changing locations imply additional logistic and practical work.

#### 5.4.2.6 Content

Initially follow-up meetings were grouped in three general types: (a) meetings aiming at the referral of the patient, (b) meetings aiming at fine-tuning the individual care trajectory of the patient and the roles of the services involved, and (c) meetings aiming at super- or intervision moments for those services that lack expertise about the target population and need some support to care for that patient.

During the focus-groups it became clear that the within the second category some meetings focus more on the content of care to be provided, while others mainly focus on the organisational model on how to coordinate the care of providers involved, including administrative and practical issues in order to avoid follow-up work for the coordinator.

#### 5.4.3 Ending a care trajectory within the TP

Very little information is collected on the way projects organised the end of care and support through the TP. We obtained no clear information on which criteria and procedures were used to dismiss a patient from activities within the TP. Main reasons mentioned why patients “left” the TP was death or a request to be dismissed from the project by patient or family,...

When introducing the issue during the focus groups the participants did not consider it necessary to organize a specific meeting for this matter. Some respondents said this decision could be taken within the framework of a regular follow-up meeting, but it was clear that this issue was not been thought through.

#### 5.4.4 Crisis situations

Similarly, when asking questions about how meetings should be organised in case of a crisis of the patient, very few strategies could be described. It can be deduced from the answers that that in case of crises everything should be handled ad hoc and informally between (some of) the professionals involved. Quite striking is that some TP considered crisis-situations not as part of the TP approach, but should be dealt with by emergency services.

### Key points

- The development and the efforts to obtain a mutual understanding of partners –especially in the start-up phase of the project- impeded a smooth development of the inclusion process at the beginning of the project
- Overall interviewees are convinced of the relevance to explicitly use inclusion and exclusion criteria. While initially the comments on the obliged use of criteria were primarily negative, daily experiences showed that the mechanism helped internal working processes and avoided unnecessary discussions
- too broadly defined criteria makes it difficult to use them in practice and often hampers the smooth running of inclusion meetings. A too bureaucratic approach is of no use either. Criteria should be used as a frame of reference rather than a decisive technical list.
- Although we have no formal data on the case mix, we have plenty of indications that many projects included patients for which questions can be raised whether these are the “chronic and complex” target audience
- In daily practice projects experienced some difficulties to organize inclusion meetings with all the formal partners involved, particularly for big partnerships. In larger partnerships the professionals consider that only an agreement is needed between the professionals that will be actually involved in the support and treatment of the patient, rather than a signature of all partners involved.
- The obliged use of the DSM IV diagnosis was criticized by many, particularly in the cluster children and adolescents (and particularly very young children) and elderly. The use of a psychiatric diagnosis can be perceived as stigmatizing and as such increase the reluctance of potential patients to participate.
- The inclusion process of patients is reported to be strongly influenced by the obligation to obtain an informed consent of the patients.
- There is an overall consensus on the principle that bringing together all professionals involved in the care process of a patient is necessary and useful: it helps to develop knowledge about activities of other sectors and professionals; it helps developing mutual understanding and trust, it helps to better understand the situation of the patient.
- Respondents had layered opinions on the efficiency (in terms of use of time) of the imposed three- or four monthly meetings, especially in the phases where the condition of the patient is stable. In contrast, respondents also recognised that a regular follow-up of patients is needed in order to not lose track of the patient.
- Related to the issue of the number of meetings many projects also experienced practical problems to decide on places and dates for meetings with participants (from the 3 obligatory partners)
- It was mentioned by some that the use of a reference person who knows the patient very well and has an overall image of the patient, facilitates the follow-up.
- The organisation of patient follow-meetings varies between projects: Some projects grouped the follow-up meetings of all patients included in the same rhythm, while other projects organised patient-specific individual patient meetings, in which a team of professionals together with the patients and their families decided (and judged it necessary) to meet
- A changing team of professions around the patient impacts heavily on working processes around the patient.
- Very little information is collected on the way projects organised the end of care and support through the TP. Similarly, when asking questions about how meetings should be organised in case of a crisis of the patient, very few strategies could be described.

## 5.5 PATIENT AND 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.

The involvement of patient and family is considered on the one hand as an added value and on the other hand as a delicate issue with potential disadvantages. During the interviews, projects reported that the involvement of the patient increases his/her sense of responsibility in his/her own care. They also noticed that the participation of family in follow-up meetings is experienced as an opportunity to be heard. However, it was also mentioned that it is sometimes difficult to involve the patient in the consultation process and, especially, to have the patient present during the follow-up meeting. Arguments put forward are privacy and professional secrecy, lack of experience of certain institutions to deal with the involvement of patients. Respondents described 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.

It was mentioned that participation of the patient and their family should be assessed on a case by case and a situation by situation basis. Some people mention that the final decision should be taken by the professionals. The example was given from a project in the cluster elderly, where the involvement of the patient during the meeting was counterproductive for the professional decision making process. Other projects also mention that patients should be given the opportunity for themselves to decide whether they want to participate or not.

More than other clusters, in the cluster elderly and the cluster children the importance of involving the family in the meetings is stressed.

## 5.6 THE ROLE OF THE COORDINATOR

### 5.6.1 General considerations

Reflecting on the experiences respondents all projects value the relevance of a coordinator for the viability of the project. In bigger partnerships their role is seen as essential, as auto-regulated collaboration without an intermediate function seems not realistic. But it has to be explicitly stressed that overall the coordinator is seen as a crucial node in the functioning of the partnership. There is a clear consensus that the function of a coordinator is a necessary condition to reassure that activities get form and that a TP partnership is viable, but it is neither a sufficient condition to have effective partnerships: there needs to be commitment of the partners and professionals too.

#### 5.6.1.1 *The coordinator as a facilitating agent*

It has also often been stressed that the way a coordinator functions is a key facilitating element to develop shared knowledge and experience and develop trust between professionals and partners. This role should not be conceived as purely administrative. A coordinator needs to be a facilitator, taking the necessary initiative to lead, promote and facilitate the collaboration on the different levels. In those projects where the coordinator role was reduced to a administrative function, without any management support, projects struggled more with credibility issue and aspects of developing trust.

The stimulating and leading role of the coordinator is especially considered essential in the start-up and launch of the partnership. In this respect a difference can be made between partnership (in which a core group) already previously collaborated versus entirely new established partnerships. In the latter case the role of the coordinator (whether or not with a coordinating management team) is seen as absolutely necessary to streamline activities and coach a shared approach.

This facilitating role requires particular competencies, and generally respondents refer to the importance of a certain level of seniority (also expressed as work experience or maturity) and change management competencies. A coordinator should have at least a basic acquaintance with the specificities of the activities of different partners involved. Moreover, the persons should not be mere executor of tasks, but be able to motivate, convince and stimulate a wide range of people: communicative skills and a certain maturity and experience in a health care or welfare working environment is considered necessary. It was said though, that the available financial resources (within the TP funding) did not always allow to recruit coordinators with this particular competency profile.

The coordinator should take up a *facilitating* role (in the literature described as a broker) rather than a “organizes everything” role. This facilitating role aims at enhancing collaboration and urging different levels in the TP to take responsibilities in the collaboration process. If all responsibility for developing collaboration is projected on this one role, the TP will not survive.

#### 5.6.1.2 *Coordinators work at different levels*

The coordinator functions on different levels: the person is responsible for coordinating tasks on the level of the partnership, but in most TPs this extends to coordinating task concerning patient related activities. Core activities in a vast majority of the patients administrative logistic and support tasks for activities around the patient. Coordinators are far less implied in strategic governance tasks of the partnership as such. They are involved in partnership activities, but more on an executive than a strategic role.

The different tasks and mixed role explains that rather big variability on how projects have filled in the function of a coordinator. Moreover, some individual projects shared the coordinator function between two persons.

#### 5.6.1.3 *The perspective of the coordinators*

Many coordinators experience that organizations and professionals have high expectations of the coordinator. They expect coordinators to be both mediators and problem-solvers for organizations 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. Moreover, some leadership and authority is needed in order to be directive in certain activities (eg: deciding on a date for meetings, requesting administrative information, setting the scope of the activities of professionals etc...)

#### 5.6.1.4 *Combining coordinator tasks with other activities*

One considers it necessary that a person should be mandated and released from other tasks to coach and support the partnership development primarily at the level of interprofessional collaboration around the patient. One recurring remark in all projects, independent of the variability of tasks assigned to coordinators, is that coordinating is difficult to combine with other tasks. Projects that tried to organise the coordination activities of the TP on top of other activities experienced soon that this is an unworkable practice. Based on their daily experience trying to implement the collaboration, complaints were made that the 0,5 FTE was not sufficient to guarantee a smooth running of a collaborative partnership, especially not in the start up phase, and especially not because of the administrative obligations.

Some projects mentioned particular problems in which a coordinator combined the role of a coordinator with clinical tasks: the combination of this work often leads to potential role conflicts in the follow-up meetings between the coordinator as a health care professional versus the role as a project coordinator. Other projects also focused on the potential advantage of a coordinator with clinical experience, as this allowed to coach the care process with sufficient knowledge of patient situation.

### 5.6.1.5 *Differentiation of coordination tasks*

The issue of differentiating coordination tasks has to be discussed on two levels: first there is the issue of assigning the overall coordination role of a project to more than one person (the same content is executed by different persons : horizontal division of labour)

Secondly there is the issue of differentiating types of work within the coordination function and delegating these to different persons (the division of labour takes place on the level of different types of work: vertical division of labour)

#### **Horizontal differentiation**

Assigning one unique person to the role of coordinator is perceived as more useful than differentiating coordination tasks over different persons. It improves the visibility of the role of the coordinator and facilitates information streams. One TP also mentioned that the lack of “one face” for a project hampers the external visibility and representation of the TP.

Some TPs mention though that differentiating coordination tasks between persons creates more possibilities to coach the individual professionals, handle the workload and avoid that coordinatorship becomes dominated by one of the partners.

#### **Vertical differentiation**

First, there are those projects that installed an “administrative coordinator”, a person specifically assigned for administration concerning the government requirements.

- In many Flemish speaking projects that part of the job was taken up by the ISHC: This was experienced as an added value especially to respond to the administrative requirements of the NIHDI. Interviewees consider this aspect though not as a core mission of the coordinator tasks, within the network. Moreover the coordinator remains responsible for internal administrative tasks such as minutes of meetings, etc.

Secondly there are the projects in which administrative tasks were delegated to a support staff member (administrative department or secretary's) of the institution (generally a hospital) in which they were employed. These tasks were taken up outside the financial framework of the TP programme. Coordinators appreciated this division of labour as according to them it helped them focus on their key tasks (see also infra).

Other forms of support for the coordinator tasks were mentioned too: eg: a reference person becomes responsible to organise patient meetings, or secretarial staff supports in logistic tasks.

### 5.6.1.6 *Acceptance, legitimacy and trust*

The role of an independent ‘external’ coordinator becoming involved in support activities both on patient as on organizational level is rather new, for patients as well as the professionals involved. The role of the coordinator has to be learned, as coordinators have to get acquainted both with the partners and the professionals involved and vice versa in order to develop shared practices. Developing collaborative partnerships appears also as an issue of coaching a change management in which partners and individual professionals have to adapt to the new working processes. Time is needed to delineate roles, to manage initial skepticism and to allow all people involved to mutually adapt to expectations. A core element in this development process is developing trust and legitimacy.

Coordinating is to a large extent described as a matter of developing trust. The roles assigned to the coordinator have to be accepted by all professionals and partners. Apparently this role is seldom discussed for logistic and practical administrative work. However much more efforts seem to be needed when coordinators take up more steering roles particularly with regard to patient activities. As the role and tasks of the coordinator(s) were not always well elaborated in the plans, this resulted in many projects in a process in which a lot of energy and time had to be spent in identifying practical working modalities.

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 establish this role of the coordinator within the partnership.

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. Coordinators need to have or develop the necessary authority to intervene, discuss and manage the professionals involved in individual patient activities.

It is also stressed that a coordinator should be neutral for all partners, meaning that some (initial) mistrust could be part of member partners if a coordinator is seen as a person from e.g. a hospital or one particular organization. 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 (often a hospital). All of these partners should be reassured that management and activities should be for the partnership and not favouring individual partners.

## 5.6.2 A coordinator for all times?

Quite interesting were the remarks of the projects on the question whether a coordinator would be needed for all times. The interviewees had different opinions on this matter:

Some respondents assumed that a very active and stimulating role of the coordinator with regard to patient activities would only be needed during an initial period, until new working practices are settled and people became acquainted with the processes of collaboration. These projects judge that professionals can over time become empowered themselves to autonomously collaborate, organize the necessary activities and maintain communication between them all. Therefore one could expect that coordinators will in the longer run not be needed to initiate and maintain patient related activities. Some projects mention that the installation of a “reference person” (see supra) for the patient could take up this role of coordinating tasks around patients.

But other projects judged that coordinators will always be needed, in order to reassure that within the partnerships someone keeps the overview of working practices and activities. On the one hand, respondents stress the fact that coordinating tasks around patients is not just an issue of working around individual patients, but also an issue of developing a common approach as a project. Some individual projects said that it has to be guaranteed that patients and families are kept informed. A coordinator is expected to have and maintain an overall overview.

## 5.6.3 Facilitating factors and barriers in the coordinators role

### 5.6.3.1 *Contributing to the decision-making process on patients*

Different opinions were expressed on the contribution of the coordinators in the patient meetings. On the one hand coordinators can play a support role especially in those situations where expertise is missing in the partnership and additional expertise has to be sought. If a coordinator is involved in patient discussions, this will facilitate understanding the situation and facilitate seeking for additional (informal) partners.

However, projects also mentioned that some professionals expect that a coordinator sticks to a facilitating role and do not interfere in content discussions on a patient, especially if the professionals, patient or family have the impression that the coordinator is co-deciding on what should happen with a patient. A more complicating situation occurs when coordinators also have tasks as a professional carer in one of the partner organizations for patients included in the TP: in these situations it is almost impossible to maintain the “neutral” coordinator of the TP position in combination with the role of the committed professional as part of a member organisation of the partnership network. Moreover as a professional they are sometimes bound to rules of professional secrecy, while they know information should be brought into the discussion (we heard this aspect often in forensic projects or in projects in the cluster addiction).

Some arrangements could be discussed within the partnership for managing this issue, but in general this situation of having a double role is experienced as complicating matters. Some interviewees mention that this double role can be managed, but this would require particular competencies. Sometimes it could be a positive element that the coordinator is well acquainted both with the problems of the target audience as well as the activities of partner organizations being a health care professional: this experience and knowledge enables finding solutions for the patients.

### 5.6.3.2 *The coordinator and the patient*

Projects approach the coordinator-patient relationship quite differently and their experiences during implementation of the TPs vary.

Many projects consider it an advantage to maintain a certain distance between patient and coordinator, as this avoids role confusion between defending the interests and preferences of the patient or choices by the team of health care professionals. Complementary to this general position, and especially in those case where the coordinator participates in the patient meetings, interviewees stress the importance that at least some personal contact with the patient and families is needed in order to avoid the patient gets confronted with a mix of professionals s/he does not know and to clarify to the patient that the coordinator is not a health or care professional.

As discussed before: the most challenging situation is the one where a coordinator of the TP is also a health professional involved in the care of particular patients. Almost all projects experience this as a barrier in the functioning of the patient meetings because of potential role conflict. But at the same time it is recognized that in these cases the coordinator knows the patients and his personal context better.

### 5.6.3.3 *Support for the coordinator*

The experience of the TPs learn that the role of coordinator should not be conceived as a stand alone function. The person fulfilling this role needs some support too. Interviewees mention two different types of support: 'practical support' and 'emotional support' as essential elements to avoid too much job strain for the coordinator.

Emotional support can be provided within or outside the partnership. Coordinators experience that moral and practical support in their functioning facilitates the development of their daily activities. This requires that individual organizations and partnership members should also commit to the activities. A passive attitude and behavior of the core partners and professionals becomes a barrier and potentially leads to the resignation of the coordinator. Some TPs reported that the resignation of coordinator in such a process had vast implications for the further functioning of the project.

With regard to the practical and logistic support (mainly administrative) for the project coordinator, experience learned that good preparation and coordination of these activities is required: Some projects introduced this support during implementation to avoid too much job strain of the coordinators. These TPs learned that including other persons requires training of the new support staff to understand all administrative procedures.

#### 5.6.3.4 Human resources issues

A resignation of a coordinator has a major impact on the functioning of the network, especially in those TPs where the coordinator was the driving force. In TPs with coordinators playing a more support role the substitution was easier.

The substitution of a coordinator implies anyway that the process of building trust and developing a shared meaning about this role between partners has to be started all over again. In some projects coordinators resigned because they were disappointed with the content of the job, felt unsupported by their employer and the partnership, or though the workload of the job was too high for a half time assignment. Some coordinators – based on their experiences- warn for the risk of miscasting persons for this role. Many coordinators also stressed that the job content of a coordinator is less attractive if one expects that one can be actively involved in the treatment and support process of individual patients.

#### Key points

- **The coordinator is seen as a crucial node in the functioning of the partnership. a coordinator functions is a key facilitating element to develop shared knowledge and experience and develop trust between professionals and partners.**
- **This facilitating role requires particular competencies, and generally respondents refer to the importance of a certain level of seniority (also expressed as work experience or maturity) and change management competencies.**
- **The coordinator should take up a *facilitating* role rather than a “organizes everything” role. If all responsibility for developing collaboration between partners is projected on this one role, the TP will not survive.**
- **The coordinator functions on different levels: the person is responsible for coordinating tasks on the level of the partnership, but in most TPs this extends to coordinating task concerning patient related activities and has to handle administrative tasks.**
- **The role of an independent ‘external’ coordinator becoming involved in support activities both on patient as on organizational level is rather new, for patients as well as the professionals involved.**
- **The role of the coordinator has to be learned, as coordinators have to get acquainted both with the partners and the professionals involved and vice versa in order to develop shared practices.**
- **Coordinating is to a large extent described as a matter of developing trust. The roles assigned to the coordinator have to be accepted by all professionals and partners. 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.**

## 5.7 EXPERIENCES WITH TOOLS SUPPORTING THE NETWORK

Many projects implemented tools to support the daily activities. These tools were used both for the overall network activities (cf. external reporting, administration) as well as to support interprofessional collaboration. There are projects that developed ICT applications integrating both functions.

The information collected on the use of tools generally concerns the support of activities of the professionals around the patients. This bias can probably be explained by the fact that the government programme obliged to work with “care plans” in which the upcoming activities of different professionals and peers have to be written down.

### 5.7.1 Tools supporting the collaboration in general

In general, projects stress the relevance to use in a systematic manner standardized documents to support the working processes (e.g. communication by email, using an electronic patient file, standardised form for proposing patients,...). The tools potentially increase efficiency (use of time) of working processes. However there is some avoidable bureaucratic burden too:

A balance has to be found between what individual partner organizations and professionals already use within their proper context, and what is needed for the partnership. With regard to this it is often stressed that more attention should be paid *in advance* to what extent TP specific instrument overlap existing documents and information sheets on patient used by individual partners. The double registering of the same information is experienced as a real problem for all people involved.

- Eg. In many Flemish speaking projects standardized instruments (care plans) were used developed in the framework of other activities of the ISHC. These instruments require though to collect information in a different manner/format for information already collected by other partners for their own purposes, increasing the administrative workload for the partners

The development and use of the project specific instruments is described by many as a pragmatic incremental process including regular changes to the instruments used. A number of projects introduced and developed new forms along the way (e.g. standard candidature form, leaflet for patients) because experience learned that the execution and coordination of activities could be smoothened. Other projects changed the content of their reports/minutes of discussions about patients (i.c. very brief reports instead of extensive reports).

One particular tool is considered supportive for implementing and developing the TP activities: a document or leaflet briefly summarizing the purpose, working procedures and activities of the TP. These kind of leaflets is relevant both to disseminate for patients as well as individual professionals that would be solicited.

### 5.7.2 Tools supporting the collaboration between professionals

The government’s programme requires the development of a “care plan”. Care plans are patient specific documents describing the status of the patient, the interventions and intended results of patients in the different stages of the care process. It is considered as a logging of the evolution of the patient and a crucial communication tool across the trajectory of care.

The care plan was often limited to the minutes of the patient meetings, indicating the responsibilities of all persons involved in the care and support of the patient. The level of detail varies greatly between projects, also affected by the fact whether the meeting was dealing with content of care, or just describing which care was provided by whom (cfr supra paragraph content of patient meetings)

There is a general consensus that a document is needed briefly documenting the characteristics of the patient, his condition and needs. But some difference could be observed on where this information should be stored and to whom this should be communicated.

- It was suggested to keep this inclusion file as a separate file holding basic information, informed consent forms, general description of the situation of the patient, contact information, motivation to include patient in TP etc...
- In one French speaking focusgroup it was mentioned that this document is not necessarily useful to share with the patient or family: It was experienced that some patients read this document as a “prescription” of activities to be performed until the next meeting, while the document does not serve this purpose.
- Specifically in the cluster forensic the example was given that sharing information on the legal status or problems of a patient could impact on the care relationship and the attitude of health care professionals (ofte an issue of safety feelings)

In order to avoid these type of problems an individual project introduced two types of instruments: one holding all the basic background information on the patient, and another type of document holding the “functionally required” information for interprofessional collaboration. The latter type of document would not lead to problems to grant insight in delicate patient information as it would not be shared by all professionals.

### Key points

- **Projects stress the relevance to use in a systematic manner standardized documents to support the working processes. The tools potentially increase efficiency (use of time) of working processes. However there is some avoidable bureaucratic burden too.**

## 5.8

### AREA OF ACTIVITY

The area of activity differs between projects: some projects cover more than an entire province, others act on local level, while others only cover the working area of an hospital being a partner in the TP.

As projects had to identify an area of activity (catchment area) for which they would recruit patients this criterion technically also serves as an inclusion or exclusion criterion for patients.

Projects use different perspective on this “area of activity”: in some projects the reference basis for defining an area of activity is the providers that offering services (mainly hospitals). In this perspective patients are considered eligible for inclusion when they use the services of TP partner within the area of activity. This is especially seen as a potential problem in the cluster children and adolescents where in some areas there is a shortage of adequate services. Another interpretation is that patients can only be included in the TP if they actually *live* within the area of activity preset by the tp, without considering whether they (already) receive services from one of the partners of the TP..

Overall projects have delineated their catchment area on the basis of the working area of their core partner organisations, or on the residence of patients of a hospital partner (on the base of the RPM data), rather than on an assessment of the needs of a defined population. The choice of a specific area of activity is sometimes closely related to the available supply of (hospital) mental health care services in a region too or activities of one of the formal partners (e.g. a legal court)

- Many TP in the Flemish part have defined their area of activity on basis of the existing ‘care region’ of the ISHC. In the South of Belgium, 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’)

The choice for an area is also pragmatically based on the activities of preexisting collaborations between partners including a preexisting shared vision on the organization of mental health care.

- The particularities of the provinces 'Liège' and 'Namur' have been emphasized. These provinces have a history of collaboration, good means of transport, many patients and health care services. In the province 'Liège' the ideas of antipsychiatry have penetrated more in the activities of different providers of care, facilitating collaboration. The province 'de Namur' consists of many mental health 'networks', although these separate 'networks' lack mutual interaction, which probably hampers developing initiatives crossbordering the historically established collaboration

Some projects prefer operating in a small catchment area mainly inspired by reasons of feasibility and practicality (such as transport time). For individual Flemish projects, the choice was deliberate to show the particularities of that region (the lack of adequate and established care) to the policymakers. The south west of Brussels deliberately aims at avoiding the concentration of service provision in one particular part of the province

Interviewees reported that the initial delimitation of geographical areas is worth reflecting better than was initially done:

Projects with very small catchment areas reported difficulties to recruit patients especially since they did not really assess the prevalence of mental health problems in the selected area. Some projects had to stop their activities (and were thus ineffective) because they selected a bad catchment area in order to reach the preset caseload. However, it is also reported by other projects that a major advantage of working within smaller geographical area's guarantees that partners and professional involved know each other already, which facilitates the process if installing collaboration. Additionally smaller area also put less strain on the resources (distances for coming to meetings, time use, etc)

Other projects redefined their geographical area of activity along the implementation. TP with initially smaller catchment areas that wanted to increase their area of activity for instance realised that extending an area of activity also implies extending the partnership, which itself can have major consequences on the development of the partnership in itself (including motivating partners, information providing on the scope and mission of TP, changing governance, including more professionals). Some projects reported some experienced resistance when they wanted to redefine their area of activity into neighbouring area's.

- Projects with an area of activity congruent with the provincially MHCCP, experienced that eligible patients often lived outside these provincial boundaries while their providers functioned within the province: This revealed to be a problem for providing adequate services.

Some TP with rather large area's of activities subdivided their initial area. Defining larger catchment area's (e.g. the whole French speaking region) increased the chance to realise the caseload, but requires though to reflect on the organisation of the collaborative practices. In the Flemish parts some projects split the catchment area in more delineated sub-areas for which activities and professionals to be included were identified. Often this subdivision is made to allow professionals and persons involved to work with patients, professionals of providers with whom they are used to work. One project argued that sub-dividing the area of the TP was a means to guarantee that all partners could propose patients for inclusion This latter project even used inclusion thresholds on the number of patients to be included on the level of sub-areas.

Larger areas of activity put a burden on resources (to much transport and use of time (including the cost factor for agencies and professionals) when many meetings are needed,..) which at a certain stage impedes the will and motivation to keep participating.

- Although very specific, but worth mentioning are the problems of projects who are working on cross-border areas (e.g. German speaking area of Belgium where collaboration is developed with services in Germany as the area lacks adequate support service). This projects is confronted with particular practical and administrative problems concerning cross-border health care use.

### **Key points**

- **Projects use different perspective on this “area of activity”:** in some projects the reference basis for defining an area of activity is the providers that offering services (mainly hospitals). In this perspective patients are considered eligible for inclusion when they use the services of TP partner within the area of activity.
- **Overall projects have delineated their catchment area on the basis of the working area of their core partner organisations, or on the residence of patients of a hospital partner (on the base of the RPM data), rather than on an assessment of the needs of a defined population.**
- **The choice for an area is pragmatically based on the activities of preexisting collaborations between partners**

## 6 GENERAL DISCUSSION

### 6.1 THE SCOPE OF THIS RESEARCH PROJECT

The initial intention of this research was to assess to what extent the proposed collaboration models by the sector contribute to the development of needs-based care and reach the aim of continuity of care in a less residential-oriented approach for persons with complex and chronic psychiatric problems. However, these initial ambitions cannot be met. The report does not offer information to what extent the provision of mental health care services has been improved with regard to defined targets (e.g. the development of needs based care in a less residential oriented approach), does not offer insights in the effects of these changes on the clinical status and the well-being of the patients and as a consequence, neither does it offer insight on financial efficiency of the models. Due to the circumstances and decisions with regard to a data collection tool (patient monitoring), the research activities ultimately focused on experiences with the implementation of collaborative practices rather than on patient issues.

However, within this reoriented scope the results offer relevant information for policymakers and (future) partnerships wanting to implement collaborative approaches. The findings give clear indications on how the development of interorganisational networks and interprofessional collaboration mirror the characteristics of a complex and layered organisational field. The development of the TPs takes place in complex multi-agent environment and is influenced both by “external” and “internal” processes and barriers, in which interests and values interplay.

This section discusses the main findings, and starts with some methodological considerations to be considered when reading the findings.

#### *Key points*

- **This report does not offer information to what extent TPs improved the provision of care with regard to pre-defined government objectives (e.g. the development of needs based care in a less residential oriented approach). Neither does not offer insights in the effects of these changes on the clinical status and the well-being of the patients and as a consequence, nor does it offer insight on financial efficiency of the models**
- **The results offer relevant information for policymakers and (future) partnerships wanting to implement collaborative approaches. The development of collaborations takes place in complex multi-agent environment and is influenced both by “external” and “internal” processes and barriers, in which interests and values interplay.**

### 6.2 METHODOLOGICAL ISSUES

#### 6.2.1 Overall limitations

Some reflections should be made on the use of the data sources. The findings are based on document analysis, interviews and focus groups aiming to understand the implementation of organisational innovations in a real world context. The documents were used to understand the design and aims of the TPs. This information was complemented with in-depth interviews to better understand the development of the TP plan and have a better understanding of the projects. The focus-groups were organized after two years of implementation experience with the TPs. Based on these qualitative data the inventory is made of facilitating and hindering factors for collaboration. The data-collection and analysis thus only allows to organize and summarize factors playing a role during implementation, rather than an in-depth analysis of the effectiveness or efficiency of TPs. So the findings of this research (and the experimental experiences of the TP) do not allow to draw any conclusions on the development of care programs or care circuits.

The analysis of the TP is cross-comparative, meaning that we did not focus on an analysis of each individual project.

Neither does this analysis represent an in-depth analysis of the visions and opinions of different interested parties participating in the projects. We sampled interviewees as representatives of the projects, not at the level of different professional categories, managers, or representatives of individual organizations. The data allow however on the content level to detect different opinions and meanings about TPs within the project. As was already indicated in the results section, the process of implementation is to a large extent an issue of developing a shared meaning and understanding of aims and working processes taking into account the interests of those involved.

The analysis focuses on an inventory of themes rather than a statistical description of the number of problems mentioned in terms of frequencies. We aimed at content generalisability rather than statistical representation, which is a common approach in qualitative research designs.

#### 6.2.1.1 *Patient monitoring*

The formal decision not to implement a patient monitoring limits the knowledge generated on patient information in the projects. 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.

#### 6.2.1.2 *Interviews*

The first round of interviews with representatives of the TP were done in stage where the TPs were already formally launched. In the interim reports we discussed the issue of the 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 nearly two years) For some TPs this implied 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.

Moreover, a retrospective interpretation of the initial plans can induce a reinterpretation of the initial meanings given to the projects based on ongoing experiences. Within these constraints the cross-comparative analysis shows though that similar patterns emerge with regard to the development of the plans (and its impact on the implementation of the TP).

#### 6.2.1.3 *Focus groups.*

Focus groups per cluster and language group were chosen for collecting data on implementation experiences for feasibility reasons (timing and practical modalities to reach all projects). Methodologically we could have opted for interviews at project level, but practical constraints did not allow for this strategy. A future additional step for this type of research would be to develop validated questionnaires in order to retrieve the opinions of the different stakeholders involved.

A focus group allows sharing of ideas with people who have lived the implementation of the TP. This interactive approach is an excellent tool in a cross-comparative approach. The reported lived experiences of people involved in the TP offer rich and useful material on practical conditions and experiences with the implementation of the TP. One has to remain aware, although we urged the projects to delegate different stakeholder perspectives on their project, the analysis does not allow to confront different perspectives of different stakeholders within the project. It were mainly coordinators of the projects that were participating, and certainly not all professional groups or representatives from individual TP partners.

#### 6.2.1.4 The research team

The composition of the research team has changed a couple of times in the course of the three year project. These personnel changes had implications on developing an analysis of a rather complex field of innovations, especially since in more qualitative oriented approaches the researchers themselves build a lot of tacit knowledge along the research process. As a result, we probably focussed more on the communalities than on an elaboration of the differences with the implementation experiences.

#### Key points

- **The analysis aims at content generalisability not at statistical representation**
- **The data-collection and analysis only organizes and summarize factors playing a role during implementation, rather than drawing conclusions on the effectiveness or efficiency of TPs.**
- **The data collection methods did not focus on an in-depth analysis of the visions and opinions of different interested parties (different professional groups).**
- **The formal decision not to implement a patient monitoring limits the knowledge generated on patient information in the projects.**
- **Personnel changes had implications on developing an analysis of a rather complex field of innovations, especially since in more qualitative oriented approaches the researchers themselves build a lot of tacit knowledge along the research process.**

## 6.3 FINDINGS

### 6.3.1 Preparing the design of the collaboration

A first observation concerning the plans is that the reflections on and identification of particular working objectives remained very general in most of the projects. 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.), but not elaborated. 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'. Projects do not analytically separate objectives on patient level or objectives in terms of the partnerships. 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).

The guidance framework of the government's tender combined with bottom-up strategy has lead to a great variety in collaboration designs, on the level of aims, partners, working processes, etc. The differences can to a large extent be explained on how TPs deal with intertwined dimension "*organising and coordinating the partners of a TP*" and "*coordinating activities around the patient*". Projects seldom clearly disentangle both aspects. They implicitly focus more on one of these two dimensions namely the inter-professional collaboration around the patient. Projects are generally not very explicit on the partnership model. This seems to have an impact on the daily functioning of the TPs, as we clearly heard that organizing activities and inter-professional collaboration has to be embedded in a well elaborated inter-organisational model.

Previous experience influences the development of the TP-plan. The interpretation of what is to be considered as a TP is not developed in a knowledge void, it thrives for many partners on experiential knowledge with previous collaboration experience. A substantial part of the TPs has developed a TP-plan that is largely inspired by previous experiences or ongoing initiatives. Previous experiences of partners had an impact on setting the scope of the TP. 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 design of the individual TP plans was also strongly influenced by the MHCCP. The TP-proposals reflect strategic choices taken at the provincial level. 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), especially in the French-speaking part of Belgium.

The preparation and implementation process 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. Developing a shared language and common understanding of the activities requires bridging language, norms, values and expectations particular to domains and professions. This requires time. The negotiation process becomes even more apparent during the implementation phase than during the preparation phase, as in many projects the actual preparation and writing of the plans was in many projects done by individuals or core groups (see results section). It seems that TPs with a more elaborated preparation process allowed for a better common understanding between all the partners than projects with shorter preparation times. In the same way, the more involved partners and the greater the diversity between these partners, the more difficult it is to progress towards a common view on the TP. Clarifying the expectations and working practices and involving different levels of the partnership in the preparation phase seems to facilitate the implementation, though. 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.

### 6.3.2 Variety of collaboration configurations

The government-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 have been involved in the partnership. In general, the number of primary care partners is smaller than the number of partners from second and third line. Part of the explanation is that (mainly Dutch-speaking) projects involved umbrella organisations of the ISHC rather than individual primary care providers. Moreover, the complexity varies substantially.

#### 6.3.2.1 Complexity

##### **Number and type of partners**

The structural complexity of a partnership is determined by the number of partners, the mix of public service sectors involved and the task differentiation between partners. Moreover, the governments framework allows to differentiate between formal partners and informal partners (those signing an agreement versus those partners collaborating without signing a TP agreement). The complexity of the partnership has a big impact on the working practices implemented and it seems that this dimension of establishing collaboration is often underestimated.

Configurations of partnerships tend to differ between clusters. The “functional needs” to compose a partnership is affected by the clusters (without saying that there is a linear relationship). 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 For elderly the focus is put a lot more on including the primary care sector mainly to guarantee early detection of mental health problems.

The choice is not solely functionally determined. Many other factors also affect the configuration. Regional differences seem to emerge with regard to both the number and the role allocated to the partners involved. Some large partnerships are found amongst the Dutch-speaking TPs, but the mean number of formally involved partners is higher in the French-speaking TPs. This is certainly affected by the projects from the Liège region, but it shows that the bottom-up strategy mirrors local preferences and perspectives.

Beyond the distinction between formal and informal partners, we observed in quite a large part of the TP a difference between “core” and the “peripheral partners”. This difference does not coincide with other characteristics. In structural network analysis this difference would show in the number of operational and strategic activities passing via these partners. Core partners are often the strategic partners for the viability of the network. Indeed, they play crucial 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.

### ***Integrating primary care***

The obligation to include primary care in the partnership is for the entire sector a challenge. Most projects intending to include individual GP in the TP found themselves facing a series of practical problems. Other projects involve the general first line by means of the ISHC 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.

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. It is often stated by the projects that this obliged inclusion required a particular reflection on the design and tasks of this sector in mental health care. One of the future challenges for government initiatives will therefore be to actively involve primary care partners at the different levels of activity in the partnerships.

This *overall* integration of the primary care sector is certainly not realised in the majority of the TPs. The issues mentioned to integrate this primary care sector refer to resource issues to participate, mental health care competencies, cultural differences between primary care and the psychiatric sector, the difference of mobilizing umbrella organizations versus individual GPs.

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 and inter-professional conflicts. 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.

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 umbrella 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 to facilitate 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 (except for some GPs working in ‘Medical Houses’. These latter are more familiar with teamwork and sharing of patients).

## **Hospitals**

In both Flemish speaking and French speaking projects the hospital remains a key partner. Psychiatric hospitals seem to be the key players at the Flemish side while French-speaking projects depend to a large extent on general as well as psychiatric hospitals as the central actor. Indicators are 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. Part of the explanation can probably be found in the fact that in French speaking projects the (hospital) psychiatrist is seen as the dominant player in the collaboration around the patient. In many Flemish-speaking projects seem to develop more broad approaches to actively engage a broader range of partners in the actual collaborative management.

## **Modalities of coordination**

Consistent with what is described in inter-organisational network literature, we observed that the complexity of the network has implications on 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.).

Although the governments' call requested a number of meetings, it is still quite striking to observe that activities on different levels are almost solely coordinated through the mechanism of meetings. Only during implementation (some) projects developed supportive mechanisms to reduce the burden of time and resources of these meetings for the people involved. Especially on the governance of the partnership activities projects experience the need to develop other mechanisms in order to improve the efficiency of the collaboration.

Projects have developed different modalities for organising 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 is involved less in patient-related activities, more differentiating arrangements seem to develop in organising the patient meetings.

### **6.3.2.2 The coordinator**

Most projects see a coordinating person as the key for maintaining a collaboration. This does not necessarily imply that projects have defined a very explicit task description of this coordinator in advance. Because of this lack of clearly elaborated governance model in the planning of the projects, a lot of energy and time has to be spent on identifying practical working modalities. The content of work and the availability of support functions differs widely between projects. The coordinator 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 obligations. Often this coordinator is also the general "reference person" and key contact for all matters concerning the project.

The projects reported different experiences concerning the role of the coordinator in managing the partnership and the patient related issues. The role of the coordinator and identifying the content of its tasks is a process of learning by doing along the way. Many projects 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. On top of that, 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.

Collaborating partners and individual professionals expect leadership from the coordinator. Partners have high 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 on the one hand the role of the coordinator by the partners on the network level and on the other hand by individual professionals. 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 cases 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. If coordinators combine a role in the collaboration activities around the patient, the professional profile of the coordinator appears to be a core issue in this acceptance and legitimacy. Clinical expertise or at least acquaintance with the care processes and knowledge of patient profiles are needed to function smoothly at this level.

We have been told about projects in which a project coordinator resigned because of job strain and because of a lack of legitimacy. Resignations or dismissals have often led to setbacks and further difficulties in the functioning of the TP, and the process of building trust and giving meaning to this role had to be started all over again.

### 6.3.2.3 *Tools*

The use of support tools varies between projects.

There are some cluster related patterns having an impact on the use of tools especially at the patient level (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 we discussed in the results section, many other tools can be used to support the collaboration. The major objective of the use of tools is to support the efficiency of working practices both on partnership level and the level of collaboration around individual patients. It is clear from the findings that projects still have a way to go to develop, implement and use instruments to increase the efficiency.

#### ***The 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.

As mentioned in the results section some projects integrated previously developed (ICT supported) care plans in their practice or common care plans were developed by all projects in a certain area (Liège). The advantage is that standardised reporting tools are being used. However particular attention needs to be paid that the care plans are sufficiently adapted to the context of mental health care provision. Moreover, the introduction of a care plan should be assessed on the extent to which duplication of administrative work is being introduced.

### 6.3.3 Interprofessional collaboration

The introduction of new modes of working, requiring the collaboration of different individual professionals working in different organisational contexts is a learning experience, often going hand in hand with many difficulties. Many efforts are needed to convince individual professionals by means of information and gradually developing a feasible working process. Moreover, management support is also needed to free individual professionals to participate in meetings.

Important constraints for convincing individual professionals to collaborate are the time investment and the financial rewards, but more important seems to be the resistance related to the expected added value of the new modalities being introduced. The experiences with the TP learn that important efforts are needed on optimising the modalities for inter-professional collaboration. For many (medical) professionals the efforts to participate in collaborations are still too much a burden. If the conditions do not allow to increase the efficiency (and effectiveness) of collaborating professionals will tend to withdraw from these activities.

One of the challenging questions to be further reflected upon is the place where meetings will take place in order to keep professionals committed

It should be questioned too whether and to what extent meetings with professionals should be paced in different stages of the trajectory of the patient and whether for every meeting all professionals should be involved. Based on the experience and for those projects where real discussions take place and collaborative decisions are taken on content of support, a collaboration in the form of a meeting seems useful. However, one can doubt whether the intended objectives of interprofessional collaboration (shared care) are met if the meeting is reduced to instrumentally allocate tasks and responsibilities to partners. It emerges clearly that not in all projects the interprofessional collaboration is modelled around the ideas of collaborative or shared care.

Another recurring issue emerging as a barrier in the collaboration process is the acceptance of sharing information between different partners. The aspect of professional secrecy and sharing of information has to be handled before the launch interprofessional collaboration, in order to avoid fundamental barriers in the collaboration.

### 6.3.4 Promotion of the TP

The objective and working modalities of a TP cannot be taken for granted as soon as a TP plan is written. Projects experience the necessity to communicate and promote the objectives and working practices of the projects. Which requires a lot of time. Promotion is needed at three different levels, i.e. promotion to the partners, the individual professionals and 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.

### 6.3.5 Working with patient groups

#### ***The selection of the 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. Overall it are the core partners proposing patients for inclusion, and generally the ones of the initiating partner or the TP that 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.

Tps make pragmatic choices to select a target population mainly to ensure that the preset caseload is obtained. It is certainly not clear at all to what extent the Tps have reached the intended population of patients with chronic and complex problems .

#### ***Chronic and complex***

The government’s tender is developed around the notion of “complex and chronic” psychiatric patients. The results section 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. Particularly for the cluster elderly and the cluster children and adolescents it could be questioned whether the chosen target populations really addresses the intended public. The experiences also demonstrate though that the problems and mental health needs of these clusters differ from the cluster adults.

#### ***Diagnosis***

We already introduced the problems projects see with use of the DSMIV and the need to obtain a psychiatric diagnosis as a condition to be included. 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.

### 6.3.6 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.

### 6.3.7 The governments framework

The governments 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 is 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.

Most projects formulate specific remarks on the administrative requirements of the TP-framework. Projects have mixed opinions towards the obligatory constitution of the formal partnership. The obliged participation of services of second and third lines is considered to allow a continuous exchange of expertise. But in some clusters interviewees stress the potential risk of medicalisation and stigmatisation, mainly for those projects working with children and adolescents. The obligatory involvement of primary care services is considered as important in the light of community mental health care (especially with regard to the participation of the GP), but their involvement in the day-to-day practice around the patient is not always considered relevant.

As can be compared with 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 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.

Much of the resistance or reluctance to participate actively in projects has to be understood against the background of the information of the government and the concerns about the parallel 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.

### **Key points**

- **A recurring issue emerging as a barrier in the collaboration process is the acceptance of sharing information between different partners. The aspect of professional secrecy and sharing of information has to be handled before the launch interprofessional collaboration, in order to avoid fundamental barriers in the collaboration.**
- **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. Particularly for the cluster elderly and the cluster children and adolescents it could be questioned whether the chosen target populations really addresses the intended public.**
- **The bottom-up approach, which called for partnership proposals from the sector is 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.**
- **Government initiatives 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. Currently the sector itself lack the capacity to develop it purely in a bottom-up way**
- **The sector clearly experienced a lack of a clear, coherent, consistent and continuous communication on the government's framework and the intended objectives.**

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