

Reconfigurations of the Belgian health sector. An experimentation: the therapeutic projects

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KNOWandPOL

ORIENTATION 2

Public Action 1

WP 10

September 2009

www.knowandpol.eu

Project no. 0288848-2 co-funded by the European Commission within the Sixth Framework Program

Table of contents

INTRODUCTION	1
1. THEORETICAL FRAMEWORK: PUBLIC ACTION AND KNOWLEDGE	5
1.1. <i>Public action sociology</i>	5
1.2. <i>Public action approach characteristics</i>	6
1.3. <i>Regulation</i>	7
1.4. <i>Knowledge and learning</i>	8
2. ELABORATION PROCESS	10
2.1. <i>History of the Belgian mental health sector</i>	10
2.2. <i>New vision of the mental health care</i>	11
2.3. <i>Convergences on a vision of mental health care</i>	21
2.4. <i>Description of the therapeutic projects</i>	23
2.5. <i>Elaboration process: from principles to concrete modalities</i>	28
3. IMPLEMENTATION PROCESS	30
3.1. <i>Accumulated delays</i>	30
3.2. <i>Call for projects</i>	31
3.3. <i>Project selection</i>	33
3.4. <i>Launching of the therapeutic projects</i>	34
3.5. <i>Cluster "General psychiatry – Adults"</i>	37
3.6. <i>Implementation process or the diversity of local initiatives</i>	41
3.7. <i>Focus on a therapeutic project – Local case</i>	41
4. EVALUATION – CRITICAL EPISODE	49
4.1. <i>Evaluation procedures</i>	50
4.2. <i>Results</i>	51
4.3. <i>Strained Relationships</i>	53
4.4. <i>Interpretation and analysis</i>	55
5. THE REGULATION	59
5.1. <i>Top-Down Regulation</i>	60
5.2. <i>The bottom-up regulation</i>	67

CONCLUSION.....	72
COMPARISON ZONES	76
<i>Comparison zone n°1: time line.....</i>	<i>76</i>
<i>Comparison zone n°2: paradigm shift</i>	<i>76</i>
<i>Comparison zone n°3: knowledge and knowledge holders in conflict</i>	<i>82</i>
<i>Comparison zone n°4: knowledge policies</i>	<i>87</i>
<i>Comparison zone n°5: Knowledge and policy constellations</i>	<i>90</i>
<i>Comparison zone n°6: Knowledge in the wider public sphere</i>	<i>94</i>
<i>Comparison zone n°7: Local actors in the central decision-making process</i>	<i>97</i>
<i>Comparison zone n°8: Circulating patterns beyond the borders of the sector and the country</i>	<i>99</i>
<i>Comparison zones 9: The role Europe (as an institution and as a space) plays in the circulation of 'knowledge' participating in public actions at the national level".....</i>	<i>102</i>
BIBLIOGRAPHY	104

Introduction

Belgium is a Federal State with a parliamentary form of Government under a constitutional monarchy. It is divided into three linguistic communities (the Flemish, the French and the German communities) and three geographical regions (the Flemish, the Walloon and the Brussels Capital regions). Belgium is a complex and decentralized system as each level exerts its power independently within its scope of competences. Health competences are shared between those levels of power – federal, regional and communitarian. “It doesn’t exist any coherent and global policy project neither on the mid-term, nor on the long-term. There is no articulation between the preventive and the curative, there is no coordination between the different levels of power”. (Jadot 2003: 75; free translation)

Belgium is a “consociative democracy” (Lijphart 1969) which is anchored in a societal organisation on two pillars: catholic and non-religious. The Belgian political system is characterised by its influent pillarisation (Kuty 2005). “An influential aspect of Belgian society is the historically important ‘pillarisation’. The political parties emerged from strong social divisions. Church, state, regional differences and class divisions have been important in this regard. The political factions that were born out of these rifts were connected to highly developed and segmented socio-political networks: pillars of organisations (schools, health insurance, etc.) taking care of the members as well as their families [...]. The trade unions are a reflection of this historic pillarisation, and are clearly divided along these lines [...]”¹ This type of model presents two particular characteristics.

First, political representation is proportional. Each power level has its own Parliament with proportional representation of political groups and its own Government. Negotiations take place at each level, no party having an absolute majority of seats. « The complex game of cleavages, both effect and cause of conflict, call for the compromise » (Mabille 1997, free translation). The power levels multiplicity necessitates coordination structures within which interinstitutional negotiations occur. In the health sector, the Inter-ministerial conference for Public Health brings together the seven Ministers in charge of health.

Second, economic and social elites actively participate in the decision-making process. In the health care sector at the federal level, numerous consulting boards are active. They all have their own missions and scopes of competence:

¹ http://www.eurofound.europa.eu/eiro/country/belgium_2.htm

- the National Council for Hospital Facilities,
- the Multipartite structure in Hospital policy matters,
- the National practitioners-hospitals Commission with equal representation on both sides,
- seven Commissions, among which the Patient's Rights Commission,
- four federal dialogue platforms among which the mental health care platform,
- three Committees,
- the practitioners' colleges.

Those two dimensions tend to favour a mode of functioning based on compromise, the "Belgian compromise".

Within the framework of the Know&Pol research project, we more particularly invested the mental health field in Belgium.

A first exploratory phase led among various stakeholders whose activity falls within the mental health field revealed the "centrality" and importance of all dialogue and coordination practices. Within this framework, the federal pilot project "therapeutic projects and transversal dialogue" represents a potential for important change and is at the heart of serious stakes in care financing and organisation and coordination between different power levels. We made a distinction between therapeutic projects which will be the subject of the current study and transversal dialogue which will be considered in a second study.

Given the innovative and strategic dimensions of the therapeutic projects, it seemed relevant to work on that subject, which is currently at the centre of debates that preoccupy the sector and mobilise its actors. Nevertheless, this advantage is counterbalanced by the fact the research subject is a current event. Projects started on April 1st 2007 for a three-year period. Our research was completed in the course of the action. Indeed, actors are very involved and do not necessarily have the opportunity to develop a reflexive look at their practices.

When considering the French-speaking part of Belgium, health competences are shared among the three power levels concerned in this territory: the Federal State, the Regions (the Walloon Region and the Brussels-Capital Region, each in its territory) and the Communities (in the French Community and Brussels). Competences are divided according to the linguistic role played by the French Communitarian Commission, the Flemish Communitarian Commission and the Common Communitarian Commission (when bilingual cases). The Federal State kept its prerogatives on social security and

The second hypothesis fits in a perspective developed within the framework of the Know&Pol research project. It relates to the changes in the mode of regulation of contemporary societies. We will rely on a possible shift from a traditional bureaucratic model to a post-bureaucratic model characterised by, notably, diffusion of New Public Management, knowledge-based regulation, new governance, policy networks, scientisation of knowledge (Steiner-Khamsi 2008).

To write this report, we thought it was essential to present theoretical markers which influence our field work and the analysis of collected data. To make our material intelligible, we distinguished between the process of elaborating public action on the one hand, and the implementation process on the other. We will examine in detail those two processes by emphasising their characteristics and specificities. We will then focus on the evaluation practices that are at the heart of our case study. To give coherency to the analysis, we will underline the multi-polar regulation in action in the public action system studied.

1. Theoretical framework: public action and knowledge

Before proceeding to our research field description and analysis, it is important to prepare the ground by presenting some theoretical marks to give a better understanding of the subject.

Our research approach falls within the general framework of public action sociology which leads to the State's role being relativised. Contemporary public action is characterised by the diversity of participating actors, the plurality of power levels involved and the extension of public intervention scope. Increasingly complex public action led us to understand the system under study by reference to the regulation notion. This last one renders an account of political decision making and complexity of implementation processes by encouraging a public-action negotiated perspective.

Mutations which appear in the society governing mode also pushed us to develop questions related to knowledge and learning in a social and processual perspective.

1.1. Public action sociology

Public policies analysis was developed in the 1950s in the United States before arriving in Europe in the 1970s. Until then, studies focused on the State as an institution, particularly in France. In the 1970s, this literature allowed clarifying a paradox, the one related to the extension of the State intervention parallel to its intervention modes crisis. "If [the public policies analysis] had been a crisis thought, the one of a State that we had been wanted as a Welfare State and dominant and that was appearing as weak and undecided. Now, it has to participate to the reconstruction of a policy still not completely efficient, but which try to define both the principles and the conditions of its legitimacy, and the space which is its own." (Duran 1996: 108, free translation). Policy analysis explains the inefficiency of the Welfare State's action, notably with respect to the theory/implementation gap.

Policy analysis is situated at the intersection of various disciplines (sociology, political science, economy, law, etc.). This multidisciplinary approach constitutes its richness but is also the origin of its deficiency in recognition as a scientific discipline. Policy analysis must revitalise and fall in a broader perspective, that of collective action sociology. "It's for this attention paid to the new public issues that it's original and of interest because it can offer a realistic and stimulating frame to study the public action with a reintegration of the society into the policies." (Duran 1996: 111; free translation).

For many years, the influence of field actors at the implementation level has been demonstrated by most of the authors who devote an appropriation by the local of national (or regional in federal States) directives according to the specificities of the

context in which they are inserted. Recording policy analysis in a broader perspective attests to openness of the complexity of configurations resulting from the policy implementation. "The use of the concept of « public action » mark a change of perspective in comparison to the knowledge domain of social sciences devoted to the « public policies » [...] This shift marks the choice of approach which take in account both the actions of the public institutions and those of many actors, privates, publics, from the civil society or from the State bodies, all acting together, with multiple interdependence, at national, local or supranational level, in order to produce a regulation of the collective actions [...]." (Commaille 2004: 413; free translation)

1.2. Public action approach characteristics

The public action perspective led to the State being revitalised, "Understood, from now, in interaction rather than in action" (Le Galès, Thatcher 2000: 106; free translation), and to de-focusing attention on the decision-making phase. The State is perceived as an actor among others, in a exploded and complex landscape, where the various phases of public action become muddled.

1.2.1. Actors diversity

Public action is no longer the State's own will, "public policies appear now rather as the product of multiple initiatives." (Gaudin 2004: 2; free translation). Public action is conducted jointly by public actors, coming from various power levels, and private actors, whether they are social or economic actors. Multiple partnerships develop. Moreover, new actors appear, like citizens or users whose position in the public space is becoming more visible.

1.2.2. Public power level plurality

National level is no longer the more relevant level of analysis in a public action approach. The State lost its monopoly over the political decision making process. In Belgium, the Federal State is traditionally considered as a weak State because civil society, structured around pillars, is relatively well anchored in the decisional sphere. Moreover, since the 1980s, Regions and Communities have their own scope of competences where they are autonomous. New extensions of the federated scope of competences are to be envisaged. In addition to this federalisation, there is an opening that is directed up and down. Upwards, supranational and international bodies intervene increasingly in public management via directives or comparison standards. Downwards, through decentralisation processes, local entities have an increasing role whether at the public action implementation level or at the elaboration phase. "[The policies which are said multilevel] correspond to some forms of intense cooperation (voluntary or obligatory)

between the different levels of power which are distributed between different territorial scales." (Gaudin 2004b; free translation)

1.2.3. Public intervention domain proliferation and porosity

The current context is characterised by a public action domains "de-differentiation"² phenomenon. We thus witness the overlapping of previously autonomous and self-centred fields to which used to be managed by differentiated and specialised administrations. "The contemporary era [...] has known several grouping attempts [...] et some forms of deep interministerial coordination while new intersectorial domains of action were emerging [...]." (Gaudin 1999: 39; free translation)

Public action analysis aims to take into consideration the complexity of the political landscape. It underlines the necessity to analyse new forms of political collaboration and action. "The issue of the compatibility or of the need for a coherent public action in which many agencies, systems or level of actions are implicated, can lead us to use the concept of regulation." (Commaille 2004: 419; free translation)

1.3. Regulation

The regulation concept renders an account of the political decision making and implementation processes complexity. This concept can be found in numerous French speaking³ articles and books on public action.

At the theoretical and empirical levels, the notion of regulation takes root in works originating in two main sociological domains: sociology of industrial and labour relations and sociology of organisations. Their method of reasoning was then applied to public action systems, "namely [systems] of interdependent relations of exchange between some individuals or groups intervening on a common issue." (Thoenig 1998: 41; free translation)

The notion of regulation emerges in response to the faults and failures of the two traditional types of social normativity, that of the State and that of the market (Timsit, 2004). Those two mechanisms, taken independently, do not account for changes which intervene in the public management modes. For Commaille and Jobert, regulation is no longer the prerogative of the State, it is multi-polar. "The multiplicity of bodies and actors established in a growing relative autonomy, with new possibility of intervention,

² The functional dedifferentiation is opposed to the functional differentiation which characterises the Welfare State model and which is made concrete by field autonomy and by connected sector incursions shunning. (Genard 2003)

³ In this paper, we will use the concept of regulation in its meaning in French literature. Without entering into this debate, discussed in several books, we want to say that it has another significance in English.

allow to talk about a polycentric form of regulation of the social and of the policy » (Commaille, Jobert 1998 : 15; free translation)

This new mode of regulation necessitates new devices like public action proceduralisation or contractualisation development.

1.3.1. Proceduralisation

In the presence of the burst of and complexification public action, we are witness to a public action proceduralisation, that is " a type of public action which operate by the territorial establishment of instruments of knowledge, of deliberation, and of decision-making which are not much finalized a priori." (Lascoumes, Le Bourhis 1998: 39; free translation). Unlike "substantial" policies which determine clear objectives as well as an implementation rigid framework, procedural policies aim to achieve general objectives, anchored in local specificities. "The rules are interpreted, adjusted in their universalism to the particular cases, differentiated in accordance with the local scene of their implementations" (Thoenig 1998: 38; free translation)

1.3.2. Contractualisation

Contractualisation has become a means to coordinate actions by numerous actors who fall within public or private public action whether coming on the local, national or supranational scale. Contract, as "a supple device of coordination and of harmonisation." (Chevallier 2003: 216; free translation) maintains a certain degree of public action coherency while leaving the actors some breathing space.

Following these various elements, we can consider negotiated public action. "The public action is becoming the result of a long, complex and sinuous process, to which various actors are invited to take part. This confrontation must allow to reach the best equilibrium possible between different contradictory imperatives, and divergent interests; the public action is from now in debate, open to the negotiation. (Chevallier 2003 : 214; free translation). The degree of openness towards actors, within this negotiation process, is evidently variable.

1.4. Knowledge and learning

Work that deals with public action analysis emphasizes transformations which appear in modes of society governments. These changes in the regulation process have repercussions in governments which have to respond to efficiency demands requiring new skills development and to find new ways of gaining legitimacy (Pons, van Zanten 2007). In a changing context, knowledge becomes central and "learning imperative" (Schon 1994: 221; free translation) spreads.

In scientific literature, notions of *organisational learning* and *organisational knowledge* are approached according to two distinct and independent approaches, creating theoretical confusion and disorder. Chiva and Alegre propose to go beyond this distinction by supporting an integrated approach that reconciles the two notions (Chiva, Alegre 2005). This approach emphasizes a perspective in terms of social process and the idea that "[...] reality is socially constructed or conceived and is based on social interaction and discursive behaviour, which give rise to social constructions" (Chiva and Alegre 2005: 57). Learning and knowledge are fixed, they develop constantly; they are processual.

Our analysis falls in this perspective and favors relational and dynamic dimensions of knowledge and learning, while replacing them in an approach of public action. "The use of the concept of learning give us two possibilities to enrich the analysis of the public action. It permits to enlarge the reading by introducing the issue of the knowledge and of the use of information in the conduct of the governmental programs. [...] [It] lead us also to replace implicitly the public action in a temporality and to analyze how the individuals perceive the effects and the results of anterior policies, and how they try to modify the course of the public action" (De Maillard 2004 : 58; free translation).

Presenting theoretical and methodological markers which have guided our field work and our analysis will allow readers to understand our reasoning better. Once the interpretation framework is defined, we can move to the description and analysis of the public action elaboration process and its implementation process.

The first institutionalisation forms of this movement are found, in 1975, in the legislative creation of the ambulatory sector⁴. The legislator's will, in 1975, was to establish a mental health ambulatory sector, by giving it status and means according to its assigned missions. Recalling that this approach contextually falls in the time of protest against the monopolistic cultures of asylums and of opening towards social psychiatry practices in partnership."⁵

In Belgium, the ambulatory sector was created by opposition to the hospital sector. "When mental health services were created, they wanted to distance itself from the true blue psychiatry, psychiatry which did not have a nice corporate image. They wanted to do a very innovative movement at the care level, they did not want to say that they did psychiatry but mental health."⁶ Competition between these two sides to mental health was reinforced by the devolution process in 1980⁷. Some people talk about a "real trench war".⁸

2.2. New vision of the mental health care

2.2.1. Genesis of the new vision of mental health care in Belgium

At the end of the 1980s, a study, commissioned by the Minister of Social affairs Busquin, emphasized "the necessity of a resocialisation of the chronic patients stabilised in their own living environment." (Groot, Breda 1989; free translation). Following these conclusions, in 1990, an important reform of the psychiatry sector came into being. It was inspired by the reform carried out by previous Minister Dehaene in long-term care which consists in reconvertng beds into Care and rest homes. The main goal of the 1990 reform is the 'dehospitalisation' of psychiatric patients.

A set of Royal and Ministerial decrees of July 10th 1990 is aimed "expressly [...] [at] a mental health care improvement",⁹ notably through the creation of residential alternative structures, psychiatric nursing homes and sheltered accommodations.

⁴ Royal Decree of March 20th 1975 on the approval of Mental Health Services and the grant of subsidies.

⁵ Comment text written by T. Lahaye, civil servant at the Administration of the French Communitarian Commission, cited in *Actualités en santé Mentale ambulatoire, Rapport sur l'évaluation de l'activité des Services de Santé Mentale bruxellois francophones (juin 2001)*, Les Cahiers de la Santé de la Commission Communautaire Française, n°17, 2001 – Free translation

⁶ Quoted from an interview with a hospital sector representative

⁷ Institutional Reform Act of 8 August 1980. MB 15/08/1980

⁸ Quoted from an interview with a hospital sector representative

⁹ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the psychiatry reconvertng evaluation of May 9th 1996

The reform provoked an upheaval in the hospital sector, particularly in Flanders where the inner care capacity is more developed for historical reasons. *“The fact that there were so many psychiatric beds in Flanders, it is because in years when those institutions were created, in the 17th-18th centuries, misery was principally located in Flanders. And this misery and the whole social life were carried by congregations which created orphanages, care institutions and notably psychiatric institutions.”*¹⁰ Moreover, this reconverting was not perceived by the sector as constructive; on the contrary, it was criticised because it did not include a project for the future.

In 1995, the “Psychiatry” permanent work group of the National Council of Hospital Facilities was created. The National Council is composed of members who either have a particular knowledge of the sector, participate in hospital administrative management, are concerned by hospital medical or nursing activities, or belong to insurance bodies. The National Council is a consultative body which must compulsorily be consulted about any questions related to hospital policy. It provides opinions to the federal government.

The “Psychiatry” work group prepares and writes opinions which are then ratified by the National Council. It is composed of representatives of hospital federations, representatives of the sector from the various regions, managers, professors from the various universities and, for the first time, representatives of the Communities and Regions.

The “Psychiatry” work group played an important innovative role in mental health policy matters. Its members achieved profound thinking on mental health care organisation, initiated in the 1980s, on several points.

The prevailing approach in mental health in Belgium at that time was put into questions. On the one hand, psycho-social problems, mostly managed by the outpatient sector, and psychiatric diseases, generally treated at the hospital, are perceived as the two extremes of a continuum comprising a broad range of situations. Thus, the necessity to create intermediary structures¹¹ between inner and outer appeared. On the other hand, psychiatric and psychic problems are addressed as the result of a combination of three factors: social, psychological and biological. These three aspects must be taken into account in the treatment. From this twofold observation, a perspective turnaround emerges: the care approach must be centred on the patient and his or her needs, no longer on the care offered.

¹⁰ Quoted from an interview with a hospital sector representative

¹¹ Psychiatric nursing homes and sheltered accommodations are part of those intermediary structures.

Members of the "Psychiatry" work group then carried out an inventory of what was happening in matters of the offer of mental health care in other countries like France, Italy, England, Denmark, and so on. Study trips were organised in that perspective.

Among the members of the "Psychiatry" work group, representatives of the two main hospital federations - the VVI (Verbond der Verzorgingsinstellingen) in the North of the country and the FIH (Fédération des Institutions Hospitalières) in the South - played a major role in particular the VVI. The VVI¹² is a federation of almost 80% of psychiatric structures in Flanders and the FIH¹³ represents, in Wallonia, almost half the structures in the psychiatry sector. These two actors carried the project since the first opinions of the "Psychiatry" work group. *"The initiative is ours, we took the pen. And the one who takes the pen, it is him who gives the tone."*¹⁴ The opinions appear to be the subject of a consensus within the "Psychiatry" work group: *"In the group, we understood each other. An understanding existed and it is still the case. There never were linguistic, professional or ideological divergences. Maybe precisely because we started from the same concern: how to better help someone who has psycho-social problems?"*¹⁵

Moreover, these two federations, representing a large part of the sector, not only enjoy great support because they bring their members concerns to the political level, but they also have a heavy weight at the implementation level. *"When the VVI and the FIH push something, the sector follows. [...] With our members, we can try to change mentalities."*¹⁶

Following a question asked by Ministers Galan and Colla, in an opinion of 1996 related to psychiatry reconverting evaluation,¹⁷ the "Psychiatry" work group criticised the financial accessibility of the newly created structures, the patient's juridical status and offer of rehabilitation. It also underlines the necessity of a mental health care policy coordinated between the different power levels and the "development of a more adapted and

¹²In terms of beds, the VVI represents 85% of beds in psychiatric hospitals, 86% in psychiatric nursing homes and 90% in sheltered accommodations in Flanders. Statistics from the VVI 2007 activity report. Source: Ministerie van de Vlaamse Gemeenschap - Administratie Gezondheidszorg - Overzicht erkenningen psychiatrie - Beddenbestand op 23/12/2006

¹³ In terms of beds, the VVI represents 43% of beds in psychiatric hospitals, 53% in psychiatric nursing homes and 45% in sheltered accommodations in Flanders. Statistics from FIH website www.fih-w.be, source : SPF - 01/05/2007

¹⁴ Quoted from an interview with a hospital sector representative

¹⁵ Quoted from an interview with a hospital sector representative

¹⁶ Quoted from an interview with a hospital sector representative

¹⁷ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the psychiatry reconverting evaluation of May 9th 1996

differentiated care offer in the mental health care sector according to a vision in which the patient occupies a central place."¹⁸

In an 1997 opinion concerning¹⁹ the upcoming organisation and development in mental health care, the "Psychiatry" work group emphasized the mental health specificity and "proposes a mental health care development concept which, either on the content side and on the organisation side, differs on a certain number of points from somatic medicine organisation principles and from the hospital concept proper to general hospitals." This concept relies on conclusions from experimentation carried out in other countries and is anchored on the Belgian system's specificities: "Our system's complexity necessitates a specific assemblage."²⁰

The "Psychiatry" work group underlines that the mental health care policy must be organised around target groups and their therapeutic needs. "For each target group, it is convenient to develop a care circuit within the framework of a mental health care network." Notions of *care circuits* and *care networks* appear officially for the first time in mental health in this opinion. These notions were introduced in the Hospital Law²¹ in 1999.

The "Psychiatry" work group suggests that public powers assume a different role, "a stimulation, 'regulation' and supervision role, and that "programming and agreeing norms", based on needs, must have a more dynamic and more objective-oriented nature, and be more regularly adapted to available data on epidemiology and treatment possibilities evolution." The legislative context must leave room to manoeuvre for care stakeholders and institutions while giving them responsibility.

The mental health care reorganisation proposed by the "Psychiatry" work group depends on a transformation model. "*It is necessary to start from the existing institutions and to give them the possibility to redefine themselves, with their means, human resources and knowledge. If you say to an institution that change will make it disappear, it will mobilize its energy to defend its position instead of using it to improve patient care.*"²²

In March 2001, the Minister of Social Affairs and the Minister of Public Health wrote a policy note entitled: "Psyche: my latest concern? Mental health care: participation and

¹⁸ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the psychiatry reconverting evaluation of May 9th 1996

¹⁹ Opinion (second part) of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the upcoming organisation and development in mental health care of June 12th 1997

²⁰ Quoted from an interview with a hospital sector representative

²¹ Coordinated Hospital Law of August 7th 1987, article 9b. MB 07-10-1987

²² Quoted from an interview with a hospital sector representative

coordination paths.”²³ This note promotes a global vision of mental health and underlines the diversity of factors at stake (environment, relationships, psychic condition, etc.). “A mental health efficient policy must be included within a social policy framework.” This note falls within a mental health care reform perspective, the force lines of which are in the “Psychiatry” work group opinion of 1997.

A new vision of mental health care developed and the patient was the starting point. As far as possible, patients receive the necessary care in their day-to-day lifestyle and ambulatory care is favoured. “In other words: home care or ambulatory care if possible, and hospital care if necessary. This choice implies, on the one part, a greater promotion and increased support to the family support as well as the development of ambulatory care, and on the other part, a more rational use of medical technology.”²⁴ The emphasis is also placed on the necessity of a multidisciplinary approach.

From an organisational point of view, for each of the six defined target groups,²⁵ an adapted therapeutic approach should be developed. Moreover, practical and financial accessibility must be reinforced. “This is a desirable and necessary evolution, but it should be carried out progressively. [...] The move to the new structure will only be completely achievable after a reform of the funding mechanism: of funding based essentially on the number of beds, it will have to move to a global budget focused on the target groups and managed regionally.”

The Dialogue Platforms are central actors in the mental health care re-organisation. “In time, the consultation platforms should assume their share of the responsibility in the organisation and the financial management of the care circuits in their own region.”

In Belgium, the mental health sector is complex and several power levels are involved. A mental health care reform necessitates cooperative agreement between power levels but also between field actors. The objective is to favour a decompartmentalized dialogue. “The emphasis is no longer on psychiatry itself but it is moving towards a mental health care integrated approach.”

Following a request written by the two Ministers, the “Psychiatry” work group, in a 2002 opinion,²⁶ formulated a synthetic opinion on the new “mental health care” concept and a proposal for a five-year operational plan.

²³ ‘Psyche: my latest concern? Mental health care: participation and coordination paths.’ Policy note of Minister of Social Affairs, Vandenbroucke, and the Minister of Public Health, Aelvoet, Bruxelles, March 2001- Free translation

²⁴ ‘Psyche: my latest concern? Mental health care: participation and coordination paths.’ Policy note of Minister of Social Affairs Vandenbroucke and the Minister of Public Health Aelvoet, Bruxelles, March 2001- Free translation

²⁵ Target groups are defined in terms of age: youth, adults and elderly people. In addition, other specific groups need special attention: drug addicts, inpatients and handicapped persons with mental disorders.

²⁶ Opinion of the “Psychiatry” work group of the National Council for Hospital Facilities concerning the new “mental health care” concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

The "Psychiatry" work group recalls the basic principles pertaining to the new mental health concept: it must be based on patient, guarantee care continuity in a made-to-measure perspective and be organised on care circuits and networks based on target groups. It is also suggested to favour collaborating with partners from related sectors. Moreover, "implementation of the new concept of mental health care requires federal and communitarian authorities to harmonize their mental health policies and to jointly develop a coherent and integrated offer."

In the interim between the Ministers' request (June 15th) and the "Psychiatry" work group's opinion (July 10th), the Interministerial Conference for Public Health, which is composed of the seven Ministers in charge of health matters, met and agreed on a Joint Declaration.²⁷ This Joint Declaration stipulates that "the new mental health care organisation will be achieved through the concepts of care circuits and equipment and stakeholders networks."

The development of a coherent mental health policy must go through a *cooperative agreement* between the Federal State, the Regions and the Communities. This agreement was never the subject of a consensus within the Interministerial Conference. Criticism essentially concerned the framework's too strict aspect, the territoriality problem, the failure of stakeholders to have freedom of choice and therapy, the fear of a non-pluralistic and hospital-centred network development.²⁸

2.2.2. International movement in mental health care reorganisation matters

Supranational bodies

Various supranational bodies took a stand on the mental health question. Since its creation in 1948, the WHO has fought for an enlarged health vision and for a community mental health care development. This vision has been included in various declarations (Declaration of Alma Alta²⁹ in 1978, Ottawa Charter³⁰ in 1986). The European Commission also spoke out for this vision, emphasizing prevention and patient well being. Other organisations took parallel initiatives, notably at legislative level.

²⁷ Joint declaration of Ministers of Public health and Social affairs on the upcoming policy on mental health care of June 24th 2002 - Free translation

²⁸ Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005 - Free translation

²⁹ The Declaration of Alma-Ata, International Conference on Primary Health Care, World Health Organization, Alma-Ata, Kazakhstan, 6-12 September 1978

³⁰ Ottawa Charter for Health Promotion, First International Conference on Health Promotion, organized by World Health Organisation, Health and Welfare Canada et Canadian Public Health Association, 21 November 1986, Ottawa

Since its creation in 1948, the WHO has recognised the mental health importance, as it is mentioned in its Constitution: "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".

In 1978, in Declaration of Alma-Ata,³¹ the WHO "strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector."

In 1986, First International Conference on Health Promotion presented the Ottawa Charter for Health Promotion³² which aims to achieve health for all by year 2000.

In 2001, The WHO world health report was entitled: "Mental Health: New Understanding, New Hope".³³ It supports an integrated vision of mental health care. "The idea of community-based mental health care is a global approach rather than an organisational solution. [...] Mental health care should not only be local and accessible, but should also be able to address the multiple needs of individuals. It should ultimately aim at empowerment and use efficient treatment techniques which enable people with mental disorders to enhance their self-help skills, incorporating the informal family social environment as well as formal support mechanisms."³⁴ Along with the recommendations, there is also the reduction in stigma and discrimination reduction and the need for an intersectorial and multidisciplinary approach to mental health.

Among the Helsinki Declaration³⁵ priorities, the user's place is also presented as essential. We have to "recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services". In the Action plan,³⁶ it is stipulated that it is also important to "ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and

³¹ Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

³² Ottawa Charter for Health Promotion, First International Conference on Health Promotion, organized by World Health Organisation, Health and Welfare Canada et Canadian Public Health Association, November 21st 1986, Ottawa

³³ World health report "Mental Health: New Understanding, New Hope", WHO, 2001

³⁴ World health report "Mental Health: New Understanding, New Hope", WHO, 2001, p.54

³⁵ Mental Health Declaration for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005,

³⁶ Mental Health Action Plan for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005,

inspection of mental health activities". The goal is to give the user a central place in the elaboration process of the therapeutic approach and in its implementation.

At the European Commission level, the Green paper³⁷ proposes that a possible communitarian strategy depends on aspects linked to prevention.

Moreover, the international trend is characterised by a particular focus on patient's rights. In 1991, the United Nations general Assembly adopted a resolution on "The protection of persons with mental illness and the improvement of mental health care".³⁸ At the European Council level, recommendations were also approved, like, in 1994, the Recommendation 1235 on psychiatry and human rights and, in 2004, the Recommendation 10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorders.

International pressures

Besides the prevailing discourse defended by the supranational bodies, Belgium is regularly the subject of international pressures concerning its high number of psychiatric beds. Those pressures come from various bodies like the OECD, the WHO, the European Commission. *"After 20 years of initiatives, the WHO always comes back with the same remarks on the way to organize the mental health system in Belgium."*³⁹

The table below emphasizes two characteristics of the Belgian psychiatric system. On the one hand, the number of psychiatric beds per 100,000 inhabitants is the highest in the European Union and is four times higher than the European average. *"There are a lot of psychiatric beds in Belgium, particularly in Flanders. It is historical."*⁴⁰ On the other hand, dehospitalisation is slow, the number of psychiatric beds decreased by 3% between 1997 and 2005 while the average rate of reduction for Europe was 23%.

	1997	1998	1999	2000	2001	2002	2003	2004	2005
EU (27 countries)	78.0	75.3	71.2	69.4	66.0	64.9	62.4	60.9	60.4
Belgium	259.4	259.6	259.4	259.5	252.8	249.0	248.0	248.5	250.8

Source⁴¹ : Psychiatric care beds in hospitals (per 100 000 inhabitants)

³⁷ Green paper "Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union", European Commission, 2005

³⁸ Resolution on The protection of persons with mental illness and the improvement of mental health care, adopted by the United Nations general Assembly, n°46/119, December 17th 1991

³⁹ Quoted from an interview with a political actor

⁴⁰ Quoted from an interview with an administrative actor

⁴¹ <http://epp.eurostat.ec.europa.eu/portal/>

It should be noted that “The counting of 'beds' has always been difficult and controversial. [...] The high provision in Belgium of 2.5/1000 beds must be understood to include general hospital units and many in settings other than psychiatric hospital.” (Kovess 2004). Belgium’s figures then include places in psychiatric nursing homes and in sheltered accommodations.

This high degree of the Belgian sector institutionalisation explains the predominant role played by the National Council of Hospital Facilities in the sector reform. “[It] took the leadership of the policy reform by arousing necessary coalitions for a fundamental modification of the sector cognitive maps.” (de Munck and al. 2003: 50 – Free translation). It also is the major initiator of the therapeutic projects.

Field practices

Network field practices are widespread in the mental health sector, either in the ambulatory sector or in the hospital sector.

The actors from the ambulatory sector are, for the most part, already enrolled in a situation of network. Relations between medical and social actors are common in the mental health field. *“Working in network, we already did it. We did not wait for politicians to tell us it was a necessity.”*⁴²

“The political context is a context of formalising of network functioning: that is to say that public health policy integrate this mode of functioning and this services coordination imperative, often initiated by field local initiatives and try to systematize them.” (Deliège 2007: 8; free translation). This will to formalize has sparked comments: some think that network formalisation will make the network lose its main characteristic – its dynamism: “Formalizing the network, too much, I think is like killing it. One cannot “prescribe” network at any time, without taking into account the singularity of a situation, or one leaves the mental health, social, individual, law State citizen field, to enter a technocratic and bureaucratic drift which can only worry us.” (Martens 2007); while others claim for this political reappropriation, provided that it comes with appropriate financing: *“We are looking for political reappropriation. It is normal that politics are inspired by what is done on the field. We always are ready to talk about it.”*⁴³

The actors who, a priori, could be opposed to these structural transformations are the hospital facilities which, until then, constituted the principal site of diagnosis and treatment. The new sector structure affects the hospital monopoly since it tends to favour ambulatory care. However, the “Psychiatry” work group of the National Council for Hospital Facilities plays a central role in setting up the new organisation. It even is the official instigator since it officially introduces the care circuits and networks notion. “At the end of the 1990’s, the National Council for Hospital Facilities overstepped the role of hospital conservative protection which it could, by inertia, have adopted. It took the leadership of the policy reform by arousing necessary coalitions for a fundamental modification of the sector cognitive maps.” (De Munck and al. 2003: 50). The “Psychiatry” work group then positions itself as an incontrovertible actor. It defines the new organisation of mental health care and determines modalities of making it operational.

⁴² Quoted from an interview with a field actor

⁴³ Quoted from an interview with a field actor

Moreover, the hospital also collaborates with external partners to optimise the patient's discharge.⁴⁴ Debates on article 97b in the Hospital Law, which allows dedicating 10% of the hospital budget to care circuits and network experimentation, are current.⁴⁵ *"Our new main theme is article 97b. If we succeed in making it real, that is, giving carte blanche to the institutions and asking them to render account of their activity, it will be a great step."*⁴⁶

Nevertheless, passing from an institutional monopoly to a network system must be put into perspective. The hospital remains central in the mental health care organisation and related knowledge still prevail, notably "because there are convergences between them and the administrative logic." (Genard 2003 : 46)

According to Deliège, "Traditionally, we witness a seizure of power from the medical sector in terms of mental health matters, linked to the predominant place of medical power in the hospital institution." (Deliège 2007: 23). This asymmetry within the network depends on the difference of means allowed various types of structures and on the size of the structure itself. For Brilot, "The risk is high that [vertical structures] do not play the game, that they fall back on themselves, that they infiltrate the coordination structures and that they then develop the network to their own advantage, risking blocking it. (Brilot, 2006: 26)

2.3. Convergences on a vision of mental health care

Evolutions in the vision of mental health in Belgium fall in a general trend which accompanies the shift from psychiatry to mental health (Castel 1981). "We will remember also that the transformations of the mental health care devices lead to the shift from an archetype to another: from the mental illness to the mental health, from the psychiatric services to the services in the community, from service which are mostly hospitals or ambulatory to a system integrating different institutional actors. »." (Hoyois 2003; free translation)

This new vision adopts a holistic perspective which takes into account the diversity of factors at stake and aims to give a central place to the patient and his or her needs. This vision is made concrete in a restructuring of mental health care in terms of care circuits and networks. This vision and its implementation seem to constitute on the one hand

⁴⁴ Hospital referent function aims to favour collaborations between extra and intra-hospital institutions at the time of patient's exit.

⁴⁵ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the application of the article 97ter of the Hospital Law, of April 13th 2007

⁴⁶ Quoted from an interview with a therapeutic project coordinator

diffuse and normative knowledge, and on the other practical and organisational knowledge.

Principles based on this new conception seem to be the subject of a broad consensus, not only at the national level, between field actors and politics, but also at the international level where supranational bodies distribute them broadly.

The shift from psychiatry to mental health proceeds to a two-fold enlargement. First, a therapeutic problem is also understood as a social, economic and cultural problem. Second, actors mobilised around a case are diversified and come from other related fields. Mental illness is seen in a global perspective.

Lack of coherence between power levels in mental health matters and its negative impact on the development of new vision were underlined by the "Psychiatry" work group in 1996.⁴⁷ It is necessary to achieve an interinstitutional cooperation. Collaboration with connected sectors being developed, it is of primordial importance to mobilise Regions that are notably in charge of care policy, help to people and housing, and Communities that are responsible for education and youth help.

At the heart of the new conception appeared the patient's centrality. This turnaround perspective has several corollaries.

First, the new conception aims to set up made-to-measure care for the patient, not only for his or her pathology but also adjustable according to his or her psychosocial characteristics and their evolution. As far as possible, care should be made in the patient's day-to-day lifestyle.

Second, care continuity appears as a necessity to avoid ruptures in care trajectory. "[The principle of the continuity of cares] can be stated in two maxims: thinking to the upstream and the downstream of the take in charge and to pay a special attention to the passing and the transitions between two places." (Deliège 2007: 29; free translation). In order to do so, collaborations between structures funded by various power levels are encouraged.

Thirdly, patients are considered actors in their own future. "The new practices are incentive, build on the activation of the individuals, of their affects, their resources and their social network." (Vrancken 2002: 42; free translation) Patients become active partners in their treatment and follow-up.

Those principles are made concrete in a reorganisation of mental health care in terms of care circuits and networks for target groups. This concept is moving away from principles

⁴⁷ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the psychiatry reconverting evaluation of May 9th 1996

of somatic medicine organization. "A network, it's [...] a device of confidence in which the professionals exchange information, take part collectively in the care taking of the patients, and look for a maximum quality of the cares given [...]." (Schweyer and al. 2002; free translation)

Network functioning seems also generally admitted either by political and institutional levels or by field actors. A political consensus came out of the Interministerial Conference for Public Health and was the subject of a Joint Declaration.

At the level of field actors, professionals in the ambulatory sector have worked for many years in network. The mental health vision held by this sub-sector, notably at its creation, favours a multidisciplinary and day-to-day life approach, and is therefore open to network. Nonetheless, hospitals set up opening initiatives towards the other actors in the field. Moreover, the "Psychiatry" work group rapidly positioned itself as a incontrovertible and pro-active actor.

Nevertheless, passing from an institutional monopoly to a network system must be put into perspective. The hospital remains central in the care organisation and the influence and centrality of the "Psychiatry" work group seem to attest to this.

2.4. Description of the therapeutic projects

2.4.1. Genesis of the Therapeutic projects

Idea of pilot project

As we demonstrated, Belgium has been following a reconfiguration of its mental health sector since the last 1980s. The idea to proceed to a restructuring of the field via an experimental phase appears from the 1997⁴⁸ opinion of the "Psychiatry" work group. It suggested that this structural transformation should be implemented through pilot projects. "Either politics and the mental health sector will be able to acquire a useful expertise before those concepts are generalised as forthcoming mental health care organisation models."

In the 2001 policy note,⁴⁹ Ministers proposed testing the new structure by a pilot project dedicated to young people. "The advantage of young people as a target group is that the optimal scope of action to organise the care circuit matches more or less a County." At that time, the county scale appeared to be the most relevant for the reorganisation.

⁴⁸ Opinion (second part) of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the upcoming organisation and development in mental health care of June 12th 1997

⁴⁹ "Psyche: my latest concern? Mental health care: participation and coordination paths." Policy note of Minister of Social Affairs Vandenbroucke and the Minister of Public Health Aelvoet, Bruxelles, March 2001- Free translation

Dialogue platforms were considered central actors whose role should expand. “[...] They shall obtain a supra-institutional decision-making power greater than the one they currently have.”

In 2001, an article was introduced in the Law on compulsory health care and compensation insurance,⁵⁰ allowing the National Sickness and Disability Insurance Institution, the paragonovernmental institution in charge of the administrative management of Social affairs, financing innovative and experimental projects. The article stipulates that “The Insurance Committee⁵¹ can conclude conventions which are time and/or application field limited and which aim to: [...] grant repayment for special models (of prescription) of dispensation and of payment for health care that has been characterised experimental [...].”

In 2002,⁵² the “Psychiatry” work group reaffirmed that reorganising mental health care must be carried out through an evaluation phase of the basic principles within the therapeutic projects setting up framework. Equipments participating in pilot experimentation must have the possibility to work in a creatively and flexibly [...]. This approach [...] requires a minimum five-year period, as well as a coherent and efficient policy supported by the various competent authorities.”⁵³

Pilot projects in mental health

Before the therapeutic projects, federal authorities set up various pilot projects aimed at testing the feasibility of a care model centred on the patient’s needs and on care continuity before {possibly/eventually} generalising it. As an administrative actor emphasises: “It is not a simple task to prepare a new law that states ‘network is that’ and that defines the good characteristics of the network. To know what is efficient or not, I think that this type of experimentation is necessary.”⁵⁴ Those projects were most often financed by the service.

Each pilot project is the subject of a convention between the Federal public service and the structure coordinating the project. It covers a territory defined by the project itself and follows its own objectives adapted to the target group.

⁵⁰ Law on compulsory health care and compensation insurance, coordinated on July 14th 1994, article 56

⁵¹ The Committee is composed of equal number of representatives of insurance mutual companies and care professionals. Representatives of social partners have consultative voice.

⁵² Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities on the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

⁵³ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

⁵⁴ Quoted from an interview with an administrative actor

All those pilot projects are integrated in a global perspective of a reorganisation of the mental health field. They aim to establish norms, test new devices (telephone help {line/desk} for {primary/front-line/first line} stakeholders, mobile team, etc.), and set up new functions (hospital referent). They are followed by a scientific team which set up evaluation instruments.

Following these various experimentation, two observations were made.

First, the sector felt, over the years, disillusioned and frustrated about the absence of formalisation of pilot experimentation. *“If it works, it is necessary to generalise it, and if does not work, it is necessary to stop it and to allocate the means somewhere else.”*⁵⁵ But, in most cases, contracts were extended from year to year, sometimes for more than ten years, leaving stakeholders in uncertainty. Moreover, those projects, by definition, only concern a few institutions and the lack of means did not allow for higher speeds.

Second, evaluations realised by various research centres or universities created a kind of scepticism, the field but also in the administration. *“There were evaluation practices but they were very spread out among various academic interlocutors. [...] There was no real comparative evaluation, nor a scientific evaluation aiming to guide politics.”*⁵⁶

Besides, pilot projects had to meet some criteria and to respond to some conditions, restricting field actors' room to manoeuvre. A field actor said the following about a project which was not selected:

“Not registered as practitioners within a state health care scheme, we retain a precious characteristic: the freedom to be a true pilot project, the freedom to look to model our interventions based on the perceived needs of the patients, the freedom to offer indispensable specialised care to some. But the price to pay is high because if, among big partners, each one eats away at its own funding, the smaller cannot do as much.” (Demeter 2003)

Interministerial Conference for Public health

As mentioned above, the development of a coherent mental health policy should go by a cooperative agreement between the Federal State, the Communities and the Regions. In the Joint declaration drafted at the Interministerial Conference, priority was given to the paedo-psychiatry.

Nevertheless, following the same route addressed by the critics in previous pilot projects, the sector raised reservations about the target group choice: *“paedo-psychiatry is a particular sub-sector: stakeholders are numerous, structures are not well distributed on*

⁵⁵ Quoted from an interview with a hospital representative

⁵⁶ Quoted from an interview with a hospital representative

the territory. It is not the easiest one! Moreover, the whole sector is waiting for change and novelty and you only focus on a single {segment/part}."⁵⁷

An amendment⁵⁸ to the Declaration took the option to enlarge the target group to all age groups, providing patients present a chronic and complex pathology. The emphasis is put on these patients because their care trajectories crystallize the need for continuity of care and for a multidisciplinary approach. Besides, "there is, among members, a consensus on the fact that it is not necessary to have a cooperative agreement to start a pilot project."

2.4.2. A wide-ranging pilot project: the therapeutic projects

Main lines

Based on the amended Joint Declaration, Minister of Social Affairs and Public Health Demotte drew the main lines of the new mental health care policy in a 2005 policy note.⁵⁹ This note, inspired by the numerous opinions written by the "Psychiatry" work group, was jointly written by the strategic cell of the Minister and by civil servants from the Federal Public health service and by the National Sickness and Disability Insurance Institution. It should be noted that the Minister's counsellor in psychiatric care is detached to the Cabinet by the VVI, the most powerful hospital federation which played a central role in the "Psychiatry" work group.

This note focuses on the mental health care reorganisation by means of a wide ranging pilot project which comprising two parts: the therapeutic project and the transversal dialogue.

First, the therapeutic project is a coordination organised around a patient, financed by the National Sickness and Disability Insurance Institution for a yearly budget of €2,209,000. All practitioners involved meet and coordinate their actions around the patient's needs.

Second, coordination organised around a patient falls within a larger frame in order to proceed to redefining the mental health care organisation. The transversal dialogue aims to formulate a structural proposal in terms of care circuits and networks. The Federal Public health service released a yearly budget of €2,795,000.

A Support committee was also created, it gathers data and proposals from the transversal dialogue. The objective is "to [progressively transform] 'experimental'

⁵⁷ Quoted from an interview with a hospital representative

⁵⁸ Amendment to the Joint Declaration, May 24th 2004 - Free translation

⁵⁹ Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005 - Free translation

therapeutic projects into structural networks with their own care circuits, related to a norm and an authorisation as well as to a structural financing.”

Definition of the concrete modalities

In this first public action analysis, we will principally focus on the therapeutic projects. The second one will be dedicated to the transversal dialogue as an innovative dialogue device.

Concrete modalities for implementation were defined within the Support Committee, which is composed of representatives of the seven Ministers in charge of health matters, the Federal Public health service, the National Sickness and Disability Insurance Institution, the Commission of conventions between hospitals and mutual insurance companies, the Federal dialogue platform for mental health care, the National Council for Hospital Facilities, the Superior Council of Health and patients and families.

The Support committee met for the first time on September 13th, 2005, its mission is:

- defining “chronic and complex”,
- defining criteria for selection of therapeutic projects.

The committee met again on October 11th, 2005. It adopted a consensus note on a “work definition proposal of patients presenting (potentially) long-term and complex psychiatric pathology.” At that meeting, the representative of the National Sickness and Disability Insurance Institution presented, as a working paper, a basic note “Experimentation of conditions for mental health care circuits and networks. The therapeutic projects.” The basic note constitutes the founding document for the whole pilot project, it was discussed and written in the “Psychiatry” Commission of conventions.⁶⁰ It must be approved by the Insurance Committee, which is the decision making body within the National Sickness and Disability Insurance Institution. The entire procedure, including selection criteria, must be entirely fixed in a Royal Decree before any implementation measure is taken.

At the third meeting, on November 8th, 2005, the basic note was discussed. The day before, the Interministerial Conference work group agreed on “a consensus [...] concerning the distribution of the projects among the various regions according to demographic data.”⁶¹

The committee met on January 2006 when the basic note was again discussed.

⁶⁰ It is a body within the National Sickness and Disability Insurance Institution with equal representation among both mutual insurance company representatives and sector representatives.

⁶¹ Report from the meeting on November 8th, 2005 of the Support Committee “therapeutic projects and {transversal dialogue/horizontal consultation}”

The Insurance Committee examined the basic note and gave its approval on March 27th, 2006. This note recalls the general context and specifies that the experience running period is a maximum of three years. "Once they are finished, therapeutic projects should led to a structured approach in partner collaboration and in matters of complementarity as parts of care circuits and networks."

The candidate project must complete a file available on the National Sickness and Disability Insurance Institution's website. The following elements are required:

- definition of the target group,
- description of objectives and expected results,
- presentation of partners: three types of partners are compulsory: a psychiatric hospital (or psychiatric service within a general hospital), a mental health service and a first-line service,
- determination of the activity zone,
- description of partners collaboration modalities with an emphasis on the innovative character,
- bibliographical references.

Projects must be communicated to the dialogue platform concerned to allow potentially interested partners to participate and to avoid redundant projects.

A selection procedure is put in place within the National Sickness and Disability Insurance Institution where a work group has been created. The definitive selection is completed by the Insurance Committee.

Selected projects signed a three-year convention with the Insurance Committee. The National Sickness and Disability Insurance Institution allocated a yearly budget of a maximum €46,500 to each project, which comprises a fixed amount (€24,000) to cover fixed costs and personnel costs and a variable amount (maximum €22,500) depending on the number of meetings about patients.

To benefit from this financing, each therapeutic project must have cared for at least 30 patients by the end of the first year, to organise for each patient at least one meeting per quarter and to participate in the transversal dialogue. A yearly evaluation is planned.

2.5. Elaboration process: from principles to concrete modalities

Since the 1980s, a new vision of mental health care has developed under the influence of the "Psychiatry" work group, which played a major role.

First, this new vision relies on diffuse and normative knowledge at the level of defining principles. It adopts a holistic perspective which takes into consideration the diversity of factors at stake and aims to give a central position to the patient and his or her needs. Subsequent principles seem to be subject of a consensus at the national level but also at the supranational level.

Second, practical and organisational knowledge are mobilised at the level of determining concrete modalities which is made concrete by a restructuring of mental health sector in terms of care circuits and networks. This new vision development necessitates an interinstitutional cooperation, collaborations with related sectors being developed.

At the federal level, authorities set up various pilot projects aimed at testing the feasibility of this new model centred on patient's needs and care continuity before eventually generalising it. These projects were criticised by the sector.

At the same time as these various observations, the Interministerial Conference for Public Health made a commitment to support a wide ranging pilot project. The Minister of Social Affairs and Public Health drew the main lines of the new policy of mental health care in his or her 2005 policy note where concepts of therapeutic project and transversal dialogue were developed.

Project selection criteria and project functioning are described in the basic note of National Sickness and Disability Insurance Institution which was negotiated within the Support committee, before being ratified by the Insurance Committee.

In the next chapter, we will focus on the way these principles and modalities are implemented.

3. Implementation process

In this chapter, after describing in detail the elaboration process, we will focus on the implementation process. This has its own characteristics, its autonomous mode of functioning because it falls within a local reality specific to each project.

Therapeutic project implementation started, after an much delay, on April 1st, 2007. The National Sickness and Disability Insurance Institution launched a call for projects and then proceeded to the selection of 78 therapeutic projects with which a conventions were signed.

Within our study frame, we completed deeper field work on the general psychiatry cluster – Adults at the French-speaking level. During the implementation, field actors benefited from a wide room to manoeuvre in their project definition, in the choice of pathology, in defining the geographical zone, in specifying objectives, in selecting partners, and in choosing methodology and bibliographical references. Field work allowed us to underline the diversity of initiatives set up locally.

In order to illustrate the various dimensions of a therapeutic project, it seemed relevant to proceed to an extensive description of a particular project and to its examination.

3.1. Accumulated delays

In the amendment⁶² to the Joint declaration, it is stated that: "Given that in 2004, no budget can be freed up, pilot projects can only be launched in 2005 at the earliest." The 2005 policy note establishes that means were freed in the 2005 health care budget (National Sickness and Disability Insurance Institution) to develop the therapeutic project.

The Support committee started its work in September 2005. At this first meeting, a schedule was defined:

- November 2005: launching of the call for therapeutic projects
- April 2006: launching of the therapeutic projects
- July 2006: launching of the transversal dialogue

At the third meeting, it was said that the schedule could not be respected.

At the next meeting, a new schedule was proposed:

⁶² Amendment to the Joint declaration, May 24th 2004 – Free translation

- February 2006: decision of the Insurance Committee
- March 2006: launching of the call for therapeutic projects
- May 2006: publishing of the Royal decree
- October 2006: launching of the therapeutic projects

The Insurance Committee approved the basic note on March 27th, 2006, with a month delay, marking by that the start of the procedure.

3.2. Call for projects

3.2.1. Sequence of events

Budget Minister gave an agreement on July 27th, 2006. On October 22nd, 2006, the Royal Decree⁶³ related to the therapeutic financing was promulgated. It presented the main lines of the basic note and described conditions and procedures. It specified the deadline for submitting an application for therapeutic projects.

There are compulsory partners and potential partners. The *compulsory* partners are: a psychiatric hospital (or psychiatric service within a general hospital), a mental health service and a first-line service. Among the *potential* partners, some of them must take priority in being invited to participate in the project: home care integrated services, pilot project financed by the Federal public service (psychiatric care for patients at home and outreach) and structured care linked by a psycho-social functional re-education convention with the National Sickness and Disability Insurance Institution. On home care integrated services, the National Sickness and Disability Insurance Institution wished to give a role to these new structures, all the more so because part of their budget had not been disbursed. The interest of their participation to the therapeutic projects is that part of the budget dedicated to collaboration is paid through the home care integrated services' budget, allowing the financing of a greater number of projects. If a home care integrated service is a project partner, it is in charge of the administrative coordination.

It is interesting to underline the fact that mental health services are compulsory partners. This type of structure is financed and regulated by the Community in Flanders, the Region in Wallonia and by the Commissions in Brussels Capital. The fact that this type of structure is mentioned in a legal federal text and, moreover, as a compulsory partner, is a legislative first. This bridge-building can be considered as an attempt to improve the coordination between political power levels.

⁶³ Royal decree of October 22nd 2006 setting the conditions within which the Insurance Committee may conclude conventions for funding pilot projects in mental health care. MB 06-11-2006

To be known by a maximum of partners, candidates must launch a formal call for collaboration at the Dialogue platforms. In Liège, the applications were jointly written within the platform, according to the number of projects that were allocated to the county, to avoid competition.

A standardised form is available on the National Sickness and Disability Insurance Institution's website. This form lists all the criteria which will be the subject of the evaluation. Once it is completed, it is sent to the Dialogue platform concerned before being officially submitted to the Insurance Committee.

3.2.2. *Reasons for the participation*

Participants in the therapeutic projects mention different reasons for wanting to respond to the call for projects.

The main reason mentioned by the participants is that a mental health care reorganisation is unavoidable and inevitable and, as long as they have to face it, it is better to participate actively, as several interlocutors underlined: *"It is {better} to be with it!"*⁶⁴ or *"I'd rather be in the train and grumble, than not and that it falls on me afterwards!"*⁶⁵ or *"It really is to stay in the change train!"*⁶⁶.

For some, therapeutic projects are an opportunity to make ideas that are in the pipeline more concrete: *"We already had ideas like that before: opening this type of place, a house where people can come."*⁶⁷; or to deepen avenues of reflection: *"There used to be a group where representatives of the various services met on network functioning. At that time, there was the call for projects of the Minister and we jumped at the chance."*⁶⁸ Projects are also sometimes perceived as a means to continuing and reinforcing initiatives which developed over the previous few years. As a field actor told us, changes emerged in his or her institution when the call for projects was launched: *"Before, there was no coherence in the treatment between services. All hospitalised people were in the same place, in the same services. And at the network level, few things were in place. Then, we started to reorganise the services, to set up specific programs... and, at that time, we thought that it could enter the therapeutic projects framework."*⁶⁹

In an institution, projects are considered an opportunity to highlight the specificity of their work: *"As a big partner confronted with particular field realities, those of the*

⁶⁴ Quoted from an interview with a therapeutic project coordinator

⁶⁵ Quoted from an interview with a therapeutic project coordinator

⁶⁶ Quoted from an interview with a therapeutic project coordinator

⁶⁷ Quoted from an interview with a therapeutic project coordinator

⁶⁸ Quoted from an interview with a therapeutic project coordinator

⁶⁹ Quoted from an interview with a therapeutic project coordinator

psychiatric hospital with a heavy population presenting characteristics that are not necessarily met by others, it seemed important that we could be actors for the change, reflect those patients' needs and so work to inter-partner coordination modelling which correspond to the field realities we meet."⁷⁰

The financial aspect is rarely mentioned and when it is, means do not seem to constitute an incentive: *"The financial aspect is not fundamental, all the more so it does not cover the effective cost."*⁷¹

3.3. Project selection

The number of projects to be selected was determined according to the budget of the National Sickness and Disability Insurance Institution and the home care integrated services' participation (or not), because the latter allows reducing the costs. A distribution grid was established by the Insurance Committee work group, according to the projects geographical distribution,⁷² which was the subject of an agreement within the Interministerial Conference, and the age categories distribution⁷³.

	Youth	Adults	Elderly	Total
Flanders	9	24.8	11.3	45.1
Brussels	1.5	4.1	1.9	7.5
Wallonia	5.1	13.9	6.3	25.4
Total	15.6	42.9	19.5	78

For each age category and each linguistic group, a jury⁷⁴ was created. This jury was made responsible for evaluating the content of the application forms. Each jury is composed of four people: a internal, a external, a representative of the mutual insurance

⁷⁰ Quoted from an interview with a therapeutic project coordinator

⁷¹ Quoted from an interview with a therapeutic project coordinator

⁷² The Interministerial Conference for Public health found a consensus, on November 7th, 2005, on the projects distribution at the geographical level. The distribution is balanced by the demographic weight of the various regions: Flanders – 57.87%, Brussels – 9.62%, Wallonia (included the German speaking Community) – 32.51%.

⁷³ Each region must include at least one project per target group. The ideal distribution per age group is: young people – 20%, elderly people - 25% and adults – 55%.

⁷⁴ Except on the French-speaking side, where adults and elderly age groups were grouped together because the number of therapeutic projects for elderly people was to low.

companies and a civil servant from the National Sickness and Disability Insurance Institution. The final quote is an average of the four quotes.

To be selected, candidates had to have a result of 80%. The number of projects achieving those results was lower than the number of projects that could be selected, so the limit was lowered to 60%. If the number of projects which had achieved 60% in one of the categories is lower than the number in the grid, then this excess is transferred to another age group within the same geographical entity.

It is interesting to note that the main criterion is the geographical distribution. The community debate in Belgium is a sensitive and topical question. It would seem that this characteristic of the Belgian system can be likened to an institutional knowledge which has to be taken into account by the various stakeholders.

The Insurance Committee concluded a convention with 78 projects. The table below presents the effective distribution.

	Youth	Adults	Elderly	Total
Flanders	10	25	10	45
Brussels	2	4	1	7
Wallonia	8	16	2	26
Total	20	45	13	78

The main distortion in comparison to the first grid is located at the Walloon region level where the elderly people age group is under-represented.

3.4. Launching of the therapeutic projects

3.4.1. Comments

In a special issue, "Formaliser le réseau" (2006) – "Formalising the network" – published before the projects began, a space was reserved for "Reactions to therapeutic projects" (2006: 22-25). The contributions do not reflect a unanimous position.

For the Belgian Confederation of Health Care Private Structures (Confédération belge des établissements privés de soins de santé - Cobéprivé): "It seems to us [...] that in this reinforced dialogue among field actors, we could invent an original policy for mental health integrated care, avoiding the obstacle of psychiatric care sectoring applied by our neighbours which leaves little room for the patient's choice, and, at the same time we

could open a true dialogue and complementary natures between hospital and ambulatory sectors [...].”

The Federation of Hospital Institutions (Fédération des Institutions Hospitalières - FIH) “approves of the principles which underlie the therapeutic implementation [...]. By supporting this approach, [it] hopes that therapeutic projects will avoid obstacles of the imposed rigid model, like [those] met within the [previous] pilot projects framework, but also the abstract and theoretical analysis which misreads the reality in the field, like some scientific studies previously carried out.”

For the Health Institutions French-speaking Association (Association Francophone des Institutions de Santé - AFIS), “the initiative [...] seems interesting to support. [...] It seems [...] obvious that those who already work in the network will be reinforced and supported within the framework of the therapeutic projects and that, for others, we can hope a new curiosity will follow... depending on the way the experiment takes place.”

Remarks⁷⁵ from the Ambulatory Mental Health Workers Associations (Association des Travailleurs de Santé Mentale Ambulatoire - AT SMA) concern several aspects notably on the obligatory nature of the dialogue: “Dialogue and coordination should not be an imperative in itself, risking making the network rigid [...]. It is important to be able (to carry on) functioning on a case-by-case basis [...]”; and on the place of the partners: “What place can the mental health services take in those networks and their development, if they are created from the hospital world (which can more easily bring together the minimum number of patients [...] necessary for setting up a therapeutic project) [...]?”

The Home Care Structure Federation (Fédération des Centrales de Soins à Domicile - FCSD) notes that “the fact of participating in a network and in care circuits will allow the Home care structures to share their difficulties and expertise on home care matters. [...] The structures will certainly be involved in therapeutic projects.”

For the General Practitioners Associations Forum (Forum des Associations de Généralistes - FAG): “The general practitioner’s central role for ambulatory care patients must be upgraded and his or her collaboration must be viewed as indispensable, if not, the project cannot be accepted.”

For the President of the Liège Federation of General Practitioners Associations (Fédération Liégeoise des Associations de médecins Généralistes - FLAMG): “I have the feeling that the psychiatric world does not have the intention, despite reassuring words and what seems like attentive listening, to give us their trust in this matter.”

⁷⁵ Those remarks were written by the IWSM, based on the participation in various AT SMA’s meetings on therapeutic projects.

Reading these various contributions, it appears that opinions are divided between enthusiasm and scepticism. Hospital federations adopt a globally positive attitude towards the projects by approving and encouraging the initiative. Ambulatory structures, which are financed by the Walloon region, are reluctant to network formalisation and point at a hospital-centred trend. The remarks of front line actors vary. Home care structures show themselves to be ready to participate, as far as those collaborations will facilitate exchanges of experience. General practitioners associations, by contrast, adopt a critical attitude, notably concerning the place they will take.

3.4.2. Conventions with selected projects

Seventy-eight therapeutic projects were selected by the National Sickness and Disability Insurance Institution. Besides these projects, four projects are financed by the Federal Public health service. They have the same obligations and must respond to the same conditions and procedures as the others. In all, 82 projects are participating in the pilot project.

A "convention on the financing of therapeutic projects in mental health care matters" was signed by the administrative coordinator of each project and the National Sickness and Disability Insurance Institution (or the Federal Public health service). This convention will last three years and started April 1st, 2007, so with a one-year delay compared to the first schedule of the Support Committee.

In addition to this convention, the pilot experimentation abounds with a multitude of contracts between the various stakeholders.

First, a collaborative agreement between partners is signed by all the structures participating in the pilot project. It stipulates procedures on inclusion of patients and a dialogue meeting and describes the modalities of information transfer regarding the patient and his or her care.

Second, a consent document written by the patient attests to his or her participation in the project. This consent has to be enlightened; project principles as well as the implications must be explained to the patient. This approach falls within a global perspective of new modes of public action which favour participation and activation. "The matter is no more « to do on » or « to do in place of » but « to do with » (the beneficiary which became associate in the action), or « to make do » [...]." (De Backer 2000: 39; free translation)

Third, a convention on the "collection of information related to mental health care therapeutic projects within the framework of the transversal dialogue" is signed between each project's administrative coordinator and the Minister of Social Affairs and Public

Health. Projects commit themselves to participate in the transversal dialogue, the modalities of which will be defined later on.

The abundance of contracts, conventions and other types of agreements at the therapeutic project level is illustrative of the contemporary public action which tends to favour multiple partnerships.

3.5. Cluster “General psychiatry – Adults”

Within the framework of this research, we completed field work focusing on the Cluster “General psychiatry – Adults” at the French-speaking level. This cluster includes 12 therapeutic projects.⁷⁶

3.5.1. Care characteristics

When the call for tenders issued by the National Sickness and Disability Insurance Institution, forms were completed by the various teams. The starting objective of the therapeutic projects is to draw inspiration from field practices and to propose a general frame leaving candidates room to manoeuvre where the choice of the target group, the territory, partners and so on are concerned. We will briefly describe these points to underline the diversity of the project.

As regards the target population, choice is linked to various reasons. For some, it responds to internal concerns: *“For the target group, we chose the population who exhausted the most workers, the population for which the hot potato has always been tossed back and forth...”*⁷⁷ For others, more pragmatic reasons are mentioned: *“We chose to work with this target group because it constitutes the majority of our patients. It was easy to fill the quota.”*⁷⁸ In the County of Liège, projects were written within the

⁷⁶ Therapeutic projects included in this cluster are:

- n°65 : Club thérapeutique - Pathologies mentales chroniques et complexes de adultes à partir de 25 ans à Tournai
- n°67 : Pathologies psychotiques adultes à Nivelles
- n°70 : Personnes souffrant de troubles de l’humeur chroniques et complexes à Verviers
- n°71 : HERMES - Troubles psychotiques et troubles bipolaires à Bruxelles
- n°73 : Améliorer le pronostic du patient dépressif chronique et/ou résistant à Liège
- n°74 : La Maison de la Concertation à Mons
- n°80 : Troubles bipolaires de type I et II à Liège
- n°90 : Psychose avec troubles schizophréniques à l'exception de schizophréniformes à Namur
- n°93 : Concerto - Adultes souffrant de troubles borderline à Tournai
- n°97 : Newton – Psychose à Bertrix
- n°104 : Adultes atteints d'handicap mental et de troubles psychopathologiques à Manage
- n°107 : Un lieu, un lien – Club thérapeutique à Mouscron.

⁷⁷ Quoted from an interview with a therapeutic project coordinator

⁷⁸ Quoted from an interview with a therapeutic project coordinator

Platform where this question was negotiated: *"Between partners of the Platform, we wanted not to be in competition uselessly and then we found an agreement on the pathology distribution, on who entered what."*⁷⁹

The size of the territory varies from one project to the next, ranging from a town (and often its peripheral towns) to a county. This choice generally depends on practical reasons: *"Our hospital is the only psychiatric hospital in the county; it explains why we cover the whole county."*⁸⁰ Or *"Our zone of activity is limited because we wanted to stimulate local relations around precise objectives."*⁸¹

Objectives followed by projects are also variable and aim at, in particular, improving care continuity between hospital and first-line actors, to improve patient prognosis, to create a therapy group, to rehabilitate patients socially, to reduce exclusion situations, to improve crisis care, and so on.

3.5.2. Partners

The project coordinator is a central actor, he or she is member of the institution which completed the application form. He or she is in charge of the project administrative management (invoicing and relations with the funding authority) and of the organisation of dialogues (meetings, information centralisation and transfer). Five projects are carried out by the hospital sector, three by the ambulatory and four by a home care integrated service. When a home care integrated service participates in a therapeutic project, it is compulsorily the administrative coordinator for cost reasons mentioned below. It is not necessary for the project initiator. In this case, administrative management is undertaken by the home care integrated service, and the "clinical" management, linked to the dialogue organisation, is undertaken by a member of the institution which is at the basis of the project.

The number of partners varies. For example, two out of the three projects in Liège have more than fifty partners. *"We called a maximum number of partners. The more we are the better!"*⁸² Difficulties and cancellations appeared along the months: *"At the level of project management, the more partners there are, the more difficult it is. [...] Partners network functions around a hard core of six partners."* The third one voluntarily limited the number of partners: *"The objective is to see within the network how we can stimulate a few structures, that is, three to four structures, and to see what we can mobilize together. [...] Small projects are more practicable and give more information, or*

⁷⁹ Quoted from an interview with a therapeutic project coordinator

⁸⁰ Quoted from an interview with a therapeutic project coordinator

⁸¹ Quoted from an interview with a therapeutic project coordinator

⁸² Quoted from an interview with a therapeutic project coordinator

at least create more enthusiasm and opportunities to change things."⁸³ Moreover, practical arguments go this way: *"For each meeting, at least three signing partners must be present and for the inclusion meeting, all must be present. It is inconvenient and it did not appear as functional to have a lot of partners."*⁸⁴

Adjacent reasons to the choice of partners are diversified. Most of the projects called their usual network of partners, while being open to new collaborations. In some cases, partner selection and mobilisation rely on inter-personal relationships, so: *"The doctor director of the mental health service is also the psychiatrist in our hospital."*⁸⁵ Other projects launched a call to all interested structures at the platform level.

Despite coordination with connected sectors being encouraged, few projects actively collaborate with partners coming from fields other than mental health. *"In patient care, there are social dimensions. We work with Welfare services, schools... Nevertheless, we are in a health thought process. [...] Basic partners are health actors. We are not doing a social help network, it is a health care network."*⁸⁶ The target population is made up of patients presenting chronic and complex pathologies. For this population, using medical treatment and care is, generally, necessary. *"I think that the care aspect must remain central, it still is a medical practice. We should make it a social question."*⁸⁷

Several projects faced difficulties when mobilizing some actor categories. Globally, difficulties to mobilize self-employed is underlined, they are linked to financial aspects or to practical reasons: *"Given the distance and the time it takes, it is difficult to mobilize partners for meetings, mostly self-employed."*⁸⁸ Those new collaboration practices do not necessarily fit into the medical vision held by some actors. *"Network is a field practice but not for all actors; doctors and psychiatrists are not quite for it."*⁸⁹

Moreover, a project carried out by an ambulatory structure meets reluctance from the hospital sector. *"We regret the difficult articulation between our work and the hospital which is nevertheless a primary partner in our project. The institutional functioning of the psychiatry service gives, for the moment, little latitude for a member of the team to involve himself [in the project]."*⁹⁰

⁸³ Quoted from an interview with a therapeutic project coordinator

⁸⁴ Quoted from an interview with a therapeutic project coordinator

⁸⁵ Quoted from an interview with a therapeutic project coordinator

⁸⁶ Quoted from an interview with a hospital representative

⁸⁷ Quoted from an interview with a therapeutic project coordinator

⁸⁸ Quoted from an interview with a therapeutic project coordinator

⁸⁹ Quoted from an interview with a therapeutic project coordinator

⁹⁰ Qualitative evaluation of the therapeutic project n°107, April 2008 – Free translation

It would appear that decompartmentalising a public action operates principally within the health field, between actors funded by different public powers, but it scarcely extends to related sectors.

3.5.3. *Therapeutic projects contribution*

Meeting practices multiply. In the therapeutic projects, all partners must be present at the inclusion meeting and at least three signing partners must attend the quarterly dialogue meetings about patients. Physical meetings and exchanges allow a better reciprocal knowledge of the structures and what they offer. *"We each have our little network. The project is: let all sit at the table with our networks."*⁹¹

Moreover, "We can distinguish several types of innovative and federative activities linked to the particular therapeutic projects such as : the creation place of reception and listening co-managed by the partners, activities of internal and external promotions of the project, sessions of training on a particular aspect of the dialogue, development of a proper method of pooling, development and formation of a "pool of referees" for the patients, organization of workshops on an aspect of the work in network, development of specific activities destined to the patients of the project, etc." (De Coninck, Henry 2008: 22; free translation)

3.5.4. *Mobilised knowledge*

On the application form, a point is reserved for "scientific support" where projects are invited to add some scientific references which underlie their approach. Bibliographical references mentioned here are many. Two main categories can be drawn from these: network methodologies and clinical references.

First, most of the projects rely on a general network methodology. How networking is put in place. What the facilitating factors for this type of collaboration are. This work relies on theoretical and methodological references. The main methodologies on which therapeutic project partners base their work are first the *institutional psychotherapy* (Déliion 2005), which centres on patient participation to put in place a multidisciplinary care device, and second the *Clinique de la Concertation* (Lemaire and al. 2003), which also relies on the patient who invites all professionals and anyone else he wishes to participate in this network therapeutic activity.

Second, some projects rely on acute clinical literature related to the pathology: innovative care approaches, studies on combinations of medicine, and so on.

⁹¹ Quoted from an interview with a therapeutic project coordinator

3.6. Implementation process or the diversity of local initiatives

The general philosophy of the pilot project is to favour “meeting between initiatives (top down) taken by politics and those (bottom up) taken by mental health street-level actors”⁹² in order to proceed to restructuring the mental health field in Belgium. Partners have then benefited from a wide room to manoeuvre in defining their project.

The various elements described below testify to the diverse and innovative character of locally based initiatives. The latitude from which actors benefit is situated at various levels: choice of pathology, definition of geographical zone, specification of objectives, and so on. “The innovative strategies are rather issued from intervention at the basis, nearest from the problems, than from the formal interinstitutional partners.” (Dumoulin and al. 2006; free translation)

This approach involves a project common to all partners, it comes close to the project approach developed in France in the health sector where “The organization of the work within this sector rely on a project management [...] It incites the promoters to engage themselves in a common reflexion on the goal pursued, the means they envisage, the principles and the values which are theirs [...] [The arguments constructed and mobilized in order to justify the organization of a new action] take part in a process of construction of the group’s identity.” (Borraz, Loncle-Moriceau 2000: 59; free translation)

3.7. Focus on a therapeutic project – Local case

To illustrate various dimensions of a therapeutic project, it is relevant to continue with an extensive description of a particular project. This focus constitutes our local case. In this perspective, we took an interest on the project n°107 “Un lieu, un lien” (“a place, a link”).

3.7.1. General description

Project no. 107 “Un lieu, un lien” is a therapy group for psychotic adults. It addresses the population of Mouscron and of peripheral towns. In the yearly activity report sent to the National Sickness and Disability Insurance Institution at the end of the first year, 48 patients entered the project, 38 of them came from the activity zone defined by the project while 10 came from outside this zone.

⁹² Partial opinion (2 and 3) on “{transversal dialogue/horizontal consultation}”: towards the definition of mental health care organisation new modalities of February 8th 2007

The therapy group is a welcoming space, of conviviality and of mutual-aid. Different categories of professionals are on duty two afternoons per week. The added-value of such a enterprise are, from now, proved: added-value of the action that oblige to get out of home, to adapt himself to a place, to practice a chosen activity; added-value of the dialogue, pedagogy of the liberty and of the responsibility." (Roques 2005; free translation). Moreover, the therapeutic project also constitutes a dialogue formation place for professionals.

The project aims to offer a place likely to re-establish social links, whence the project's name. "The project's ambition is to re-constitute social and relational interconnection by proposing a place where the patient, seen as a partner, is a stakeholder in the "Un lieu, un lien's" decisions and orientation."⁹³

3.7.2. Project's philosophy

The project is explicitly largely inspired by principles lauded by the Institutional psychotherapy movement. This movement was born in the meeting of psychoanalysis and public psychiatry in the 1940s in France while the failure observations of the hospital institution grew along with the perverted effects which it generated (hyper-specialisation, compartmentalisation by pathology, sanitary system's hierarchy). The most renowned representatives of this movement are François Tosquelles, Paul Sivadon, Georges Daumézon and Jean Oury.

"The Institutional psychotherapy is a method of treatment of the mental disease which take into account the individual in global." (Déliion 2006; free translation). It principally addresses serious psychiatric pathologies which necessitate plural and multidisciplinary care, like psychosis. The psychoanalytical model constitutes the base "but it must adapt itself to the particular conditions of this work in a collective frame [...]." (Ayme 1994: 33; free translation). Institutional psychotherapy presupposes the participation and importance of social and care partners, bearing their own specificities. "It bears the necessity of going ahead together, every professional categories as a whole [...]" (Déliion 2005; free translation)

The therapy group is a central operator in institutional psychotherapy. It aims to allow the gradual institutionalisation of "living together". It is constructed through interaction between users and professionals; the program is not pre-established. "*It is a place where people are creators, there is a minimum of structure which is put in place with everybody.*"⁹⁴

⁹³ Application form for a "Mental health care therapeutic project", Therapeutic project no. 107 "Un lieu, un lien", December 2006 – Free translation

⁹⁴ Quoted from an interview with a professional partner of the project

In Belgium, "[Institutional Psychotherapy Movement] succeeded in concretizing itself essentially in "intermediary structures" which benefit, for the major part, of a particular convention of psycho-social reeducation with the National Sickness and Disability Insurance Institution." (Turine 2007 : 17; free translation). This project coordination is assumed by this type of a structure, the Centre Laurent Maréchal.

Moreover, the Belgian Institutional Psychotherapy Movement⁹⁵ groups together associations and persons interested in this type of philosophy and practices and "try – without willing to copy on what has been done in France - to understand the meaning and to articulate it with the context particular to our proper structures." (Maebe 2003 : 172; free translation)

3.7.3. Project's origins

The project's origin responds to a dual request, that of patients and that of professionals.

On the one hand, patients, after hospitalisation, are left to their own devices in day-to-day life, which can appear strange to them. *"When you leave hospital, you do no longer meet people who have problems, you feel lonely. It is very beneficial to keep a foot in an institution where other people have problems."*⁹⁶ According to a professional we met: *"users regularly attending the group were not hospitalised despite their desire sometimes! Some entered a care network more "slowly" thanks to Un lieu, un lien."*⁹⁷

Psychotics can adopt unexpected behaviours, especially when medication has not been respected. Thus, of the 48 patients who entered the project, 12 left it without giving an explanation. This fact seems to have been anticipated by the project's promoter. "The project is seen as a very supple structure. The patient will define the use he will make in dialogue with partners. He could only go by... or to settle down; he will come to do something... or just talk; with a certain regularity or punctually when he needs it; he will invest himself in the project management or not."⁹⁸

On the other hand, a request comes from professionals themselves. They sometimes feel resourceless when faced with the social suffering they meet. Home help services, especially, are often confronted with situations they cannot bear. *"Besides, two home services sent their personnel to theoretical training and here, it is a field training. Here, we train each other, we exchange."*⁹⁹

⁹⁵ <http://users.belgacom.net/PI-IP/>

⁹⁶ Quoted from an interview with a non-professional partner of the project

⁹⁷ Quoted from an interview with a professional partner of the project

⁹⁸ Candidature form for a "Mental health care therapeutic project", Therapeutic project n°107 "Un lieu, un lien", December 2006 – Free translation

⁹⁹ Quoted from an interview with a professional partner of the project

Moreover, the therapy group is perceived as a response to a lacuna in mental health care system. "The flexibility of this type of structure constitutes its specificity compared to what exists, that is, hospitalisation on the one hand and intermediary structures, more restrictive for the user (treatment length limited according to diagnosis and other administrative constraints) on the other hand."¹⁰⁰

Participation in therapeutic projects was an opportunity to initiate this project which was in the pipeline for several years and to obtain financing to set it up.

3.7.4. Concrete organisation

The group is a supple structure. Contrary to other structures where constraints, notably administrative constraints, define care length, here, it will be the patient – in dialogue with professionals partners – who will determine the possible term of the engaged work. This possibility to individually adjust the length of our structure use responds at the same time to the demand for "made-to-measure care" [from the National Sickness and Disability Insurance Institution].¹⁰¹ Users use it according to their needs and desires. Those practices are representative of the new forms of social action. "The imperative is now no more to exert a pressure (emancipating or controlling) on the individuals, but to succeed in inciting him to mobilize his resources, his feeling, his affects, his willing in order to help him to take himself in charge" (Vrancken 2002 : 41; free translation). It consists in starting from the user's resources and abilities rather than dwelling on the deficiencies.

Three elements seem fundamental at the level of organisation: the group's concrete functioning, partners and meetings.

Functioning

The convention between "Un lieu, un lien" and the National Sickness and Disability Insurance Institution started, like all conventions, on April 1st, 2007. Nevertheless, the room in which the group meets, made available by the Hospital Centre of Mouscron, required some substantial renovation and the first entry was recorded in September, so five months after signing.

The National Sickness and Disability Insurance Institution financing dedicated to coordination function was divided among several partners in order to allow them to participate in their duty: coordinator (8 hours), psychologist (2 hours) and auxiliary nurses (8 hours).

¹⁰⁰ Candidature form for a "Mental health care therapeutic project", Therapeutic project n°107 "Un lieu, un lien", December 2006 - Free translation

¹⁰¹ Candidature form for a "Mental health care therapeutic project", Therapeutic project n°107 "Un lieu, un lien", December 2006 - Free translation

Concretely, the group is accessible two afternoons per week and at least three professionals are present.

Partners

Project coordination is assumed by the Centre Laurent Maréchal, a psycho-social re-education service. Network is a mode of functioning which existed previously but informally. "These therapeutic projects were, indeed, the occasion for our sector to give witness and to make our work of collaboration known, which sin ever at the basis of our intermediary offer of cares."¹⁰²

When filling in the form of the National Sickness and Disability Insurance Institution, in December 2006, among the compulsory partners, there were two psychiatric hospitals, a mental health service and two home care structures (not specialised in psychiatric care). At the non-compulsory partner level, there were four general practitioners and two local neighbourhood authorities which pursue socio-professional re-insertion missions.

The partner list is seen as non-exhaustive and likely to change. "Recently, a new structure showed its interest in our project and wishes to become partner. It consists in a support service of [the Walloon Agency for the Integration of Handicapped People], which should then soon join our current partners."¹⁰³

Besides, the patient is considered a full-time partner. "*Another aspect of the project specificity is that it wants to be an attempt to optimize resources and competences of the key partner who is the patient and more particularly to give him the chance to position himself as an actor in the project conception and then actor of his own future.*"¹⁰⁴ In the same way, "*users became partners for other users.*"¹⁰⁵ From their experience, they know structures and activities; this experience sharing is developed.

For the group personnel, this principle is at the basis of the organisation. "*When we say that there is no difference, it is true. We share tasks; the difference is that there are professionals: we are not here to do everything, we are here to support, to make it run [...], at least at the beginning. We will see how it develops; it will depend on us all.*"¹⁰⁶

¹⁰² Letter from the Psycho-socio-therapeutic Structures Federation (Fédération des structures psycho-socio-thérapeutiques) to the National Sickness and Disability Insurance Institution, from January 22nd 2008 – Free translation

¹⁰³ Qualitative evaluation of the therapeutic project n°107, April 2008 – Free Translation

¹⁰⁴ Application form for a "Mental health care therapeutic project", Therapeutic project n°107 "Un lieu, un lien", December 2006 – Free translation

¹⁰⁵ Quoted from an interview with a professional partner of the project

¹⁰⁶ Quoted from an interview with a professional partner of the project

Meetings

Within the Institutional Psychiatry Movement, the meeting is considered the “principal operator of this large policy of intensive cares” (Delion 2005; free translation) or as a “concept which organize the collective” (Oury 1976; free translation).

The project “Un lieu, un lien” is organised around meeting practices. To recall, as one of the obligations of the project, there is the obligation to organise a quarterly dialogue meeting for each patient. Meetings are situated at various levels. First, a monthly meeting only takes place between professionals, practical and therapeutic aspects are addressed. Second, a bi-monthly meeting on club co-management gathers users and professionals. The objective is to determine together group organisation modalities: alcohol-free bar, membership cards, task distribution, and so on. And third, *“The group’s opening times are also considered as dialogue times because, technically speaking for the administration, representatives of various structures and users are present.”*¹⁰⁷

Dialogue practices set up by the group are anchored in a particular local dynamic. *“At the geographical level, there is a local specificity. Numerous projects have great difficulties gathering partners. Here, it has not been a problem at all. There is conviviality, there is local.”*¹⁰⁸

3.7.5. Difficulties

The project “Un lieu, un lien” enters, after a launching phase, a stabilisation process during which four types of difficulties appeared.

First, one of the group’s specificities is to allow the project to build itself as one goes along; organisation modalities are not pre-defined. Group users feel sometimes a certain distress or confusion when faced with this mode of functioning. This theme was addressed during a co-management meeting.

Second, the club is an innovative initiative not only for patients, but also for professionals. The latter considers that working at “Un lieu, un lien” is a rewarding experience. Nevertheless, some of them are preoccupied concerning the appropriateness of their practices: *“What is missing is a meeting between workers to know how to react in some situations, to know what distance to adopt or to know if what we do is right.”*¹⁰⁹ Promoters contemplate setting up a meeting between professionals in order to draw lessons from practice.

¹⁰⁷ Quoted from an interview with a professional partner of the project

¹⁰⁸ Quoted from an interview with a professional partner of the project

¹⁰⁹ Quoted from an interview with a professional partner of the project

Third, project legitimacy seems to be discussed in comparison with the medical logic. The main hospital institution does not seem interested in the project. *"We regret the difficult articulation between our work and the hospital which is nevertheless a primary partner in our project. The institutional functioning of the psychiatry service does not, for now, leave much room for a team member to involve himself in the group field. Nevertheless, we hope that this can evolve."*¹¹⁰

Fourth, a certain confusion seems to appear at the institutional and organisational levels. *"Other initiatives, from the region by example, make it more complicated at the understanding level for the professional structures."*¹¹¹

3.7.6. Relations with the National Sickness and Disability Insurance Institution

The National Sickness and Disability Insurance Institution is the body that subsidises the therapeutic projects. Therefore it is appropriate to describe the relationships between "Un lieu, un lien" and the National Sickness and Disability Insurance Institution.

At the end of the first year of operation, an evaluation took place. Projects completed a questionnaire. As mentioned above, there are two main conditions that each therapeutic project must meet by the end of the first year. First, a case load of 30 patients must be met. As regards "Un lieu, un lien", 48 patients entered the project, 12 of them left. This first condition is thus met. Second, for each patient, a quarterly dialogue meeting with at least three partners must be organised. During this first year, 124 dialogue meetings were organised and 93 of them were invoiced to the National Sickness and Disability Insurance Institution.

A priori, the operation of the project appears to be incompatible with the National Sickness and Disability Insurance Institution's management mode, which could be qualified as bureaucratic.

First, the general philosophy of the whole pilot project came with a will to preserve modalities to control administration. *"The interest is to propose something from the basis, from the local [...], it is a good idea. In the convention with the National Sickness and Disability Insurance Institution, we immediately saw that we could bring things but that we had to remain in cases. There are conventions that become more and more uniform in order to suit the most. We feel that everything that is asked to us forces us to be less creative."*¹¹²

¹¹⁰ Qualitative evaluation of the therapeutic project n°107, April 2008

¹¹¹ Quoted from an interview with a professional partner of the project

¹¹² Quoted from an interview with a professional partner of the project

Second, principles underlying the operation of Un lieu, un lien promote a progressive institutionalisation and co-construction process. *"Given that it is a project, it does not necessarily develop as we planned it but it is also what is interesting. And we see that compared to the National Sickness and Disability Insurance Institution's request, it is difficult because we do not know where we go. And we want to keep this spirit."*¹¹³

Moreover, each therapeutic project promoter specified in their application form the code for the pathology they will focus on (DSM IV, ICD 9 or ICD 10). But, for the Institutional Psychotherapy supporters, diagnosis is a complex process. "This diagnosis, this fundamental act which permit to learn to know, thought what we observe of what's going on in the patient, is far from the astrucltural caricatures of the DSM3 and the others neo-positivist gadgets" (Delion 2006; free transaltion)

Finally, terminologies employed by one or another are not necessarily the same and seem to come from different linguistic registers. *"The administration talks about inclusion, we talk about entrance. It is a fundamental difference."*¹¹⁴

Globally, the Institutional Psychotherapy movement seems like it can only register difficulties in a bureaucratic management mode. "We also had to fight against the administrative rigidity and its conservative tendencies in order to preserve the institutional creativity." (Ayme 1994 : 68; free translation)

¹¹³ Quoted from an interview with a professional partner of the project

¹¹⁴ Quoted from an interview with a professional partner of the project

4. Evaluation – Critical episode

The analysis of the elaboration process allowed underlining subjacent stakes of the restructuring of the mental health sector and the fundamental role played by the "Psychiatry" work group of the National Council of Hospital Facilities. The implementation process was then the object of a particular attention. The re-appropriation by field actors of national directives led to a diversity of local initiatives.

The evaluation is also an important phase in the contemporary policy lead. In this chapter, we will focus on two types of evaluation used within the framework of the therapeutic projects: the yearly evaluation of the National Sickness and Disability Insurance Institution and the transversal dialogue device.

The development of policy evaluation falls within a context of a State's loss of legitimacy and of a growth of public service mission delegations to multiple actors. "The evaluation procedures are constraints by the exigencies of « governance », which means a public action which mobilize a configuration of actors more and more diversified, which give priority to the territorial dimension, which seek to mobilize on shared goals." (Richard, Verdier 2002: 9; free translation). To this governance demand is juxtaposed a political will to responsabilize actors.

In 1993, J. Leca defines evaluation as "the activity of gathering, interpretation and analyze of the information about the implementation et the impact of measures aimed at acting on social situation and to prepare new measures." (Leca 1993 : 165; free translation). This definition emphasizes two aspects of evaluation; not only does it point to achieving a state of the art but it is also contemplated as a help to forthcoming political decision making.

Evaluation practices are at the heart of the pilot project we are studying. The objective of the therapeutic projects is to achieve, by the end of the three-year period, a definition of guidelines and an implementation of norms in terms of care circuits and networks.

In that perspective, two types of evaluation were set up. First, a quantitative evaluation is carried out yearly by the National Sickness and Disability Insurance Institution, the para-administration in charge of the Social affairs. Second, transversal dialogue process, supervised and financed by the Federal Public health service, the administration in charge of the Public health, also constitutes a type of evaluation.

4.1. Evaluation procedures

4.1.1. National Sickness and Disability Insurance Institution's evaluation

Therapeutic projects started on April 1st, 2007. At the end of the first year, an evaluation was carried out by the National Sickness and Disability Insurance Institution. Conditions to respect, as they are mentioned in the convention, are:

- Respect arrangement in terms of target group, partners and activity zone,
- Assure care for at least 30 patients by the end of the first year,
- Organise at least one meeting per quarter per patient with at least three compulsory partners present.

These conditions constitute a prerequisite to obtaining financing for the second year.

In a first version, evaluation was only quantitative and achieved by completing a standardised questionnaire (Excel table) which was sent to all the therapeutic projects. Required information principally concerns the number of patients by age category and by pathology (according to DSM IV code). This questionnaire was completed and sent to the National Sickness and Disability Insurance Institution by March 31st, 2008.

4.1.2. Transversal dialogue

In the convention, it is also stipulated that project partners promise, "for a complementary fee from the Federal Public health service to cover the cost flowing from it, to participate to a follow-up, evaluation and work evaluation process [...] within the framework of a "transversal dialogue [...]."

Transversal dialogue aims to organise confrontation between field experiences and political initiatives through three complementary approaches.

First, an *empirical* approach via transversal dialogue projects is put in place. The objective is to launch a learning process between partners of the various therapeutic projects addressing the same target-group and in the same linguistic role by organising exchange and thinking moments. This aspect is entrusted to the Dialogue platforms that organise meetings that gather therapeutic projects per cluster.

Second, a *scientific* approach via an analytical study is developed. It is organised around three dimensions: evaluation of the initial cooperation plan, data collection on network by interviews and data collection on patients through a scale manual. In this way, the

Belgian Health Care Knowledge Centre¹¹⁵ (KCE) plays a central role; it is in charge of data collection, analysis, interpretation and transposition into political choice.

Third, a research project¹¹⁶ aiming to “favour user participation at all levels: relationship cared/carer, care structures, politician”¹¹⁷ is put in place. This project comprises two elements: support for users, users’ families in the effective participation to the therapeutic projects and transversal dialogue and collection of good practices in empowerment matters.

4.2. Results

4.2.1. National Sickness and Disability Insurance Institution’s evaluation

The evaluation completed by the National Sickness and Disability Insurance Institution is, in their own words, more of an administrative control than an evaluation practice. Criteria are intended to run a verification of respect for administrative conditions.

Concerning results, of 78 projects selected by the National Sickness and Disability Insurance Institution, 41 reached the case load of 30 patients, 4 abandoned and two merged; the other 22 wished to carry on the experimentation but they did not respect all the conditions.

Given the difficulties met by numerous projects, results were discussed in the National Sickness and Disability Insurance Institution work group¹¹⁸ where divergences emerged. On the one hand, some people wished for revision of conditions: projects argued that conditions were too strict and that problems linked to starting up explained the delay. *“The interest is to propose something from the street level, from the local [...], it is a great idea. In the convention signed with the National Sickness and Disability Insurance Institution, we immediately saw that we could bring something but that we had to enter cases. There are conventions which become more and more uniform in order to suit the most people. We feel like everything that is asked of us will force us to be less creative.”*¹¹⁹; the federal Public health service, in charge of the transversal dialogue,

¹¹⁵ The Belgian Health Care Knowledge Centre (KCE) was set up in 2003 to counter a lack of policy-oriented research in health care. The KCE is scientifically and professionally independent but works with all main stakeholders in the health care sector, the universities, other scientific institutions and international organisations. The Centre is active in producing policy papers, recommendations and research in four main research fields: good clinical practice, health technology assessment, health services research, and equity and patient behaviour. The KCE makes its results available to policy-makers and must also ensure that feedback is given to health care providers.

¹¹⁶ This project is jointly held by user federations (Psytoyens and Uilenspiegel), by users’ families federations (Fédération des associations de Similes Francophone and Federatie van Vlaamse Simileskringen), by the Association Intercommunale de Guidance et de Santé and by a university centre LUCAS – KULeuven.

¹¹⁷ Presentation of the research project during the General Assembly of June 29th, 2007

¹¹⁸ This work group prepares the work for the Support committee.

¹¹⁹ Quoted from an interview with a project coordinator

wants a maximum of projects to participate in the study to increase the validity and reliability of the results. On the other hand, mutual insurance companies balk at fund projects which do not respect conditions and which do not bring any added value.

Finally, the work group proposed softening conditions for the second year. This softening consists in leaving some time to the project to reach the case load of 30 while being more rigid on the financing: a quarterly financing will be done at the pro rata of the patients included and if they are at least 20 and that by the end of the year they are 30.

The solution is a compromise: increased flexibility at the case load level and reinforced strictness at the financial level. The Insurance Committee formalised this proposal by sending a convention endorsement to the project coordinators.

Moreover, the therapeutic projects were invited to send a qualitative evaluation of their experimentation to explain in more detail their mode of operation and the difficulties they met. These data will be analysed by the work group.

1.1.1. Transversal dialogue

Transversal dialogue process should have started at the same time as the therapeutic projects, that is, in April 2007. Delays were recorded in some parts of the study. They were caused by field actor protests or by technical or internal organisation problems.

The *empirical* part, held by the Platforms, started on December 2007. In March 2008, platforms in charge of the various clusters handed in a report to the Federal Public health service. Globally, actors are satisfied with this mode of functioning but they wonder about its real impact.

Two positive aspects are particularly underlined. First, patient's physical presence at the dialogue meetings is seen as positive and rewarding; it leads to a more appropriate treatment meeting the made-to-measure care principle. Second, collaboration formalisation increased exchanges between structures, giving the possibility to more reciprocal knowledge and understanding.

Among recommendations, some are recurrent: softening administrative demands in order to allow each project to take into consideration local realities, allow the timing of the meetings to be more appropriate to patients' needs and find solutions regarding patient monitoring. It is interesting to note that the "collective learning" aspect is not developed in these reports.

As regards the *scientific* part, scales linked to patients' evaluations that were selected by the Belgian Health Care Knowledge Centre were sent via Platforms to projects in September 2007. A specific manual was allocated each target group in which selected scales are described and commented. Great resistance and reluctance emerged

immediately – these will be described in the next section – creating blockages. This part has not yet started; it should begin in September 2008.

Research on users' participation is also put in place. Participants ensure the follow-up of the transversal dialogue various clusters and of some therapeutic projects. Besides, coaching the voluntary participants is also carried out by the support team¹²⁰.

4.3. Strained Relationships

The evaluation topic appears to be difficult and generates strained relationships between various stakeholders. A special issue of "Confluences", the journal published by the Walloon Institute for Mental Health (IWSM), was devoted to this theme: "S'évaluer pour évoluer" (2007) – "Evaluate to evolve". The first article starts by: "The evaluation is an issue that is of concern for everybody in the mental health sector, and which, most of the time, give rise to suspicion. [...] Yes, the professionals of the sector think it's legitimate to assess their practices but yes, they are afraid by the evaluation" (Olivier 2007 : 18; free translation)

Sector's criticism does not concern evaluation itself but the devices recommended and used by the administration. Professionals underline the difficulty in evaluating situations linked to human subjectivity. "The sector of mental health would be "the place of the subjectivity". To understand it, the evaluation called "objective" of the type "evidence-based medicine/practice", which means based on the proofs, on the results, with the use of comparative scales would be inappropriate. But, it's precisely these scales that are the most often used by the subsidizing authorities." (Olivier 2007: 18; free translation). Evaluation tools used by public powers generally rely on objectivable data collection. Those figured evaluations do not allow showing each situation's specificity.

4.3.1. National Sickness and Disability Insurance Institution's evaluation

The evaluation completed by the National Sickness and Disability Insurance Institution is the subject of criticism by field actors. Therapeutic projects evaluation procedure is described as too rigid. As a field actor underlines it: "*In the convention with the National Sickness and Disability Insurance Institution, we immediately saw that we could bring things to bear but that we had to remain in cases. There are conventions that become more and more uniform in order to suit the majority. We feel that everything that is asked of us forces us to be less creative.*"¹²¹

¹²⁰ The support team is the « Association Intercommunale de Guidance et de Santé ».

¹²¹ Quoted from an interview with a professional partner of the project

Strained relationships between administrative demands and field actor practices turn out at the evaluation moment. The National Sickness and Disability Insurance Institution functions according to the classical bureaucracy model, characterised by a “command and control” feature (Salamon 2002). But “the network is a management by project” (Le Boeuf, Dupré 1999; free translation). “The principles of the evaluation can’t be separated from the management by project, fundamental principle of the network organization.” (ANAES 2001; free translation)

Among the points criticized, three appear as particularly problematic: the presence of three partners during meetings, the timing of the meetings and the case load.

The presence of three partners at the dialogue meetings is sometimes not very feasible. For some projects, the territory is an explicative factor: “*Given the distance and the time it takes, it is difficult to mobilize partners for meetings, mostly self-employed.*”¹²² For others, patient’s follow-up does not require the simultaneous mobilisation of three partners.

The frequency of the dialogue meetings is too rigid and is not adapted to an optimal patient follow-up: psychotics constitute a specific population, “*patients can stop their treatment from one day to the next and closet themselves away at home.*”¹²³ and people with chronic depression also have disadvantages, “*patients might feel much better and they do not see the point to attending quarterly meetings.*”¹²⁴

The case load was not achieved by about one third of the projects. But this case load is a preliminary to the financing renewal. “*Those who tried to really work with patients see their project hanging in the balance. Their institution is putting pressure on them because they did not achieved the case load and they have to do everything to achieve it.*”¹²⁵ Moreover, the geographic criterion is not taken into consideration: some projects are established in urban environment where the demographic density is high while others cover Counties with low populations.

Given the difficulties met by actors faced with this *administrative stranglehold*¹²⁶ during the first year in operation, coordinators were invited to join a qualitative evaluation of their initiative with the standardised questionnaire.

¹²² Quoted from an interview with a therapeutic project coordinator

¹²³ Quoted from an interview with a therapeutic project coordinator

¹²⁴ Quoted from an interview with a therapeutic project coordinator

¹²⁵ Quoted from an interview with a therapeutic project coordinator

¹²⁶ Expression used several times by field actors.

4.3.2. *Transversal dialogue*

At the transversal dialogue level, criticism is levelled mainly at scales selected by the Belgian Health Care Knowledge Centre. Relations were strained between professionals and platforms on the one side and the Belgian Health Care Knowledge Centre and the administration on the other. Criticism¹²⁷ about the scales relate to different levels. From a feasibility point of view, too much time and personnel must be invested in completing questionnaires. At the "scientific" level, scales, principally issued in the Anglo-Saxon world, were only translated. A validation procedure was not organised. At the therapeutic relationship level, by introducing evaluation practices, there are risks of distorting the patient/therapist relationship. Moreover, some questions are judged to be inappropriate or intrusive, and some ethical questions were raised, which some patients would not be able to answer. Another reproach concerns the relevance of the choice of scales. Selected scales evaluate the patient even though the starting objective was to evaluate dialogue added-value.

Numerous mails were sent to the Federal Public health service by various professional associations or by projects to criticize the scales and relay what the professionals thought about this type of evaluation.

Following these strained relationships, the Belgian Health Care Knowledge Centre made some modifications at the scale level by notably giving the patient the possibility not to answer and the therapist not to ask the question. The Support committee work group on transversal dialogue made some proposals concerning feasibility problems: the frequency of completing the scales (quarterly to annually except in the first year when it was applied three times) and increase in the funding such that the projects could engage one person on a part-time basis to complete the scales.

4.4. Interpretation and analysis

The evaluation will be based on the thinking and analysis of S. Jacob on institutionalisation of policy evaluation. In a comparative study, he is interested in institutional devices of policy evaluation in four countries, he made "the choice of the comparizon in order to determine the importance of the national traditions in the trajectory of this movement." (Jacob 2005: 836; free translation).

He proposes a typology based on two criteria: finality of evaluation (control or managerial) and degree of openness. By combining those two elements, he defines four ideal-types:¹²⁸

¹²⁷ Criticisms are more bitter on the French speaking part than on the Flemish speaking part.

¹²⁸ Free translation of the table

		Finality	
		Control	Managerial
Openness degree	Narrow	Technocratic	Corporatist
	Wide	Participative	Liberal

Without dwelling on factors which allow understanding this institutionalisation phenomenon, we will try to interpret our case study from Jacob's categorisation. The situation of the evaluation in Belgium at the central level, which is the federal level,¹²⁹ corresponds to the technocratic model. "The evaluation of the public policies is developing slowly in Belgium. The device is orientated toward a control finality and its openness degree is completely limited to the administrative actors or to researchers coming from institutions near the partisan movement of the silent partner." (Jacob 2005: 850; free translation)

Compared to this typology, when we focus on therapeutic projects, it clearly appears that the evaluation issued by the National Sickness and Disability Insurance Institution falls within the technocratic model. Indeed, evaluation criteria are defined by the Commission of conventions, which is composed with equal representation on the side of both mutual insurance company representatives and the sector representatives. Results were analysed within the National Sickness and Disability Insurance Institution work group. Decision-making power is held by the Insurance Committee, which has equal representation from both the legitimate and usual sector representatives and mutual insurance company representatives. The evaluation process is circumscribed to a limited number of usual representatives; it is not open to external actors. The finality of the device is to check that convention conditions are respected. Therefore, it is a control finality.

The transversal dialogue seems to initiate an extension on both dimensions. Indeed, at the degree of openness level, various actors are solicited: platforms, users and an independent expertise centre (Belgian Health Care Knowledge Centre). The objective is similar to a managerial finality because it aims to arrive at a definition of norms and guidelines by the end of the experimentation phase. This type of evaluation is nevertheless not completely novel. "In this type of system which seems completely closed, it is interesting to notice that some punctual initiatives emerge. These are from politicized actors who are moving away from the established norms and who initiate a « savage » process of evaluation. » (Jacob 2005: 850; free translation)

¹²⁹ For more information on evaluation at the federated levels, see Varone, Jacob 2004 : 289

Moreover, the scientific evaluation mission was outsourced to a centre of expertise, the Belgian Health Care Knowledge Centre, which claims its independence towards public powers. "[...] The main critic addressed to the internal evaluation is its lack of credibility and independence." (Jacob 2006: 24; free translation). This outsourcing can be seen as a way to increase the legitimacy of the study carried out by the Belgian Health Care Knowledge Centre.

Moreover, according to J. Leca, the culture of evaluation must be assimilated by the whole policy system, either by decision-makers or by field actors passing through intermediary bodies. It appears that, not only are evaluation practices not widespread in Belgium, but moreover the mental health sector feels some resistance towards quantitative evaluation because it does not allow taking into consideration the specificity of each situation.

Evaluation must not be integrated " neither as something external, nor as a sort of split of personality (I'm actor, but I'm also evaluator) but [...] as a sort of perspective, of regard of the public apparatus on itself [...]" (Leca 1993: 171; free translation). However, in the case of the scales devised by the Belgian Health Care Knowledge Centre, this splitting was implemented: the one who applied the patient's evaluation was therapist and evaluator. For field actors, this situation is perceived as a hindrance to the therapeutic relation. Following those criticisms, additional subsidies were allocated to therapeutic projects; they allow hiring additional part-time staff to complete this mission.

We would like to briefly return to Leca's evaluation definition. This definition emphasises two aspects of evaluation: evaluation as achievement of a state of the art concerning the implementation and evaluation mobilised in a prospective approach.

The evaluation devised by the National Sickness and Disability Insurance Institution seems to relate only to the first aspect: the objective is to control the efficiency of the implementation; it corresponds to the technocratic model. On the contrary, the transversal dialogue approach seems to combine both aspects: it falls within a perspective of State modernisation by proceeding to an extension to both Jacob's dimensions.

Evaluation practices do not constitute a novelty; innovation appears more on evaluation forms. On the one hand, classical technocratic evaluations, as devised by the National Sickness and Disability Insurance Institution, adapted itself to the functioning per project by in particular softening the convention conditions. On the other hand, transversal dialogue is representative of new participative evaluation forms. New evaluation practices appear as a corollary to the evolution of the role and form of the State. The State delegates, decentralises, contractualises, tries to increase its action efficiency by favouring a local anchor and by giving actors responsibilities. Evaluation is a way to adopt a form of reflexivity towards those new public action forms while legitimating it. "It's one of the dimensions of this reflexive State which is in constitution after the Welfare State." (Genard 2007: 20; free translation)

Therapeutic projects fall within a project logic, not only by their label but also by their implementation characteristics. "The project is, the more often, a form of action associating – in network – several actors, with limited and precise goals on the short-term, with letting to the implicated actors some possibility and autonomy to achieve their ambitions. It's why the logic of project calls the one of evaluation." (Genard 2007 : 20; free translation). Therapeutic projects' punctual and experimental character makes evaluation practices essential.

To conclude, it is interesting to underline the phenomenon of invasion of the evaluation carried out by the National Sickness and Disability Insurance Institution on transversal dialogue. Thus the annual reports submitted to the administration form give the National Sickness and Disability Insurance Institution more its due. Moreover, transversal dialogue as a place for mutual learning among partners does not appear to have fulfilled its claims in this matter. The meetings and the lessons learned are similar to places and forms of demands rather than of the reflexive nature.

5. The regulation

The increasing complexity of the decision and implementation processes for contemporary public action led the researcher to understand these phenomena following an approach in terms of regulation. "The multiplicity of bodies and actors established in a growing relative autonomy, with new possibility of intervention, allow to talk about a polycentric form of regulation of the social and of the policy" (Commaille, Jobert 1998 : 15; free translation)

In the context of our case study of the therapeutic projects, it would appear that two main sources of regulation can be identified: a top-down regulation and a bottom-up regulation. The general philosophy of the pilot project is moreover to encourage the encounter between the initiatives taken by the politician (top-down) and those taken by the mental health actors (bottom-up)¹³⁰ to restructure mental health care in Belgium.

On the first hand, a "top-down regulation" – of control, if it is based on Reynaud's theory of social regulation (Reynaud 1988) – defines a frame of action. This regulation falls within a typically Belgian political context based on a culture of compromise and on the active participation of the advisory boards in the decision-making process. The concept of mental health care is a policy innovation, which will be tested through the therapeutic projects. This approach illustrates the renewal of the work in the leadership of the contemporary public action.

On the other hand, a "bottom-up regulation" – autonomous regulation, also according to Reynaud's theory – a priori influences this defined category. The field actors see the importance of the issues that refer to the implementation of the therapeutic projects. The room to manoeuvre that left them, at the experimental stage, with the innovative forms of dialogue led to a diversity of the local experiences that nonetheless allowed characteristic elements of the public policies of the Welfare State like hospital-based medicine and the strong differentiation of the fields of action. We will then see to what extent the implementation of the projects exercise, through a feedback effect, an influence on the development process itself.

For Genard: "Process of legitimization by the high competes with process where the legitimization operates rather horizontally through the proceduralization of the normativity and of the public action." (Genard 2002b: 38; free translation). These two types of regulation are of course interrelated.

¹³⁰ Partial opinion 2 and 3 transversal dialogue: Towards the definition of new organisation modalities of mental health care of the *Conseil National des Etablissements Hospitaliers* of 8 February 2007.

5.1. Top-Down Regulation

5.1.1. *The culture of compromise in Belgium and the central role of the dialogue structures*

In Belgium, the policy-decision process is characterised by its complexity. The national context and the characteristics of its mode of political operation influence the manner in which the exchanges are organised.

Belgium is a “démocratie consociative” (consociative democracy) (Lijpart 1969). This type of political system is characterised by a political proportional representation and the participation of the economic and social elites of the decision-making process. These two dimensions tend to encourage an operating mode based on the compromise, the “Belgian compromise”. “Since 1830, all important conflicts which took place in our country [...] have been resolved by compromises negotiated between the political, social and economical elites. [...] [The compromise] has permitted to assure equilibrium despite the different cleavages which divide the Belgian society. ” (Pourtois 2007 ; free translation)

According to De Munck: "In terms of democracy, we can say that we are in front of a double source of legitimacy of the decision : on one hand, the parliamentary representation, on the other hand the representation of the interest groups. [...] In matter of public action, the decision is taken at the conjunction of these two systems of representation." (De Munck 2003: 37; free translation)

Belgium is a federal State divided into three Communities and three Regions. Every level of power has its own Parliament that applies the system of proportional representation of political groups. Negotiations are held at every level, no party having an absolute majority of seats. “ The complex game of cleavages, both effect and cause of conflict, call for the compromise. The practice of the last imposed itself to the parties when the conjugated effects of the proportional representation and of universal suffrage have instituted a regime which is the one of the Government of coalition. But, this practice imposed itself to the powers in presence and particularly to the social partners.’ (Mabille 1997; free translation). The multiple layers of power necessitate coordination structures within which interinstitutional negotiations take place. In the health sector, the Interministerial conference for public health gathers the seven ministers competent in this area.

Moreover, the consultation bodies play an important role in the decision-making process. Thus, the health sector is characterised, at the federal level, by the participation of a multiplicity of consultation structures. "Belgian health care organisation and policies are highly influenced by a number of nongovernmental stakeholders, including sickness funds, the Order of Physicians, health professionals’ associations, hospital associations,

pharmacists' associations, the pharmaceutical industry, trade unions, employer organisations, etc." (Corens 2007: 32)

The diversity of levels of power, along with their mode of proportional representation and the participation of several advisory boards, calls for a decision mode centred on the compromise. This tradition does not make it easy to access 'scientific' knowledge in the decision-making process and makes it difficult to implement the "knowledge-based" policies since the political arrangements, themselves, are difficult to resolve.

5.1.2. A Political Innovation

In the mental health sector, the "psychiatry" work group of the CNEH defined the new concept of mental health care.¹³¹ This new organisation and the principles on which they lie appear to constitute a *political innovation* the initiator of which would be precisely the "psychiatry" group.

In fact, a change of direction of the perspective is at work here: the approach should focus on the patient and his or her needs and not on the provision of care. The patients are considered actors of their own destiny. The new practices are incentive, build on the activation of the individuals, of their affects, their resources and their social network." (Vrancken 2002: 42; free translation) A new normativity is developing, that of the work on oneself (Vrancken, Macquet 2006).

According to Reynaud, "An innovation is not a choice between different propositions of which we'd make a list in order to compare the advantages, but the invention of a solution which permit to get out from contradictory exigencies." (Reynaud 2004: 145; free translation). This new vision of mental health care falls within a context under pressure. On the one hand, the policy would like to pursue the reform initiated in 1990. On the other, the sector opposed it by presenting these changes as not constructive.

Starting with the notion of "translation" (Callon 1986), Lascoumes develops that of "transcoding" "in order to describe the cognitives activities and the process of mobilization and of negotiation upon which the public action and its renewals rely on." (Lascoumes 1995 : 327; free translation). He then divides this process into four inter-related steps.

The first step bears on "the aggregation of diffusive positions and the formalization." (Lascoumes 1995: 335; free translation), which leads to the (re)definition of a problem. The "psychiatry" group, by defining the new concept of mental health care, tries to reconcile the expectations of the policy and those of the sector while falling within a

¹³¹ Opinion in the context of the new mental health care concept, summary and operationalisation opinion in the context of a five-year plan from the *Conseil National des Etablissements Hospitaliers* 10 July 2002.

general international tendency. The knowledge mobilised here are diffuse and have a normative dimension. They are then adapted to the specific context in which they have been integrated. Starting with the requirements of both and by inspiring different experiences abroad, it creates a new concept of mental health care specific to Belgium which was formalised for the first time in the opinion of 1997.¹³² Lascoumes emphasises “the fact that the contemporary public policies are, in great part, the results of compromises and of reformulations of solutions preexisting.” (Lascoumes 1995: 334 ; free translation).

The second step is aimed at “the insertion of the upcoming stakes in the intellectual devices and the existing practices” (Lascoumes 1995: 335; free translation). The new organization takes into account the institutional features of Belgium, particularly as regards distribution of competences between the different public powers, and existing structures in the field of mental health. *“It is a transformation strategy: we take as a point of departure the institutions as they are known and give them the opportunity to redefine themselves with their means and human resources in the elements of this care programme.”*¹³³ The way the concept is rooted in Belgian practices of compromise requires a thorough knowledge of the institutional and organisational mechanisms. The “psychiatry” group is a central actor at the political level, and its members are well established in civil society.

The third step is that of a “enlarged diffusion of the newly made cognitive and organisational constructions.” (Lascoumes 1995: 335; free translation), which consists in opening the negotiation space. Once the new concept was formalised, the “psychiatry” group was included in the political space through the Ministers who were in office in 2001 and authors of the first policy note¹³⁴ who drew inspiration from this work. The reorganisation necessitated interinstitutional collaboration, the file was then discussed and approved at an interministerial Conference and was the subject of a joint declaration.¹³⁵ On the basis of this, in 2005, the Minister responsible defined the main lines before the practical modalities were established by the Accompanying Committee and endorsed by the Insurance Committee. The content of the policy was not defined once and for all, it was renegotiated by the main players at each stage. Nonetheless, the “psychiatry” group appears to guarantee a certain continuity.

¹³² Opinion (2nd part) of the permanent “psychiatry” work group of the *Conseil National des Etablissements Hospitaliers* on future organisation and development of mental health care 12 June 1997

¹³³ Interview with a representative from the hospital system

¹³⁴ ‘Psyche: my latest concern? Mental health care: participation and coordination paths.’ Policy note from the Minister of Social Affairs and of Pensions and the Minister of Public Health, 2001.

¹³⁵ Joint declaration of the Ministers of Public Health and of Social Affairs on the future policy on issues of mental health care of 24 June 2002

The fourth stage gathers together "the activities of structuration of the wider audience of the decisions [...]. They create and renew the cognitive frames of reception of the public measures and the social effects they create." (Lascoumes 1995: 336; free translation). In our case, the audience comprises all the mental health care providers. To introduce the changes in an action system and give rise to cooperation among the actors, the originator should know the actors' routines and cognitive maps (Reynaud 2004). Among the active members of the "psychiatry" group, there are representatives of the two main hospital federations who possess a sound knowledge of the field since they relay their members' claims to the political realm. They are also given considerable weight at the level of follow-up which will be given the directives.

5.1.3. *From innovation to experimentation*

The innovation developed by the permanent "psychiatry" group will be implemented using an experimental phase. "To experiment, it's somehow trying to program the innovation and to make a shift from the hazardous, tinkered, and often personalized mode to a more rational mode." (Chauvière 2005: 392; free translation). The therapeutic projects are thus a wide-ranging pilot project the goal of which is to reach, at the end of three years, a proposal for reorganizing mental health care.

A comparison is likely to be made between the therapeutic projects and the "experimental laws" that were developed in various European countries. Many countries (France, Germany, Sweden, Norway, etc.) thus have recourse to legislative experimentation. According to Chevallier: "The experimentation implicates that before being completely adopted, a reform has to be tested on the reality: after, its content will be adjusted, according to the effects recorded. It pass by the combination of four conditions : a field of study must be chosen, an end has to be defined at the beginning, an evaluation has to be planned at the end of the period, and a decision of stopping or continuing the device has to be subordinated to the conclusions of this evaluation. (Chevallier 2005: 390; free translation)

Therapeutic projects constitute an experimental stage aimed at testing new methods of organizing mental health care as regards care networks and circuits. "The legislator recognizing the imperfections of his work [...] admits le provisory character of it and engage himself to improve it after having noticed insufficiencies." (Chevallier 1993: 137; free translation). The therapeutic projects meet the four characteristics raised by Chevallier.

First, a field of study was defined. It was wide-ranging, 82 local projects were selected according to a procedure defined by the Insurance Committee and made official in a

Royal Decree.¹³⁶ The selection criteria¹³⁷ set out to ensure the experimentation reflects the diversity of field practices.

Second, the experimentation theoretically lasted three years. “[The] period of experimentation is aimed at permitting to reduce the incertitude or to obtain the consensus that is missing.” (Chevallier 1993: 137; free translation). As we saw, there appeared to be a broad consensus on the principles and main lines of restructuring the field. The experimental stage appears to be more dedicated to defining the practical modalities of the implementation. An extension of the experimental stage cannot, however, be excluded. In effect, delays accumulated for different reasons, thus differing the effectiveness of the evaluation.

Third, an evaluation was planned. “Conceived as a provisory mode of direction of the behaviors and as a learning process, the experimental laws lead to an evaluation several years after their implementations.” (Kletzlen 2000: 19; free translation). The evaluation approach for the experimentation was carried out through horizontal consultation, it is not done when the deadline expires but at the same time as the implementation of the projects. It includes two elements, empirical and scientific. The empirical element of the horizontal consultation, entrusted in the Consultation Platforms, is aimed at developing moments for exchange and reflection between the various projects. *“The objective is to launch a learning process among the participants in the therapeutic projects to bring out lessons from the ‘field’ by an approach that uses follow-up and support for the therapeutic projects; it is a matter of raising the guidelines at the beginning of the experiments of the field actors as regards collaboration, interaction and complementarity among actors and as regards the content and forms of care needed by the programme of care.”*¹³⁸ The objective of the scientific element, led by the Federal centre of expertise, is to anchor the reflection in an analytical perspective.

And fourth, the goal of horizontal consultation is to draw lessons from local practices before conducting any generalisation of new modes of organisation. *“The objective of the horizontal consultation approach is to raise the directions in terms of content and form of organisation of mental health care circuits and networks starting with the experiments*

¹³⁶ Royal decree of 22 October 2006 setting the conditions under which the Insurance Committee can conclude agreements by applying art. 56(2)(1)(3) of the law on obligatory health care and compensation insurance, coordinated 14 July 1994, for the funding of therapeutic projects in matters of health care. MB (Belgian law gazette) 06-11-2006

¹³⁷ The selection criteria are the geographic distribution, the target group distribution and the quality of the projects introduced

¹³⁸ Partial opinion 2 and 3 of the Permanent "psychiatry" Working Group of the national council of hospital establishments on 'horizontal consultation': Towards the definition of new methods of organisation of mental health care of 8 February 2007.

carried out in the context of therapeutic projects, to arrive at a structural proposal for organisation like the care circuits and networks."¹³⁹

Experimentation is thus a governmental technique that offers a provisional framework for regulating practices while transferring the responsibility for the feasibility study to the care providers and institutions.

According to Chevallier, "The experimentation is conceived as a way of promotion and of learning of the social change." (Chevallier 2005: 390; free translation). The new vision of mental health care and of its organization combines the normative diffuse knowledge that was adapted to the specificities of the mode of Belgian political operation. Once the new concept has been defined, it is implemented by an experimental phase that aims at drawing inspiration from the field practices and knowledge but also to 'convince' the field actors of the need for organisational change.

5.1.4. From experimentation to regulation

The 'top-down' regulation is presented as an innovation for which the initiator, the Permanent Working Group for "psychiatry" was able to mobilise, interested in taking Callon's term (Callon 1986) back, an expanding circle of actors around this new concept of mental health care. The implementation was then achieved through an experimental stage from which lessons should be drawn.

The 'top-down' regulation falls within a complex context characterised by the variety of actors and the plurality of power levels concerned. It calls for new mechanisms like proceduralising public action or developing contractualisation.

In the face of the bursting and the increasing complexity of the forms of public action, we are witnessing a proceduralisation of public action, that is "a type of public action which operate by the territorial establishment of instruments of knowledge, of deliberation, and of decision-making which are not much finalized a priori." (Lascoumes, Le Bourhis 1998: 39; free translation). The objective being to draw inspiration from concrete practices, the candidates in the therapeutic projects were given a broad margin for manoeuvre, in particular as regards the choice of target population, the territory covered, partners, and so on.

However, the administrative procedures determined by the National Sickness and Disability Insurance Institution are limiting, particularly as regards financing conditions. First, a case load of 30 patients should be filled. Second, for each patient, a consultation

¹³⁹ Partial opinion 2 and 3 of the Permanent "psychiatry" Working Group of the national council of hospital establishments on 'horizontal consultation': Towards the definition of new methods of organisation of mental health care of 8 February 2007.

meeting with at least three partners in attendance should be organised every three months. The field actors will discuss this subject of *administrative support*.¹⁴⁰

The contractualisation has become a means to coordinate the actions of the group of actors that fall under a public action. The contract, as “a supple device of coordination and of harmonisation” (Chevallier 2003: 216; free translation) maintains a certain degree of coherence of the public action while leaving the actors margin for manoeuvre.

The public action that we have studied is characterised by the abundance of contracts between the various stakeholders:

- A ‘convention on financing therapeutic projects in the field of mental health care’ is signed by the administrative coordinator of each project and the ability to fund.
- A collaboration agreement between partners is signed by all the structures collaborating on the therapeutic project.
- A written consent document of the patient attests to his or her participation in the project. This approach falls under the global perspective of the new means of public action that favours participation and activation.
- A convention on the ‘collection of information related to the therapeutic projects of mental health care in the context of horizontal consultation’ is signed by the administrative coordinator of each project and the Minister of Social Affairs and of Public Health.

The many contracts, conventions and other kinds of agreements for therapeutic projects illustrates the contemporary public action that tends to encourage the many partners. Contractualisation tends to reduce competition between structures and encourage collaborations. “[...] Through its procedures of putting in explicit negotiation, [...] it suggests a common holding of an issue. [...] Nevertheless, if the limits of action are made more relative and permeable, the contractualisation of the public policies confirm, the more often, the asymmetric relations existing between the different powers.[...]” (Gaudin 1999: 41; free translation). In this case, contractualisation effectively tries to reduce the traditional competition that places in-patient against out-patient, since the creation of the latter. It also aims to encourage partnerships between the State and the institutions working under various statuses. Nonetheless, it would seem that the existing power relationships still exist.

Moreover, the therapeutic projects fall under a per project operating method. More than financing institutions, “the matter is now to promote and to fund projects. The State

¹⁴⁰ Expression used several times by the field actors.

establishes goals of general order and the associations have to reappropriate them and to give them specific answers and solutions (notably territorialized) that will have to prove something and that will be evaluated.” (Genard 2002b: 49; free translation). It is thus a matter of relying on the experience and the knowledge of the field actors.

5.2. The bottom-up regulation

5.2.1. *The perception of the actors*

According to Kletzlen, “The experimental laws are used in politically sensible domains [...] or when they are a potential source of social conflicts [...].” (Kletzlen 2000: 19; free translation). The therapeutic projects constitute a significant issue for field actors. The main reason mentioned by the participants as regards their participation is that a reorganisation of mental health care is unavoidable and inevitable and that they are confronted by it as much as participate actively in it. They also perceive these projects as an opportunity to make concrete ideas that are in preparation, to deepen the courses of reflection or the initiatives, and to have the specificity of their practices recognised. The financial element is not considered a stimulant, the means made available by the National Sickness and Disability Insurance Institution only rarely cover the real costs of coordination and consultation.

To the actors, participation in a political experimentation appears to be an opportunity to influence the process of determining the standards that will govern the future organisation method. *There are those who participate in the projects but it does seem that they are also there to show all the reluctance they have in relation to an operation. And it is legitimate on their part, they defend their view of mental health.*¹⁴¹

5.2.2. *Diversity of Local Experiences and Adaptation Strategies*

When these pilot schemes are being set up, the basis will be the missions and their general conditions, defined by the authorities in the context of a global agreement. It should be possible to work creatively and flexibly with the general facilities used in these pilot schemes in the development of the necessary care to achieve the recommended objectives.¹⁴² Consequently, the field actors benefited from a broad margin for manoeuvre in defining their project, in the choice of the pathology, the definition of the geographic zone covered, the specification of the objectives, the selection of the partners of the choice, the methodology and the bibliographic references.

¹⁴¹ Interview with a horizontal consultation coordinator

¹⁴² Opinion of the Permanent "psychiatry" Working Group of the national council of hospital establishments in the context of the new concept of mental health care, summary opinion and operationalisation in the context of a five-year plan of 10 July 2002

The field work carried out, allowed us to highlight the diversity of the initiatives implemented locally. Considering the administrative constraints of the National Sickness and Disability Institution, some projects developed adaptation strategies to meet these requirements. *Some projects note that the best way to operate is to adapt to the administrative context in which they find themselves. They found strategies to be able to respect everything that was necessary administratively: they spend one morning every three months to report progress on each of the patients. It is then in the context where all administrative elements are dealt with: they are in order for all but we don't know where to find the most value of the patient.*¹⁴³ Others did not meet them for practical reasons (difficulty respecting the pace of the meetings or carrying out the case load) or on 'ideological' grounds (criticism of the evaluation methods at the Centre of Expertise). At the end of the first year, they met again in a complicated situation and did not know if their funding would be renewed.

To illustrate these adaptation strategies, we will focus on the therapeutic project that was the subject of an exhaustive description. While critical of the National Sickness and Disability Insurance Institution and its procedures, the 'Un lieu, un lien' project seemed to have put in place a strategy that allows it at once to operate according to its own principles (connected to institutional psychotherapy) while submitting to the administrative conditions and requirements of the National Sickness and Disability Insurance Institution.

The ability to adapt is illustrated in the way in which the project overcame the grey area (Crozier, Friedberg 1992) that makes up the consultation for the user. In fact, several projects faced difficulties organising meetings for two reasons. First, the *sequentiality* of the meetings does not correspond to the temporariness of the follow-up of the patient who is part of this and its evolution. Second, the coordinators only manage with difficulty to have three partners attend these consultations.

The organisation of the therapy group allows getting around these difficulties since the offices of the club are held by at least three professionals two afternoons per week. These times are thus considered consultation meetings, recognised and financed as such by the National Sickness and Disability Insurance Institution.

5.2.3. *The persistence of the previous operating method*

The new organisation of the mental health care, of which the therapeutic projects constitute the experimental stage, rest on the leitmotiv "home or out-patient care if possible, and in the hospital if necessary".¹⁴⁴ It aims at structuring the sector into care

¹⁴³ Interview with a horizontal consultation coordinator

¹⁴⁴ 'Psyche: my latest concern? Mental health care: participation and coordination paths.' Policy note from the Minister of Social Affairs and of Pensions and the Minister of Public Health, 2001.

networks and circuits – and thus encouraging relationships between the types of providers – and to encourage collaboration with the related sectors

“The public action is deployed in context socially structured, bound together on certain values and regulated by certain power equilibriums; this structuration constraints and limits the innovation potential [...] and lead to deviations of trajectories at the level of the application.” (Chevallier 2005: 387; free translation) Two elements lead to a relativisation of the impact of the changes stimulated by the therapeutic projects.

First, the hospital maintains a central place within the new model. Thus, where the project’s selection criteria are concerned, two elements go in this direction. To begin, the hospital is one of three obligatory partners of each project. Then, the target group and the inclusion of patients is defined based on the DSMIV. For Genard, “between [the medical knowledge] and the administrative logics, there are convergences. Notably there are convergences of logics like illustrated by the DSMIV for the mental health matters from which the underlying rationality meet the figure of the rationality underlying the traditional bureaucratic functioning.” (Genard 2003: 46; free translation).

It would seem that, from before the launch of the therapeutic projects, the actors had perceived this possibility. The hospital federations adopt a globally positive attitude in relation to these projects by approving and encouraging the approach. The out-patient structures are reluctant when confronted with a formalisation of the network and point at the risk of a drift toward hospital centrality. “What place can the mental health services take in this network and their elaboration, if they are set up beginning with the hospital world (which can more easily gather the minimum number of patients [...] necessary to mount a therapeutic project) [...]”¹⁴⁵

The persistence of hospital primacy can be explained by the central role of the permanent "psychiatry" work group of the CNEH throughout the elaboration process of the therapeutic projects and by the fact that the target public is made up of patients who present chronic and complex troubles.

Second, in practice, while coordination with the related sectors is encourage, few projects actively collaborate with the partners from fields other than that of mental health. “*It is an era of health reasoning. [...] The basic partners are the health actors. We are not creating a social aid network, it is a health care network.*”¹⁴⁶ The population being targeted by the projects is made up of people who suffer chronic and complex

¹⁴⁵ Reaction of the Association des Travailleurs de Santé Mentale Ambulatoire (AT SMA) in ‘Réactions aux projets thérapeutiques’ in *Formaliser le réseau ?* (2006)

¹⁴⁶ Interview with a representative from the hospital sector

pathologies, resorting to care and medicated treatment is, most of the time, necessary. *"I think the care element should remain central, it remains a medical practice."*¹⁴⁷

It thus seems that the hospital, traditional structure for long-term care in the context of mental health care, maintains a central position and that the decompartmentalising is carried out mainly within the field of health, among the traditional actors, certainly being a matter of different guardianship, but that it is only rarely extended to the related sectors. This acknowledgement highlights the pregnancy of the previous means of operating linked to the Welfare State. This is symbolised by the hospital figure found at the centre of the sector's organisation, and is characterised by a strong differentiation of the fields of public action.

Moreover, the position of the field actors in the face of this new operating method is equally linked to the profession of the partners and their philosophical position. *"Those who are in psychoanalysis will have more difficulty leaving a dual relationship with the patient and one would like to attend consultations with several partners."*¹⁴⁸ This observation is in keeping with that of Philippe who, in a survey on the implementation of new mental health public policies in France, observed: "different threshold of reception for the different professional categories and the theoretical obedience." (Philippe 2004: 221; free translation). The author then explains that the demands made on psychiatry have evolved, interfering with traditional professional expectations 'The injunction addressed to the psychiatry to take into account the suffering affects the object of this medical speciality – historically constituted by the treatment of psychosis – by assigning to it a psychosocial mission." (Philippe 2004: 222; free translation)

5.2.4. The Feedback Effect

The distinction between the process of conception and the process of implementing the public action that we carried out is heuristic but soon highlight the complexity of the returns to the work. Two elements appear in particular to shed light from this point of view.

First, the administrative control achieved by the National Sickness and Disability Insurance Institution at the end of the first year revealed the difficulties encountered by many projects, particularly as regards the case load. The results were discussed in the Working Group of the National Sickness and Disability Insurance Institution where differences emerged. First, some wanted to revise the conditions: the projects only maintained that the conditions were too strict and that the delay was explained by the problems related to the starting up; the SPF Public Health, responsible for the 'horizontal

¹⁴⁷ Interview with a project coordinator

¹⁴⁸ Interview with a horizontal consultation coordinator

consultation' part, would like a maximum of projects to participate in the study to increase the validity and reliability of the results. Second, the insurance organisations are reluctant to fund project that do not respect the conditions and that do not contribute any real added value. Finally, the Working Group suggested the conditions be relaxed for the second year of operation in the Insurance Committee that made it official by endorsing it at the project convention.

The criticism made against the administrative *support* defined by the National Sickness and Disability Insurance Institution thus took into consideration and led to development of the procedures.

However, the objective of the horizontal consultation is to arrive at the wording for a structural proposal of the care circuits and the networks of the various target groups. It will play a role at the level of determining the norms that will govern the model of organisation of mental health care in the future. The implementation of the pilot projects are thus an integral part of the process of designing public action since the experimentation should lead to a possible structural reorganisation of mental health care.

These two elements attest to a phenomenon of decompartmentalising the processes of elaboration and implementation of public action.

Conclusion

Dialogue and coordination practices constitute a major stake in the mental health field in Belgium. In this framework, the federal pilot project “therapeutic projects and transversal dialogue” represents a potential of important change in terms of care financing and organisation and coordination between different power levels.

Since the end of the 1980s, a new vision of mental health has developed under the influence of the permanent “Psychiatry” work group of the National Council of Hospital Facilities. This new vision adopts a holistic perspective which takes into account the diversity of factors at stake and aims to give a central place to the patient and his or her needs. The principles on which this innovative vision lies fall not only within an international trend which aims to put the patient at the centre of the system but also within field actor practices.

This vision is made concrete in a mental health care restructuration in terms of care circuits and networks. This necessitates an inter-organisational cooperation (between care stakeholders and institutions) and an interinstitutional cooperation (between public powers).

Therapeutic projects make up the experimental phase of this new mental health care concept. It is a wide ranging pilot project which aims to achieve, by the end of the three-year experimental phase, the definition of guidelines and the implementation of norms in terms of mental health care circuits and networks.

Our field work is limited – current events and investigation circumscribed to the cluster “General psychiatry – Adults” at the French-speaking level. Those limits necessarily have repercussions on the range of the conclusions that we can draw. Nevertheless, it seems to us that the characteristics of the regulation of the therapeutic projects illustrate the changes at work in contemporary public action evolutions.

We identified two main sources of regulation. On the one hand, a “top-down” regulation defines a broad action frame, leaving field actors significant room to manoeuvre in defining their approach characteristics. This scope of action is accompanied by rigid administrative procedures and conditions that illustrate the bureaucratic mode of functioning of the administration.

On the other hand, a “bottom-up” regulation appears at the level of appropriation by local actors of directives that are produced higher up. The room to manoeuvre that local actors are left leads to a diversity of local initiatives. Nevertheless, this diversity reveals characteristics of policies of the Welfare State like hospital-centrality and the high differentiation of public action domains. Moreover, setting up therapeutic projects influences, by a retroactive effect, the process of public action elaboration itself.

In this conclusion, we wish to look back at the hypotheses that influence our field work and our analysis.

The first hypothesis relates to the extension of scope of intervention by local actors in the public action process.

Classically, the influence of field actors is found at the implementation level. It is expressed by the diversity of local initiatives and by a contextualised re-appropriation of decisions made by the decision-maker. In the therapeutic projects, this diversity is encouraged by the room to manoeuvre left to local actors in determining their project; but it is also limited by administrative conditions and demands. We saw how some projects developed adaptation strategies to meet those demands and how others, by contrast, did not succeed in doing it for practical and ideological reasons.

The influence of local actors is not limited to the implementation phase, they also influence the public action conception process.

On the one hand, the permanent "Psychiatry" work group of the National Council of Hospital Facilities, which is composed of sector representatives, has played a major role either at the level of defining new organisation principles of mental health care or determining the concrete modalities of its operationalisation. By means of this advisory board, field actors influenced the content of the public action content. It should be noted that the "Psychiatry" work group is an advisory board that benefits legitimate, and even institutionalised, access to the political sphere.

On the other hand, retroactive phenomena were observed. The distinction between the conception process and the implementation process that we used is heuristic but it is not possible to underline the complexity of the back-and-forth forces at work. Two points seem to be particularly interesting in that perspective.

First, the administrative control attained by the National Sickness and Disability Insurance Institution at the end of the first year shed light on mitigated results. Numerous projects raised the question of the difficulty to meet all the conditions defined when the convention was signed. Criticism against the *administrative stranglehold* determined by the National Sickness and Disability Insurance Institution were taken into account and led to an adjustment of the conditions and to a softening of the conditions for the second year of operation.

Second, the transversal dialogue is a reflexive device which accompanies the therapeutic projects. It aims to formulate a structural proposal of care networks and circuits for the various target groups. The implementation of the therapeutic projects is then wholly part of the policy conception process because experimentation must lead to a possible structural reorganisation of the mental health care. Nevertheless, some worries about the changes of this device were raised by field actors and platforms.

Those two elements attest to a phenomenon of de-compartmentalisation of public action elaboration and implementation processes.

The second hypothesis which guided us falls within the perspective developed in the framework of the Know&Pol project. It relates to the changes in the mode of regulation of contemporary societies. We will rely on a possible shift from a traditional bureaucratic model to a post-bureaucratic model.

Therapeutic projects seem to have characteristics originating from both regulation models.

On the one hand, elements from the traditional bureaucratic model are identified. Thus, the National Sickness and Disability Insurance Institution's evaluation procedures are classical and correspond to previous practices. Civil servants themselves describe those practices as administrative control. Field actors talk about *administrative stranglehold*, this stranglehold limiting creativity and innovation.

Moreover, the implementation of the therapeutic projects reveals the persistence of the modes of previous operation like hospital centrality and the uneasy articulation between mental health care and connected sectors. These elements are representative of the political model of the Welfare State where a high sectorial differentiation operates and where mental health care is embodied in the hospital figure.

On the other hand, principles on which therapeutic projects rely are closer to the post-bureaucratic model. Public action drive falls within project logic where field actors are invited to define, locally, modes of organisation and management. This mode of operation, typical of the Network State (Genard, Donnay 2002), relies on a diversification of care offered and on the afferent cooperation necessity.

Experimentation is also a device which makes the influence of local actors more obvious and legitimate. It is a question to start from field experiences and knowledge to test a care organisation model and to possibly generalise it. Besides, transversal dialogue as a place of collective learning and exchange appears as an attempt to anchor public action deeply in field practices.

For Genard, the shift from one model, the Welfare State, to the other, the Network State, is not simply an act of replacement. "On the contrary, the shift operates also through many the overlapping, interlacing, and contaminations, etc denaturize the expectancies placed into the new devices, discourage the initiatives, and oblige to reiterate the critics." (Genard, Donnay 2002 : 79; free translation).

Therapeutic projects embody tensions and contradictions inherent to the transition phase from one model to the other.

These tensions are expressed at the local level where setting up the pilot experimentation faces existing mentalities and practices, creating reluctance and resistance by some care professionals or institutions. Nevertheless, the latter are conscious of the inevitability of a change and have some hope about this innovation.

At the political level, the complex Belgian context does not make the change easy. Therapeutic projects require cooperation between public power levels but also, within each of them, between various scopes of competences. Innovation introduces disruption in existing equilibriums and requires inter-institutional negotiations, giving birth to compromises, which are often fragile.

These two elements obviously favour the status quo and complicate any implementation of innovative policy. Obstacles and resistance appear at all levels.

Comparison zones

Comparison zone n°1: see table Excel

Comparison zone n°2: paradigm shift

Why do you consider the public action a paradigm shift?

Concepts and notions

The public action “therapeutic projects” can be considered representative of a paradigm shift. The therapeutic projects constitute an experimentation of new modalities of mental health care work organisation. Indeed, they rely on a new approach of mental health care which goes with new discourses and concepts.

In Belgium, in the 1990s, a reform of the psychiatric sector was initiated. A discourse centred on patient centrality developed. In the upcoming organisation, the care offer is organised from the perspective of the patient, his needs and his resources. The therapeutic projects aim to ensure dialogue among the various stakeholders who are concerned by a given patient, most of the time in the presence of the patient. The goal is to put in place made-to-measure care. As regards patient care, the basic principle is that, as far as possible, each patient should receive the necessary care in his usual surrounding. “In other words: home care or ambulatory care if possible, and hospital care if necessary. This choice implies, first, a greater promotion and increased support to the family network as well as the development of ambulatory care, and second, a more rational use of medical technology.”¹⁴⁹

The new mental health care organisation concept is structured around **target groups**. Within the framework of the therapeutic project “[...] It is necessary to consider population groups based on age and sociological characteristics pertaining to it. [...] It matters that each target group comprises patients with chronic and complex diseases.”¹⁵⁰ The emphasis is on these patients because their care trajectory and their recourse to multiple stakeholders crystallise the necessity of **care continuity** and **multidisciplinary approach**. “[The principle of the continuity of cares] can be stated in two maxims: thinking to the upstream and the downstream of the take in charge and to pay a special attention to the passing and the transitions between two places.” (Deliège 2007: 29; free translation). Target groups are firstly defined according to age: young, adults and elderly. Besides these categories, other specific groups require particular consideration:

¹⁴⁹ ‘Psyche: my latest concern? Mental health care: participation and coordination paths.’ Policy note from the Minister of Social Affairs, Vandenbroucke, and the Minister of Public Health, Aelvoet, Brussels, March 2001.

¹⁵⁰ Policy note on mental health care from the Minister of Public Health and Social Affairs, Demotte, May 2005

drug addicts and the forensic sector. An adapted therapeutic approach, which includes an integrated set of specific care, is developed for each of these target groups.

The particularity of mental health requires a mental health care reorganisation in terms of "**care circuits and networks**", "a mental health care development concept which, either on the content or the organisational levels, differs in a given number of areas from the organisational principles of somatic medical practices and from the hospital concept specific to general hospitals."¹⁵¹ In the field of mental health care, this notion officially appears for the first time in 1997. "A network, it's [...] a device of confidence in which the professionals exchange information, take part collectively in the care taking of the patients, and look for the best quality possible of the cares given [...]." (Schweyer and al. 2002; free translation)

In the mental health sector, the federal authorities often test innovative practices using various **pilot-projects**. Their aim is to test the feasibility of a care model, based on patient needs and on continuity of care, before generalising it.

Within the framework of the mental health care reorganisation, "It must be possible to use the equipment used in these pilot experiments creatively and flexibly."¹⁵² The therapeutic projects constitute the experimental phase of this structural transformation. "Both the authorities and the mental health sector will acquire a useful expertise before these concepts are generalised as upcoming mental health care organisation models."¹⁵³

Discourses and actions

The necessity of a mental health care reorganisation in terms of "care circuits and networks" seems generally admitted by the actors in the field rather than at political and institutional levels. Institutionally, a consensus emerged during the Interministerial Conference on Public Health which comprised the seven Ministers responsible for health matters and was the subject of a Joint declaration¹⁵⁴ which stipulated that "the new mental health care organisation will be achieved through the concepts of care circuits and equipment and stakeholder networks."

¹⁵¹ Opinion (second part) of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the upcoming organisation and development in mental health care of June 12th 1997

¹⁵² Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

¹⁵³ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

¹⁵⁴ Joint declaration of Ministers of Public health and Social affairs on the upcoming policy on mental health care of June 24th 2002

The actors who, a priori, could oppose these structural transformations are the hospital facilities which, until now, constituted the main site for diagnosis and treatment. The new sector structure affects the hospital monopoly since it tends to favour ambulatory care. However, the "Psychiatry" work group of the National Council for Hospital Facilities is a central actor in the setting up of the new organisation. It is even the official instigator since it officially introduced the care circuits and network notion. "At the end of the 90', the National Council for Hospital Facilities went ahead the role of conservative defense of the hospital that it could have endorsed by inertia. [It] took the leadership of the policy reform by arousing necessary coalitions for a fundamental modification of the sector cognitive maps." (De Munck and al. 2003: 50 – Free translation). The "Psychiatry" work group then positioned itself as an incontrovertible actor. It defined the new mental health care organisation and determined modalities of its operationalisation.

The actors from the ambulatory sector are, for the most part, already enrolled in a network situation. Relations between medical and social actors are common in the mental health field.

"The political context is a context of formalising of network functioning: that is to say that public health policy integrate this mode of functioning and this services coordination imperative, often initiated by field local initiatives and try to systematize them." (Deliège 2007: 8; free translation). This formalisation will spark comments: some think that network formalisation will mean the network will lose its main feature – its dynamism: "To much formalize the network, I think that's killing it. We can't prescribe the network all the time, without taking into account of the singularities of a situation, or we risk leaving the field of mental health, of the social, the individual, the citizen of a legally constituted State for going toward a technocratic and bureaucratic drift which can be worrying." (Martens 2007 ; free translation); while others claim this reappropriation by politics, provided that it comes with appropriate financing: "We are looking for political reappropriation. It is normal that politics are inspired by what is done in the field. We are always ready to talk about it."¹⁵⁵

Nevertheless, changing from an institutional monopoly to a network system must be put into perspective. The hospital remains central in the mental health care organisation and related knowledge still prevails, notably "because between [the medical knowledge] and the administrative logics, there are convergences. (Genard 2003: 46; free translation).

According to Deliège, "Traditionally, we assist a seizure of power from the medical in terms of mental health matters, linked to the predominant place held by medical power in the hospital institution." (Deliège 2007: 23). This asymmetry within the network

¹⁵⁵ Quoted from an interview with a field actor

depends first on the difference of means allotted to various types of structures and second on the structure size. According to Brilot: "The risk is high to have [the vertical structures] not playing the game but, on the contrary, to see them folding back on themselves, infiltrating the structures of coordination and developing the network in way which is to their advantage." (Brilot 2006: 26 ; free translation)

Structural changes

At the structural changes level, the "therapeutic projects" pilot project elaboration and setting up process constitutes the melting pot for innovation or emphasis in terms of interdisciplinary approach.

Firstly, the Royal decree¹⁵⁶ related to the therapeutic projects financing is a legal text originating from the federal level. However, among the compulsory partners of each therapeutic project, appears, in addition to the psychiatric hospital (or psychiatric service of a general hospital) and a front-line service, a mental health service. This last type of structure is financed and regulated par the Walloon region. The fact that a regional structure is mentioned in a legal federal text and, moreover as a compulsory partner, is a legislative first. This bridge-building can be considered as an attempt to improve the coordination between political power levels.

Second, the new mental health vision emphasises the diversity of factors at stake (social, biological, psychical, environmental). "An effective mental health policy must be integrated within a social policy."¹⁵⁷ It must favour interactions with connected sector stakeholders (social aid, socio-cultural, justice,...). Promoting intersectorial collaborations is not a new idea but it is made particularly visible through the therapeutic projects device. However, various projects are associated with their approach actors coming from a connected sector like Welfare services, Employment structures, the Walloon Agency for the Integration of Handicapped People, and so on.

Third, the therapeutic projects integrate a contemporary public action general trend which favours partnerships between public institutions and private associations. 'Instead of a sharp division between public and private spheres, they blend the two together. [...] Collaboration replaces competition as the defining feature of sectorial relationships.' (Salamon 2002: 14). Some of the (compulsory or potential) partners fall under the status of not-for-profit organisation and pertain to private law.

¹⁵⁶ Royal decree of October 22nd 2006 setting the conditions within which the Insurance Committee may conclude conventions for funding pilot projects in mental health care. MB 06-11-2006

¹⁵⁷ 'Psyche: my latest concern? Mental health care: participation and coordination paths.' Policy note of Minister of Social Affairs, Vandenbroucke, and the Minister of Public Health, Aelvoet, Bruxelles, March 2001

Role of the Supranational Bodies

As regards the role of the supranational bodies in the mental health sector, discourses at that level also favour a new mental health care vision emphasising the user's centrality and the necessity to encourage made-to-measure care and to assure care continuity.

Various supranational bodies took a stand on the mental health question. The WHO has, since its creation in 1948, fought for a broader health vision and for a community mental health care development. This vision has been included in various declarations (Declaration of Alma Alta¹⁵⁸ in 1978, Ottawa Charter¹⁵⁹ in 1986). The European Commission has also supported this vision, emphasising prevention and patient well being. Other organisations took parallel initiatives, notably at the legislative level.

In 2001, the WHO world health report, entitled "Mental Health: New Understanding, New Hope"¹⁶⁰, supports an integrated vision of mental health care. "The idea of community-based mental health care is a global approach rather than an organisational solution. [...] Mental health care should not only be local and accessible, but should also be able to address the multiple needs of individuals. It should ultimately aim at empowerment and use efficient treatment techniques which enable people with mental disorders to enhance their self-help skills, incorporating the informal family social environment as well as formal support mechanisms."¹⁶¹ Among recommendations, there also are the stigma and discrimination reduction and the need for a mental health intersectorial and multidisciplinary approach.

Among the Helsinki Declaration¹⁶² priorities, the user's place is also presented as essential. We have to "recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services". In the Action plan¹⁶³, it is stipulated that it is also important to "ensure representation of users and carers on committees and groups responsible for the planning, delivery, review and inspection of mental health activities". The goal is to give the user a central place in the elaboration process of the therapeutic approach and in its implementation.

¹⁵⁸ The Declaration of Alma-Ata, International Conference on Primary Health Care, World Health Organization, Alma-Ata, Kazakhstan, 6-12 September 1978

¹⁵⁹ Ottawa Charter for Health Promotion, First International Conference on Health Promotion, organised by World Health Organisation, Health and Welfare Canada and Canadian Public Health Association, 21 November 1986, Ottawa

¹⁶⁰ World health report "Mental Health: New Understanding, New Hope", WHO, 2001

¹⁶¹ Ibid. 54

¹⁶² Mental Health Declaration for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005, WHO-Europe

¹⁶³ Mental Health Action Plan for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005, WHO-Europe

At the European Commission level, the Green paper¹⁶⁴ proposes that any community strategy depends on aspects linked to prevention.

Therefore, international discourses converge with the new vision of mental health in Belgium.

Besides the prevailing discourse defended by the supranational bodies, Belgium is regularly the subject to international pressure concerning its high number of psychiatric beds. The pressure comes from various bodies like the OECD, the WHO and the European Commission. *"After 20 years of initiatives, the WHO always comes back with the same remarks on the way to organise the mental health system in Belgium."*¹⁶⁵

The table below emphasises two characteristics of the Belgian psychiatric system. First, the number of psychiatric beds per 100,000 inhabitants is the highest in the European Union and is four times higher than the European average. *"There are a lot of psychiatric beds in Belgium, particularly in Flanders. It is historic."*¹⁶⁶ Second, dehospitalisation is slow, the number of psychiatric beds decreased by 3% between 1997 and 2005 while the European average decreased by 23%.

	1997	1998	1999	2000	2001	2002	2003	2004	2005
EU (27 countries)	78.0	75.3	71.2	69.4	66.0	64.9	62.4	60.9	60.4
Belgium	259.4	259.6	259.4	259.5	252.8	249.0	248.0	248.5	250.8

Source¹⁶⁷ : Psychiatric care beds in hospitals (per 100 000 inhabitants)

It should be noted that "The counting of 'beds' has always been difficult and controversial. [...] The high provision in Belgium of 2.5/1000 beds must be understood to include general hospital units and many in settings other than psychiatric hospital." (Kovess 2004). Belgium's figures then include places in psychiatric nursing homes and in sheltered accommodations.

This high degree of the Belgian sector institutionalisation explains the predominant role played by the National Council of Hospital Facilities in the sector reform. [It] took the leadership of the policy reform by arousing necessary coalitions for a fundamental modification of the sector cognitive maps." (De Munck and al. 2003: 50; Free translation). It also is the major initiator of the therapeutic projects.

¹⁶⁴ Green paper "Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union", European Commission, 2005

¹⁶⁵ Quoted from an interview with a political actor.

¹⁶⁶ Quoted from an interview with an administrative actor.

¹⁶⁷ <http://epp.eurostat.ec.europa.eu/portal/>

Toward a post-bureaucratic shift?

As many principles promoted by the therapeutics projects as the network form of organization, a local actors coordination, a participation of users and some forms of participative evaluations fit into the post-bureaucratic model, we could think of a paradigm shift in the Belgian mental health public action. Nevertheless, some elements suggest us to be careful with this affirmation. Indeed, the therapeutic projects have to be replaced in their institutional context. Firstly there are a pilot experience witch appear to be minor in the global mental health organization characterized by many different institutions and still dominated by the hospital facilities witch are more relevant of a bureaucratic model. Secondly, the implementation of these projects has shown the tentative of control made by a State administration. This can be related to the still hospital centred organization. Indeed, as notice some authors (De Munck, Kutu, Vranken ET Al., 2003), between hospitals and the bureaucratic organization exist congruents logics as there are dated from a same period of development of the Welfare State.

In conclusion, if the therapeutic projects fit globally into a post-bureaucratic model, there are inserted in a global bureaucratic one. The gap between the two can even be seen as a cause of the difficulties of their implementation. The shift from one model to the other is not made brutally. On doesn't replace directly the other, but they superpose each others, influence or cross themselves for many years before one them disappear. (Genard, Donnay, 2002).

Comparison zone n°3: knowledge and knowledge holders in conflict

What is the conflicting knowledge? Who are the conflicting knowledge holders? What are the factors explaining their competition?

Knowledge and knowledge holders in conflict

Within the framework of the "therapeutic projects" pilot project and as it has been underlined before, a broad consensus seems to deploy on the base principles pertaining to the new mental health care organisation in terms of care circuits and networks which:

- must be centred on the patient and his needs;
- must guarantee care continuity;
- must assure made-to-measure care;
- is organised around target groups;
- necessitates a collaboration between competent political authorities;
- must favour interactions with stakeholders of connected sectors.

These principles have been developed by the "Psychiatry" work group of the National Council for Hospital Facilities and have largely been reused by the several Ministers of Public Health who have succeeded one another since the end of the 1990's.

The therapeutic projects are financed by the National Sickness and Disability Insurance Institution. This federal para-public institution of social security, placed under the responsibility of the Minister of Social affairs, manages and controls the compulsory insurance for health care and indemnities matters.

The therapeutic projects objective is to test new forms of care organisation by leaving significant breathing space to local initiatives. "The innovative strategies are rather issued from intervention at the basis, nearest from the problems, than from the formal interinstitutional partners." (Dumoulin and al. 2006; free translation). The scope which benefits actors concerns pathology choice, geographical zone definition, objectives specifications, methodology and bibliographic references choice.

This approach implies a common project to the whole partners and then influences partner choice. "The organization of the work within this sector rely on a project management [...] It incites the promoters to engage themselves in a common reflexion on the goal pursued, the means they envisage, the principles and the values which are theirs [...] [The arguments constructed and mobilized in order to justify the organization of a new action] take part in a process of construction of the group's identity." (Borraz, Loncle-Moriceau 2000: 59; free translation)

A broad consensus on general principles does not necessarily imply an agreement on the entire procedure. Tensions between administrative demands and field worker practices are revealed at the time of evaluation. The National Sickness and Disability Insurance Institution functions in accordance with the classical bureaucratic model "command and control" (Salamon 2002). Although "the network is a management by project" (Le Boeuf, Dupré 1999; free translation). "The principles of the evaluation can't be separated from the management by project, fundamental principle of the network organization." (ANAES 2001; free translation)

Among the points which are the subject of criticism, three factors seem to be particularly problematic: the presence of three partners at the dialogue meetings, the timing of these meetings and the case load. They are all administrative constraints (*carcan administratif*¹⁶⁸).

The presence of three compulsory partners at the dialogue meetings is sometimes scarcely achievable. For some projects, the size of the territory is an explicative factor: "Given the distances and the time it takes, it is hard to mobilise partners for meetings,

¹⁶⁸ Expression used several times by street level actors

*moreover for the free agents.*¹⁶⁹ For others, the patient follow up does not require the simultaneous mobilisation of three partners.

The timing of the meetings is too rigid and does not correspond to an optimal patient follow-up: psychotics constitute a particular population, *"patients can stop their treatment from one day to the next and cut themselves off"*¹⁷⁰ and chronic depression can also have its inconvenience, *"patients may feel much better and they do not see the utility to attend the quarterly meetings any longer."*¹⁷¹

The case load has not been met by almost half of the participating projects, although this case load is a prerequisite to having the funding renewed. *"Those who tried to work with patients see their project face difficulties, their institution is putting pressure on them because they did not meet the case load and it must be met by all means."*¹⁷² Besides, the geographical criterion is not taken into account: some projects are established in a highly populated urban environment while others cover sparsely populated counties.

Measure of influence

The "Psychiatry" work group of the National Council for Hospital Facilities succeeded in positioning itself as an incontrovertible actor in the mental health care reorganisation, in general, and in the therapeutic projects creation process, in particular. The "Psychiatry" work group is composed of representatives of the various hospital federations, representatives of the sector in the various regions, managers, professors who come from the various universities and, for the first time, representatives from the Communities.

Since the end of the 1990, it is the main actor in the definition of this new operations and its operationalisation. The importance of the advisor boards in health policies in Belgium is well known. Thus, in a discourse, Minister Vandembroucke affirms that "through their advice, [dialogue boards] have shaped hospital policy. These boards play an essential role because they are the channel by which the sector may develop its own vision and modify hospital policy. Moreover, they give the authority the possibility of confronting political projects with the sector's vision in order that this can be taken into consideration at the time of definite decisions."¹⁷³

Its position strategically allowed it to direct policy to the advantage of who it represents: "The Council thinks that the federal Hospital Law should constitute the reference

¹⁶⁹ Quoted from an interview with a project coordinator

¹⁷⁰ Quoted from an interview with a project coordinator

¹⁷¹ Quoted from an interview with a project coordinator

¹⁷² Quoted from an interview with a project coordinator

¹⁷³ Vandembroucke discourse of May 7th 2003 : Hospital policy

framework for the care circuits and network development [...].¹⁷⁴ For Weyers, the most powerful hospital federation in the Northern part of the country has largely contributed, within the National Council, to the achievement of "The possibility for the psychiatric hospitals to devote 10% of their budget to an amplification of the experimentation [of the conditions of work in network and cares circuit]" (Weyers 2006; free translation)

Principles on which the organisation lies seem to be the subject of a broad consensus. It is shared or is at least perceived as unavoidable either by politics as by street-level actors. It is recorded in a global paradigm shift in mental health and more generally in policy driving.

Conflict and macro context

Therapeutic projects fall within a double context. First, the national context influences the way exchanges are organised. Belgium has developed a compromise culture. Indeed, Belgium is a Federal State divided into three linguistic communities and three geographical regions. Each power level has its own Parliament applying a proportional representation system. The multiplicity of power levels requires dialogue bodies¹⁷⁵ within which negotiations occur. And at each level, negotiations are also led, no party having an absolute majority. "The complex game of cleavages, both effect and cause of conflict, call for the compromise. The practice of the last imposed itself to the parties when the conjugated effects of the proportional representation and of universal suffrage have instituted a regime which is the one of the Government of coalition. But, this practice imposed itself to the powers in presence and particularly to the social partners." (Mabille 1997; free translation).

Second, the health sector at the federal level is characterised by a multiplicity of consulting boards. "Belgian health care organisation and policies are highly influenced by a number of non-governmental stakeholders, including sickness funds, the Order of Physicians, health professionals' associations, hospital associations, pharmacists' associations, the pharmaceutical industry, trade unions, employer organisations, etc." (Corens 2007: 32)

The mental health policy in Belgium placed itself, late in respect of other European countries, in a general trend of care circuits and networks dehospitalisation and reorganisation. First, the number of psychiatric beds¹⁷⁶ per 100,000 inhabitants is the

¹⁷⁴ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities on the joint declaration operationalisation and dialogue platforms role of May 12th 2005

¹⁷⁵ In the health sector, the Interministerial Conference for Public health is composed of the seven Ministers who are competent in health matters.

¹⁷⁶ <http://epp.eurostat.ec.europa.eu/portal/>

highest in the European Union and is four times higher than the European average. "There are a lot of psychiatric beds in Belgium, particularly in Flanders. It is historic."¹⁷⁷ Second, dehospitalisation is a slow process, the number of psychiatric beds decreased by 3% between 1997 and 2005 while the rate of reduction of the European average is 23%.

The "debate" culture in the Belgian mental health sector meets a triple context which tends to favour the compromise: the "Belgian compromise" culture, the health sector is traditionally influenced by non-governmental actors and a general trend of mental health care reorganisation.

Knowledge conflicts within the therapeutic projects

If this first case study is dedicated to the process of creation of the therapeutic projects which can be seen as a compromise between conflicting knowledge, a second level of analyse will have to be used to go further in the understanding of the innovation process within the Belgian mental health public action. Indeed, the creation of these projects can be seen as an appropriation of new international knowledge and standards in mental health. Results of a compromise, these projects are a process imagined by the "Psychiatry" work group of the "National Council for Hospital Facilities" in order to adapt the hospitals and to find them a new role in the future new network organization. From this point of view, these knowledge have been translated in the Belgian context. Indeed, this implication of the hospitals isn't independent from their dominant position. A second level of analyse about the conflicting knowledge is possible within the projects. The use of certain knowledge embodied in instruments can be very controversial. For example, some instruments of evaluations are close to psychiatry tools as the DSM and can be criticized by practitioners closer from other psychodynamic paradigm. All the debates are hold in a platform cold "transversal dialogue" which as been imagined in order to gather information about the implementation of the projects and to assess the feasibility of a care network between the different actors. After the study of the creation and implementation of the therapeutic projects, this second level of analyse need a complete study. The second public action on the "transversal dialogue" and the third orientation about the instruments should give us a deeper understanding of the possible struggle between these knowledge.

¹⁷⁷ Quoted from an interview with an administrative actor.

Comparison zone n°4: knowledge policies

How do the policy makers try to influence the conditions of knowledge production in the course of the public action?

Within the framework of the therapeutic projects, policy makers exert an influence on either the public action elaboration process or its implementation. Depending on the "Psychiatry" work group, they defined principles and operationalisation procedures. This role of political "entrepreneur" does not necessarily go hand in hand with an influence on knowledge production.

Along the creation process, mobilised knowledge is mostly tacit¹⁷⁸ and normative knowledge moved by the general trend which goes with the shift from psychiatry to mental health (Castel 1981). Policies favouring care circuits and networks functioning and depending on patient centrality are developed in numerous countries. Moreover, international bodies like the WHO¹⁷⁹ completed numerous publications that lean this way.

Within this framework, various policy makers which succeeded one another at the federal level largely depend on opinions expressed by the "Psychiatry" work group of the National Council for Hospital Facilities. Thus, in the 2001 policy note, Ministers specified that "it is now necessary to address a new step in the mental health care restructuring. The main principles of this renewal are already published in [the Opinion of 1997]."¹⁸⁰ The 2005 policy note leans in the same direction: "Through the [mental health care] long history, an important step has been overcome when the 'care circuits' and 'care networks' concepts were developed."¹⁸¹ The text then returns to an annexe showing the role of the "Psychiatry" work group. This unceasing reference to the "Psychiatry" work group works and opinions could be seen as a policy makers' strategy which aims to legitimate the restructuring of the mental health sector. Besides, this strategy could also be interpreted in terms of a removal of accountability from a politician.

The new mental health vision which is at the base of the policies undertaken over the last decades seems largely shared. Principles and concepts on which it lies are accepted by

¹⁷⁸ Tacit knowledge is "a fluid mix of framed experience, values, contextual information and expert insight that provides a framework for evaluating and incorporating new experiences and information." Davenport T. and Prusak L. (1998). Working Knowledge. Cambridge, MA: Harvard Business School Press

¹⁷⁹ For example: The world health report 2001 - Mental Health: New Understanding, New Hope; Mental Health Declaration for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005, WHO-Europe; Mental Health Action Plan for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005, WHO-Europe

¹⁸⁰ 'Psyche: my latest concern? Mental health care: participation and coordination paths.' Policy note of Minister of Social Affairs Vandenbroucke and the Minister of Public Health Aelvoet, Bruxelles, March 2001

¹⁸¹ Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005

street-level actors, politicians and various consulting boards. Initiated changes appear to be inescapable.

At the implementation level, policy makers also played a gilt-edged role. Based on opinion expressed by the "Psychiatry" work group, the 2005 policy note defines the pilot project operationalisation modalities specifying roles and competences of the administrative bodies which will be in charge of implementing it (National Sickness and Disability Insurance Institution and Federal public service of Public health).

The influence policy makers have on knowledge production at this level is less diffuse than in the public action elaboration phase, but it is indirect. The aim of the therapeutic projects is to test some network practices before before any generalisation of them. "Meeting between initiatives (top down) taken by politicians and those (bottom up) taken by mental health street level actors should enable defining new mental health care organisation modalities in terms of care circuits [...]."¹⁸²

The whole procedure gives a large autonomy to local initiatives in order to draw lessons from this experimental phase. Knowledge coming from field experimentation is mostly applied knowledge.

In the first place, they concern practical organisation forms. How networking is put in place. What are the facilitating factors for this type of collaboration? This work depends on theoretical and methodological references. The main methodologies on which therapeutic project partners base their work are first the *psychothérapie institutionnelle* (Déliou 2005) which focuses on patient participation to put in place a multidisciplinary care device, and second the *Clinique de la Concertation* (Lemaire and al. 2003) which also depends on the patient who gathers all professionals and other people he wishes to participate in this therapeutic network activity.

In the second place, street level actors have a deep understanding and knowledge of the reality they meet daily. Pathologies and their specific characteristics are the subject of a knowledge which is theoretical and practical. Actors mobilize clinical references¹⁸³ in their pathology approach. Moreover, cultural and geographical specificities also play a role in the implementation of new modalities of care. Thus, a project covers the entire county of Luxembourg which has a low population density (difficult to reach the case load), a large territory (difficult to mobilize partners to attend meetings, especially free agents) and is poorly served by public transport. Another project, situated in Mouscron, points up another geographical dimension. "There is a social network which exists in Mouscron and

¹⁸² Partial opinion (2 and 3) on "{transversal dialogue/horizontal consultation}": towards the definition of mental health care organisation new modalities of February 8th 2007

¹⁸³ In the candidate files, one of the assessment indicators relates to "scientific support" where one place was left to the bibliographic references.

*which may not exist the same way somewhere else. There is conviviality, something which is different. Numerous projects have great difficulty bringing partners together. Here, it has not been a problem at all.”*¹⁸⁴

Nevertheless, therapeutic project selection may have played a filter role. Geographical distribution criteria and target groups distribution criteria were negotiated at the Interministerial Conference for Public Health. The third criterion is related to the content. “Lastly, taking into consideration the categories in which the project number is extra, projects will be evaluated at the content level.”¹⁸⁵ The National Sickness and Disability Insurance Institution basic note specifies project assessment criteria, and eight criteria will determine the project quality.

In conclusion, if the therapeutic projects are typical of the Belgian policy system, they are also “special” in regard to its regulation process. Due, first, to the historically highly fragmented political system, and, so, to the Belgian compromise, and secondly to the competitive context between the institutions, the political power is above all a mobilizing one. Even if it exists a temptation from the administration to have a bureaucratic control on the projects, the main goal is to settle a dialogue between all the actors of the sector in order to create a new model of organization. In consequence, both influence from the central decision bodies and from the local actors are important. As we told before, we have to distinguish the creation and the implementation of the therapeutic projects – the object of this study – which constitute the frame of the debate on the new organization of the care – from the process of the dialogue between the different actors, which will be the object of the future studies. In the first, even if it exists a power of influence from the local actors because they reappropriate the guidelines and even if the influence of the advisory board which is important can be seen as an influence from the field actors since they represent the actors of the sector, the influence of the central decision bodies can be seen greater than the one from the field actors. In comparison, the direct influence from the local actors could be greater in the “transversal dialogue” which we’ll study deeper with the second public action and the third orientation.

¹⁸⁴ Quoted from an interview with a project coordinator

¹⁸⁵ Basic note "Experimentation of working in mental health care circuits and networks conditions: therapeutic projects", Insurance Committee, National Sickness and Disability Insurance Institution, March 27th 2006

Comparison zone n°5: Knowledge and policy constellations

What are the constellations where knowledge and policy unite?

Distinction between knowledge and policy blurs, knowledge influencing policy elaboration and implementation and those two acting on knowledge production and use. These interactions are incarnated in "knowledge & policy constellations"¹⁸⁶ which can take various shapes.

In the framework of the therapeutic projects, some constellations are identifiable. Before returning to the different shapes proposed in the specifications, it seems appropriate to present a particular constellation that therapeutic projects as pilot projects represent. Indeed, pilot projects are experiments which aim to test the concrete modalities of political innovation operationalisation. Because therapeutic projects originate from the will of political authorities to be motivated by field background, a public action bottom-up vision is developed. In a 2002 opinion, the "Psychiatry" work group clarifies: "the experimentation phase has precisely for its goal to search for a fair equilibrium between, firstly, care missions globally defined by the authority and, secondly, the development of progress required in care by the street-level actors and this to respond as well as possible to the demands of care in a determined field of activity."¹⁸⁷ The experiment lasts a maximum of three years. This constellation content consists in the interweaving of field knowledge (background, practical knowledge) and political concerns.

Concerning constellations proposed in the specifications, some of them appear in our public action. Thus, evaluation embodies a first version of this type of constellation. Nevertheless, in our case, evaluation carried out by National Sickness and Disability Insurance Institution remains very administrative and quantitative. In their words, it is more an administrative control. A succinct questionnaire in a standardised form (Excel) was sent to the various participating projects and was completed by the coordinator. However, "The sector of mental health would be "the place of the subjectivity". To understand it, the evaluation called "objective" of the type "evidence-based medicine/practice", which means based on the proofs, on the results, with the use of comparative scales would be inappropriate. But, it's precisely these scales that are the most often used by the subsidising authorities." (Olivier 2007: 18; free translation). Given the difficulties met by the actors during this first year of operations, notably at the case load level, coordinators were invited to join a qualitative evaluation¹⁸⁸ of their initiative.

¹⁸⁶ Specifications of Orientation 2 – Comparison zones, Final version (April 2008)

¹⁸⁷ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

¹⁸⁸ The qualitative evaluation form varies from one project to the other, from a one page document to a detailed activity report.

Furthermore, auto-evaluation practices constituted one of the selection criteria; it appears in practice that they are not the subject of a particular attention.

The second constellation proposed in the specifications present at the therapeutic projects level is the targeting. The public action is very clearly organised around target groups which have been defined at the "Psychiatry" work group and which were lightly modified by the National Sickness and Disability Insurance Institution. Each project addresses a target group defined on the basis of two criteria. The first one is related to the pathology, patients must present a chronic and complex pathology¹⁸⁹ because "the probability of having to meet several actors (care multidisciplinary aspect) is high, and then it is interesting to favour the dialogue between those actors in order to ensure good care continuity."¹⁹⁰ The second criteria concerns the age category; three broad categories were defined: "children and young people", "adults" and "elderly people". *"For once, it is a decision which can be arbitrary but it makes sense. It is good that Children and young people remains a category of its own, given the security drift in which we are; it is good that mental health says they are children. For elderly people, there have specific problems. The age limit is arbitrary but it is sensitive."*¹⁹¹ Besides, stakeholders for each target group are specific (for children: schools, youth help services, etc; for elderly people: home care, nursing homes and rest homes).

Within these broad categories, sub groups were defined based on complementary determinants. Concretely, therapeutic projects are split into seven clusters:

- Children and young people – general
- Children and young people – forensic psychiatry
- Children and young people – presenting problems linked to addiction
- Adults – general
- Adults – forensic psychiatry
- Adults - presenting problems linked to addiction
- Elderly people

This distinction seems also based, according to field actors, on relevant factors. *"People who have drug and alcohol addictions form a very negatively stigmatised population. It*

¹⁸⁹ Consensus note. Proposal of a work definition "patients presenting a (potentially) long term and complex psychiatric disease", discussion closed on the meeting of October 11th 2005 of the Support Committee "Therapeutic projects and {transversal dialogue/horizontal consultation}"

¹⁹⁰ Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005

¹⁹¹ Quoted from an interview with a {transversal dialogue/horizontal consultation} coordinator

has to be known that all care structures do not easily accept those users, they try to avoid them. Moreover, the forensic psychiatry is also a separate category; it must remain a particular case."¹⁹²

Among the proposed constellations, the one related to "the decision makers' personal knowledge/experience/disciplinary background" seems not easily identifiable. Firstly, recent years met a relatively important rotation at the Ministerial level. Thus, since 2001, when the policy note "Psyche: my latest concern?"¹⁹³ which launches the basis for a new mental health care vision, this field of competence has undergone a few modifications. Until 2003, Public health and Social affairs were attached to two different Ministers before being the subject of a fusion. Below is the list of the Ministers since the 1999 legislature:

Legislature	Minister	Party	Competence
1999-2003	Magda Aelvoet, replaced by Jef Tavernier in 2002	Agalev (Ecologist Flemish party)	Minister of Consum. protection, Health and Environment
	Frank Vandenbroucke	SP (Socialist Flemish party)	Minister of Social affairs and pensions
2003-2007	Rudy Demotte	PS (Socialist Walloon party)	Minister of Public health and Social affairs
Since March 2008 ¹⁹⁴	Laurette Onkelinx	PS (Socialist Walloon party)	Minister of Public health and Social affairs

Another point is that governmental coalitions which succeeded one another are different for each legislature. Despite these changes, continuity of the mental health care policy can be observed. The "Psychiatry" group can be considered the continuity guarantor because its opinions are at the basis of the new mental health care vision. Moreover, the mental health counsellor of the current Minister has exercised her mission since Vandenbroucke, and was detached by the VVI (Verbond der Verzorgingsinstellingen), the catholic federation in the North of the country.

Secondly, the decision-making process at the federal level is characterised by a high degree of consulting boards' participation.¹⁹⁵ The significant number of consulting boards

¹⁹² Quoted from an interview with a {transversal dialogue/horizontal consultation} coordinator

¹⁹³ 'Psyche: my latest concern? Mental health care: participation and coordination paths.' Policy note of Minister of Social Affairs Vandenbroucke and the Minister of Public Health Aelvoet, Bruxelles, March 2001

¹⁹⁴ The last legislative elections were held on June 10th 2007. The government constitution was arduous and an agreement was only signed on March 20th 2008.

¹⁹⁵ Among these active consulting boards in the health care sector, we can cite the National Council for Hospital Facilities, the Multipartite structure in Hospital policy matters, the National practitioners-hospitals

reflects the Belgian political functioning which is anchored in consensus and on a high participation of the various civil society forces. The more active in the mental health care, notably in the base principles definition of the future care organisation, is the "Psychiatry" work group of the National Council for Hospital Facilities, which gives opinions on every question related to hospital programming, agreeing and financing. The "Psychiatry" work group can also be attached to another constellation, the one related to expert mobilisation. It seems that it can be considered a group of experts, its members being influential and/or known persons in the mental health field.

Finally, the last identified constellation concerns the good practices elaboration. At this level, a distinction between displayed will and effective implementation is necessary. Objectives announced by political authorities show a will to bring up good practices. "In order to achieve a structural proposal for care circuits and networks, a great deal of data must be collected. This can be done through transversal dialogue. These data should allow elaborating "standards" or "good practices" at the level of care circuits and networks."¹⁹⁶ In practice, however, it appears that National Sickness and Disability Insurance Institution's administrative demands and procedures leave field actors little breathing space. The *administrative stranglehold*¹⁹⁷ does not allow field actors to be creative. "*In practice, we have the feeling that this administrative stranglehold prevents any possibility of creating, developing or inventing anything.*"¹⁹⁸ At the end of the first year of operations and given the difficulties met by projects, some moderating measures have been taken by the administrative and political authorities.

Commission with equal representation from both sides, various Commissions like the Patient's rights Commission, various federal dialogue platforms among which the mental health care platform.

¹⁹⁶ Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005

¹⁹⁷ Expression used several times by actors in the field

¹⁹⁸ Quoted from an interview with an actor in the field

Comparison zone n°6: Knowledge in the wider public sphere

How do different types of knowledge get articulated in the wider public sphere?

Therapeutic projects are not the subject of a large public debate; their pilot projects state does not facilitate a widened diffusion of information to the public sphere.

Firstly, the selected public action is a pilot project, much greater than previous pilot experimentation, but it is still related to some care institutions and within institutions only some stakeholders. Indeed, 82 therapeutic projects were selected for all the target groups. Within the coordinating institution, whether it is a psychiatric hospital or an ambulatory structure, there is only one person who is in charge of the project.

Secondly, information circulation seems particularly problematic even within the participating institutions: *"There are institutions which are part of our project where no one knows about the project. The director signed the participation agreement but did not relay the information to the practitioners."*¹⁹⁹ It also causes problems for the persons in charge of the project. *"I cannot follow the information flow, I'm saturated."*²⁰⁰

Information circulation being problematic within the public action, it appears to be complicated for external diffusion.

Moreover, the only type of media which seems to be concerned by the therapeutic project is specialised press. There is one journal, in particular, *Confluences*²⁰¹, published by the Walloon Institute for Mental Health (IWSM)²⁰². Two special issues were dedicated to networks in mental health care and in one of them.

In a special issue, *"Formaliser le réseau"* (2006) – *"Formalising the network"*, published before the projects began, a space was reserved to *"Reactions to therapeutic projects"* (2006: 22-25). The contributions do not reflect a unanimous position.

For the Belgian Confederation of Health Care Private Structures (*Confédération belge des établissements privés de soins de santé - Cobéprivé*): *"It seems to us [...] that in this*

¹⁹⁹ Quoted from an interview with a project coordinator

²⁰⁰ Quoted from an interview with a project coordinator

²⁰¹ The *Confluences* journal is a quarterly publication of the IWSM. Each issue comprises a special dossier devoted to a specific issue and some general (or not linked to the thematic) short articles (1 to 3 pages). The dossier is composed of a dozen short articles of which one third is written by Institute researchers, another third by researchers from Universities or Research centres and the last third by actors in the field or representatives of users and families.

²⁰² The Institute is the scientific institute specialised in mental health in the Walloon region. Its creation in 2003 relies on three arguments: openness to all actors registered in the mental health field regardless the competent power level, interface role for a real dialogue in Wallonia and "expertise" and research missions within the framework of a permanent "observatory".

reinforced dialogue among field actors, we could invent a mental health integrated care original policy, avoiding the obstacle of psychiatric care sectoring applied by our neighbours which leaves little space for the patient's choice, and, at the same time we could open a true dialogue and complementarities between hospital and ambulatory sectors [...]."

The Federation of Hospital Institutions (Fédération des Institutions Hospitalières - FIH) "approves of the principles which underlie the therapeutic implementation [...]. By supporting this approach, [it] hopes that therapeutic projects will avoid obstacles of the imposed rigid model, like [those] met within the [previous] pilot projects framework, but also the abstract and theoretical analysis which misreads the reality in the field, like some scientific studies previously carried out."

For the Health Institutions French-speaking Association (Association Francophone des Institutions de Santé - AFIS), "the initiative [...] seems interesting to support. [...] It seems [...] obvious that those who already work in the network will be reinforced and supported within the framework of the therapeutic projects and that, for others, we can hope a new curiosity will follow... depending on the way the experiment takes place."

Remarks²⁰³ from the Ambulatory Mental Health Workers Associations (Association des Travailleurs de Santé Mentale Ambulatoire - AT SMA) concern several aspects notably on the obligatory nature of the dialogue: "Dialogue and coordination should not be an imperative in itself, risking making the network rigid [...]. It is important to be able (to carry on) functioning on a case-by-case basis [...]" ; and on the place of the partners: "What place can the mental health services take in those networks and their development, if they are created from the hospital world (which can more easily bring together the minimum number of patients [...] necessary for setting up a therapeutic project) [...]?"

The Home Care Structure Federation (Fédération des Centrales de Soins à Domicile - FCSD) notes that "the fact of participating in a network and in care circuits will allow the Home care structures to share their difficulties and expertise in home care matters. [...] The structures will certainly be involved in therapeutic projects."

For the General Practitioners Associations Forum (Forum des Associations de Généralistes - FAG): "The general practitioner's central role for ambulatory care patients must be upgraded and his collaboration must be viewed as indispensable, if not, the project cannot be accepted."

²⁰³ Those remarks were written by the IWSM, based on the participation in various AT SMA's meetings on therapeutic projects.

For the President of the Liège Federation of General Practitioners Associations (Fédération Liégeoise des Associations de médecins Généralistes - FLAMG): "I have the feeling that the psychiatric world does not have the intention, despite reassuring words and what seems like attentive listening, to give us their trust in this matter."

Reading these different contributions, it appears that opinions are divided between enthusiasm and scepticism. Hospital federations adopt a globally positive attitude towards the projects by approving and encouraging the initiative. Ambulatory structures, which are financed by the Walloon region, are reluctant to network formalisation and point at a hospital-centred drift. The remarks of frontline actors vary. Home care structures show themselves to be ready to participate, as far as those collaborations will facilitate exchanges of experiences. General practitioners associations, by contrast, adopt a critical attitude, notably concerning the place they will take.

Even if they appear as very central and important in regard to what is at stake for the different actors of the sectors, the therapeutic projects constitute a minor experience in a mental health landscape which is very fragmented, made of a lot of experience, institutions or projects held by many levels of power. Very technical as its goal is to gather information on the possibility to organize a care network, information about it doesn't circulate a lot beyond the life-blood of the sector and in the wider public sphere. Mobilizing the head of the representative structures and the people the most engaged in the debates on the future of the mental health cares, these people use more general arguments when they take part to the debates in the mass media of the general public sphere. It's also interesting to note that another reason why the information doesn't circulate more widely could be that the context is very sensitive. Results of a compromise, the projects manage to create a new organizational model with a method where the "made with" prevail on "made against".

Comparison zone n°7: Local actors in the central decision-making process

How do local actors directly and indirectly influence the central decision making process?

Field actors have an influence on public action at the implementation level because they appropriate guidelines emanating top down. "At the time of setting up the pilot experiment, one will be based on general missions and conditions, defined by the authorities within the global agreement framework. Equipment being used to pilot experiments must be capable of working creatively and flexibly for the necessary care development to achieve recommended objectives."²⁰⁴

Therefore, field actors benefit from a great deal of breathing space in their project definition, to define the chosen pathology, geographical zone, objectives, partner's choice, methodology and bibliographic references. The field work we completed allows us to give prominence to the diversity of locally based initiatives.

The hypothesis related to the possibility that local actors influence public action not only at the time of the implementation but also at the central decision-making process level was confronted with our empirical research work. In that perspective, it seems important to return to three aspects of the selected public action; the first is linked to the Belgian political decision-making process, the second to the National Sickness and Disability Insurance Institution annual evaluation and the third to the fact that it is a pilot project.

Firstly, the decision-making process in Belgium, at the federal level, in particular, is punctuated by the intervention of various consulting boards. Within the therapeutic framework, the "Psychiatry" work group of the National Council for Hospital Facilities played a fundamental role more at the level of the project base principles definition than at the concrete modalities determination for the implementation phase. The "Psychiatry" work group is composed of representatives of the various hospital federations, representatives of the sector in the various regions, managers, professors from the various universities and, for the first time, representatives from the Communities. The "Psychiatry" work group can be considered a consulting board representing the hospital sector because it constitutes a relay for the field concerns towards the politico-administrative sphere.

At the National Sickness and Disability Insurance Institution level, the decision-making body is the Insurance Committee which is comprises equal representation of both mutual insurance company representatives and sector representatives. The therapeutic projects Support Committee prepares the way before presenting results to this supreme

²⁰⁴ Opinion of the "Psychiatry" work group of the National Council for Hospital Facilities concerning the new "mental health care" concept: synthetic opinion on and operationalization within the framework of a five-year plan of July 10th 2002

authority. For example, the basic note²⁰⁵ which constitutes the therapeutic projects legislation basis was discussed within the Support Committee before being submitted to the Insurance Committee that endorsed it.

Field actors are then represented within the influential bodies and boards which participate in the political decision making.

Secondly, the administrative control realised by the National Sickness and Disability Insurance Institution at the end of the first year revealed difficulties met by numerous therapeutic projects, notably at the case load level. Results were discussed in the National Sickness and Disability Insurance Institution work group where divergences emerged. Firstly, some people wished for a revision of conditions: projects argued that conditions were too strict and that problems linked to starting up explained the delay. *"The interest is to propose something at the street level, from the local [...], it is a great idea. In the convention signed with the National Sickness and Disability Insurance Institution, we immediately saw that we could bring something but that we had to enter cases. There are conventions which become more and more uniform in order to suit the greatest number of people. We feel like everything that is asked of us will force us to be less creative."*²⁰⁶ The federal Public Health service, in charge of the transversal dialogue, would like a maximum of projects to participate in the study in order to increase the validity and reliability of the results. Secondly, mutual insurance companies balk at fund projects which do not respect conditions and which do not bring any added value. Finally, the work group proposed to moderate conditions for the second year. The Insurance Committee formalised this proposal by sending a convention endorsement to the project coordinators.

Criticism levelled at the *administrative stranglehold*²⁰⁷ defined by the National Sickness and Disability Insurance Institution has been taken into consideration and has led to an adjustment in the procedures.

Thirdly, the transversal dialogue aims to achieve a formulation of care circuits and networks a structural proposal. "By the end of the therapeutic projects, the objective is: [1] define the guidelines: describe the care content (care programs for each target group) and offer a definition of optimum care modalities based on care circuits and networks [...] and [2] implement norms in care circuits and network matters: mission entrusted in competent bodies and boards (National Council for Hospital Facilities,

²⁰⁵ Basic note "Experimentation of working in mental health care circuits and networks conditions: therapeutic projects", Insurance Committee, National Sickness and Disability Insurance Institution, March 27th 2006

²⁰⁶ Quoted from an interview with a project coordinator

²⁰⁷ Expression used several times by field actors.

regulations,...).²⁰⁸ The transversal dialogue will play a role at the norms definition level which will regulate the forthcoming mental health care organisation model. The pilot-projects implementation is fully integrated in the public action creation process because the experiment must lead to a possible reorganisation of the mental health care structure.

The last two points demonstrate a de-partitioning phenomenon of the public action creation and implementation processes.

Comparison zone n°8: Circulating patterns beyond the borders of the sector and the country

Within this comparison zone framework, we will focus on three points: mobilisation of foreign references, reference to international bodies and some of their basic texts and presence of international pressures at the political level.

Firstly, some foreign models are presented as sources of inspiration. The Belgian political context is very specific and a simple and straightforward application is not conceivable. It is interesting to note that references to those foreign models are not unanimous. Thus, for the Ministerial Cabinet, the "Psychiatry" work group was inspired by the Canadian model, notably for the target group definition by age. For the Hospital Institutions Federation (FIH), which participates in the "Psychiatry" work group, its equivalent in the North of the country, the VVI, played a crucial role. *"There is not really a reference model but on the Flemish side, they might have been influenced by what was happening in The Netherlands where, effectively, the hospital type of structure is proportionally low compared to ambulatory care. But ambulatory also includes [...] other types of supervised home, which are much more developed, including our home care equivalents."*²⁰⁹

Canada and The Netherlands share similarities with Belgium.

Similarities between Canada and Belgium fall into two categories. First, political delegation to federated entities appears in both countries (Regions and Communities in Belgium, Counties in Canada. "In Canada, it is primarily at the provincial level that policy concerning mental health care is formulated and enacted. There is, however, some policy development at the federal level that provides a context for provincial actions" (Goering et al. 1994). In Canada, the reform philosophy was influenced by a document developed at the national scale "A framework for Support" (Trainor et al. 1992). "It has achieved

²⁰⁸ Basic note "Experimentation of working in mental health care circuits and networks conditions: therapeutic projects", Insurance Committee, National Sickness and Disability Insurance Institution, March 27th 2006

²⁰⁹ Quoted from an interview with a hospital sector representative

considerable success in changing the thinking about the capacities and roles of consumers; in encouraging provinces to direct resources and develop structures that support consumer participation; and in encouraging involvement of a broader array of human and social services in the lives of citizens with mental illness.” (Goering et al. 1997: 2). Nonetheless, the reform was anchored in an experimental phase. Within this health care reform framework, 140 pilot projects²¹⁰ were held from 1997 to 2001, of which 24 in mental health. Those projects “have largely contributed to the development of a practical knowledge fund in the domains of mental health policy and practices.” (Goldner 2002: iii)

Since the 1990s, Germany has developed a mental health care socialising approach aiming to improve cooperation between various care (intra and extra muros) structures and cooperation with connected sectors. A care circuits approach was set up. “In the late 1990s, to improve co-operation between psychiatric hospitals and the [Regional Institutes for Ambulatory Mental Health Care], in particular, the government pressured these organisations to merge at a regional level. Both the outpatient facilities and the psychiatric hospitals were replaced as separate organisations by so-called “care circuits” and “multifunctional units” for specific categories of patients, and “case-management” for individuals.” (Oosterhuis 2004: 413-428)

Secondly, some international bodies were mentioned. Thus, the European Commission’s Green Paper²¹¹ underlines the utility of a communitarian strategy on mental health which will aim to promote cooperation between member states and coherent national policies. The WHO, and notably its mental health action plan,²¹² also constitutes an inspiring source for the political and administrative authorities. The WHO is cited in the two policy notes²¹³ which are at the basis of the therapeutic projects.

²¹⁰ These projects were funded by the Health Transition Fund, created following a National Forum on Health advice, for a total amount of €95 million.

²¹¹ Green Paper "Promoting the Mental Health of the Population. Towards a Strategy on Mental health for the European Union", European Commission, 2005

²¹² Mental Health Action Plan for Europe. Facing the Challenges, Building Solutions, WHO European Ministerial Conference on Mental Health, Helsinki, 2005, WHO-Europe

²¹³ ‘Psyche: my latest concern? Mental health care: participation and coordination paths.’ Policy note of Minister of Social Affairs, Vandenbroucke, and the Minister of Public Health, Aelvoet, Brussels, March 2001 and Policy note on mental health care of the Minister of Public health and Social affairs Demotte, May 2005

Thirdly, Belgium was regularly subject of international pressures related to its high number of psychiatric beds. Those pressures come from various bodies like the OECD, the WHO or the European Commission. *"After 20 years of initiatives, the WHO always comes back with the same remarks on the way the mental health sector is organised in Belgium."*²¹⁴

The table below emphasizes two characteristics of the Belgian psychiatric system. Firstly, the number of psychiatric beds per 100,000 inhabitants is the highest in the European Union and is four times higher than the European average. *"There are many psychiatric beds in Belgium, particularly in Flanders. It is historic."*²¹⁵ Secondly, dehospitalisation is slow, the number of psychiatric beds decreased by 3% between 1997 and 2005 while the European average decreased by 23%.

	1997	1998	1999	2000	2001	2002	2003	2004	2005
EU (27 countries)	78.0	75.3	71.2	69.4	66.0	64.9	62.4	60.9	60.4
Belgium	259.4	259.6	259.4	259.5	252.8	249.0	248.0	248.5	250.8

Source:²¹⁶ Psychiatric care beds in hospitals (per 100,000 inhabitants)

Please note that "The counting of 'beds' has always been difficult and controversial. [...] The high provision in Belgium of 2.5/1000 beds must be understood to include general hospital units and many in settings other than psychiatric hospital." (Kovess 2004). Belgium's figures then include places in psychiatric nursing homes and in sheltered accommodations.

International pressures are mobilised, mostly by political and administrative actors, because they are critical of the actual management of the Belgian mental health sector and they legitimise the initiated reform process. This high degree of the Belgian sector institutionalisation explains the predominant role played by the National Council of Hospital Facilities in the sector reform. [It] took the leadership of the policy reform by arousing necessary coalitions for a fundamental modification of the sector cognitive maps." (De Munck and al. 2003: 50 – Free translation). It is also the major initiator of the therapeutic projects.

²¹⁴ Quoted from an interview with a political actor.

²¹⁵ Quoted from an interview with an administrative actor.

²¹⁶ <http://epp.eurostat.ec.europa.eu/portal/>

Comparison zones 9: The role Europe (as an institution and as a space) plays in the circulation of 'knowledge' participating in public actions at the national level"

As we already assessed the role of the supranational bodies in the chapter dedicated to the second comparison zone, we won't describe again so precisely the nature of the international critics addressed to Belgium and the convergence between the knowledge circulating at this level and those which constitute the therapeutic projects and the reforms they try to conduct.

Indeed, even if the European Institutions are competent for fewer matters than those upon which the WHO has an authority, his influence is quite the same on the therapeutic projects. The European activities led to the organization of meetings and to the funding of a comparative study on the issue of the prevention of the suicide in Europe while the Belgian Presidency of the European Union²¹⁷. It can be seen as a major fact regarding to the relations between Europe and the Belgian public action all the more that this process will lead to a participation of Belgium to the Helsinki declaration on the suicide issue. Nevertheless, this specific issue, even if has been mentioned in the definition of the therapeutic projects, is not central in the motivations which led to their creation. Indeed, the central issue which led to the creation of the therapeutic projects is the network organization and the necessity of continuity in care. These can be seen as a translation of the new international standards in mental health and more especially the necessity of coordinated policies and a response to the critics addressed to Belgium on his high level of hospital beds.

Even if the influence is not direct, the Europe played a role in the creation of the therapeutic projects which is quite the same than other international bodies. According to a Minister of health's counselor, if the therapeutic projects are not response the European critics against the way the mental health cares are organized in Belgium, nevertheless there a link since it exists political pressures on the Belgian Government to reorganize the mental health sector. These pressures are quite the same since many years and as well from the European Union or from other supranational bodies like the WHO even if it seems that Europe is more powerful than the others to convince Belgium to reorganize his cares system.

To conclude, the influence of Europe on the therapeutic projects is indirect but participates to create the context in which these reforms appeared as essential. If the mechanism is closer from traditional political pressures than from making knowledge circulate, this influence can also be seen as a legitimization of particular knowledge.

²¹⁷ See the O3 report on the « supra-national instruments » (WP 12) : « The WHO in Belgium: cross-level networking ».

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