Available online at www.sciencedirect.com

SciVerse ScienceDirect

Policy and Society 31 (2012) 145–158

policy and society

www.elsevier.com/locate/polsoc

When policy makers consult professional groups in public policy formation: Transversal consultation in the Belgian Mental Health Sector

Sophie Thunus *, Frederic Schoenaers

Université de Liège, Belgium

Abstract

This contribution focuses on a policy consultation process: the ''transversal consultation''. Launched in 2007 in the Belgian Mental Health Sector, this consultation had to capture the experience-based knowledge of service users and professionals involved in local projects aimed at experimenting working conditions in mental health care networks. This policy challenges the existing hospital-centred model of care, characterized by a medical approach and professional specialization, by promoting instead a pluridisciplinary approach in mental health care networks.

In this contribution, a case of this transversal consultation process is analysed by relying on a theoretical framework drawn from the Sociology of Organizations and the Sociology of Public Action. The analysis emphasizes the strategic use that is made of the consultation process, and stresses the gap observed between its formal objective and its perceived outcome: more than producing experience-based knowledge about mental health care networks, the transversal consultation challenged power relations sustaining the current organization of the mental health system. It shortly discusses, as a conclusion, the outcome of the initiative.

1. Introduction

This paper analyses the reception of an innovative policy instrument intended to capture the experience-based knowledge of professionals and service users in order to inform the structural reform of mental health care in Belgium.

The starting point for this process was a political motivation to gradually adapt the current hospital-centred model of mental health care towards a mainly deinstitutionalized policy framework (Leys, Antoine, De Jaegere, & Schmitz, 2010: 4). This progressive change is being led by a new referential composed of key-values and concepts, including patient participation, pluridisciplinary work, ambulatory and community care, and mental health care networks and circuits.

In 2005, this political motivation resulted in the development of pilot-projects, the ''therapeutic projects'', assessed in the framework of an intermediate instrument, the ''transversal consultation''. The therapeutic projects were pilot-projects intended to produce experience-based knowledge that could be used in preparing for future reform;

* Corresponding author.
E-mail addresses: Sophie.thunus@ulg.ac.be (S. Thunus), F.Schoenaers@ulg.ac.be (F. Schoenaers).

1449-4035/$ – see front matter
http://dx.doi.org/10.1016/j.polsoc.2012.04.004

transversal consultation refers to a policy consultation designed to capture this local expertise before summarizing and formalizing consultation outcomes into concrete policy recommendations.

This paper is based on the study of the therapeutic projects and the transversal consultation as part of the European 6th Framework Programme ''Knowledge and Policy'' (Schoenaers, Thunus, & Cerfontaine, 2011; Vrancken, Schoenaers, & Thunus, 2010). This paper intends to give an account, from a sociological perspective, of the concrete practices developed by those challenged to test this new organization of work within the pilot-project framework. While testing mental health networks in a hospital-centred model characterized by professional specialization and autonomy, this project was indeed very challenging.

In order to capture the concrete practices induced by the therapeutic projects and the transversal consultation, this paper relies on the Sociology of Organizations (Crozier & Friedberg, 1992; Friedberg, 1997) and the Sociology of Public Action (Commaille, 2004).[1] Together, these two theoretical lenses enable the analysis of the various interactions and power struggles arising between the multiple parties taking part in this process of change.

This paper focuses on the transversal consultation. Firstly, the changes in the Belgian mental health policies during the last few decades are described. Following this, a case study of a ''transversal project'' (which is a part of the transversal consultation as a whole) is presented. Based on this case study, the development of the consultation process between 2007 and 2010 is described. Thirdly, the main observations highlighted by the case study are discussed with reference to the Sociology of Organizations and Sociology of Public Action. Finally, the paper concludes by highlighting the main findings drawn from this research on the transversal consultation.

2. Setting the stage for the therapeutic projects and transversal consultation

Changes in Belgian public policies since the 1980s can be broadly defined as a shift from bureaucratic to post-bureaucratic regulation (Kosa et al., 2008). Before the 1980s, the state (represented by administrative agencies) was central to decision-making in public policies. This form of regulation showed the dominance of Weberian bureaucracy as a benchmark for state intervention. Other dominant features (Hood & Peters, 2004; Hughes, 2003) of this model were therefore found in the way that the Belgian state operates: centralization; the importance of universal and abstract rules to ensure equal treatment; the importance of control, subordination and specialization; and objectifying staff human resource management policy (Pichault & Schoenaers, 2003), among others. In this context, the knowledge required for policy formation consisted in quite a simple mix (Kosa et al., 2008) of academic knowledge (subject or sector scientific studies), administrative knowledge (budget data, compliance with predefined rules) and professional knowledge (abstract knowledge taught in professional schools).

In the 1980s, a combination of different elements, including budget and fiscal crisis as well as societal critique of maladministration, challenged traditional benchmarks. The dominant means of policy making then changed substantially, to the extent that the basic referential was fundamentally modified. New Public Governance (Newman & Clarke, 2009; Osborne, 2006) and New Public Management (Hood, 1991) have actually become the dominant organization standards for the management of the collective interest.

Since this time, various features of Belgian mental health policies have reflected these new standards (De Munck, Genard, & Kuty, 2003). By the end of the 1980s, the bureaucratic model had been gradually undermined by a new context of state coordination, in which top-down regulation coexists with bottom-up processes. From this point on, the state defined problems and provided measures to guide action (Greve, 2010) and reach compromises between influential stakeholders in the mental health sector. Coordination instruments and pilot-projects then became increasingly central to policy making. On the other hand, public service professionals as well as service users and national/international experts have participated in policy definition and implementation: they have become

[1] The term ''public action'' rather than ''public policy'' (Commaille, 2004) is defined as follows: ''it includes a relativization of the role of the state and a higher importance of local, and supranational actors; it accounts not only for the actions of institutions but also for a variety of public and private actors, embedded in complex interdependences simultaneously at several ''levels''; it breaks away from a linear and hierarchical view of policy process and privileges a view that is more horizontal and circular.'' (Knowledge & Policy, Specifications, Orientation 2).

co-producers or co-innovators (Dunn & Miller, 2007). This trend towards involving professionals, service users and scientific experts within the policy process has resulted in the increased diversification of relevant knowledge regarding mental health policies. In particular, experience-based knowledge (provided by service users or by professionals) and evidence-based knowledge (produced by scientific experts) have become the key drivers of Belgian mental health policies.

The starting point for this change was the first policy programme (1990) following the discourse of the deinstitutionalization of mental health care. This programme differed from previous mental health policies in two major aspects. Firstly, it promoted the conversion of psychiatric hospital beds in community mental health services adapted to the needs of chronic and stabilized patients: the Initiative Sheltered Housing and the Psychiatric Nursing Home. Secondly, it created new instruments of coordination: the Mental Health Care Consultation Platform (MHCCP). The MHCCP are innovative (De Munck et al., 2003) because of their intermediate position between decision makers and practitioners. The MHCCP are the representatives of the mental health services in a given area. As such, the MHCCP are responsible for coordinating these services and for taking part in surveys or pilot-projects launched by policy makers. Therefore, the platforms have an important intermediary role in the therapeutic projects and the transversal consultations examined further in this paper.

This programme ended in 1995, having failed to release fundamental changes in the organization of mental health care; Initiative Sheltered Housing and Psychiatric Nursing Home augmented hospital facilities, but the hospital-centred model of provision of care remained dominant.

The advice of the National Advisory Council on Health Services (NACH, 1997) comprised the second decisive influence on the development of new mental health policies. Based on its assessment of the previous policy measures, this influential council (composed of the main stakeholders of the mental health sector) encouraged policy makers to pursue policy goals defined in the 1990s, including the reorganization of mental health care into networks and care circuits.

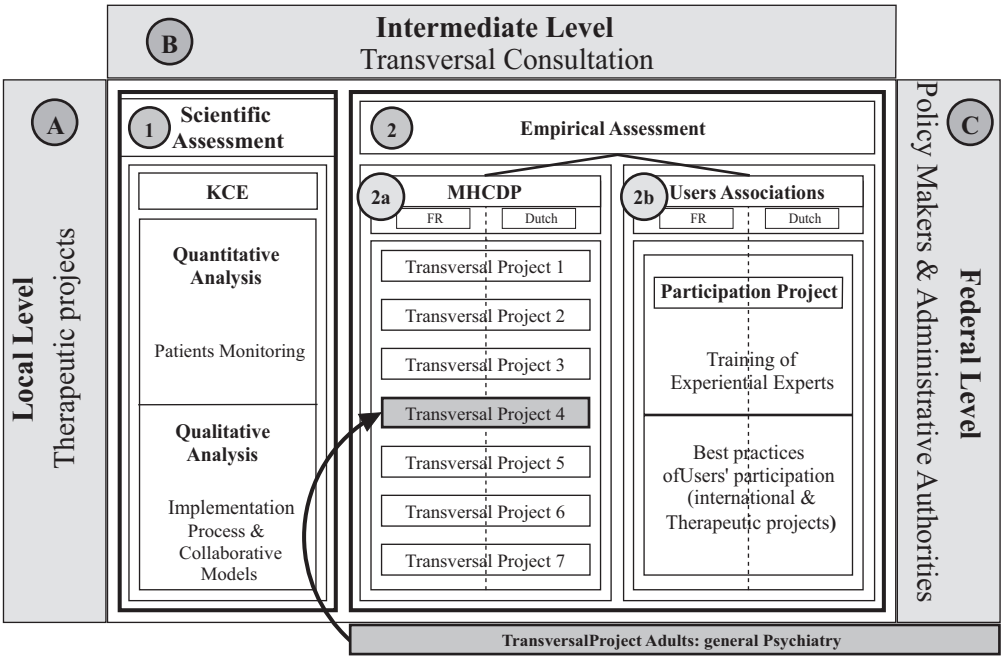
Faced with the powerful psychiatric hospitals,[2] competitive professional groups, and the sharing of responsibilities between several political levels,[3] policy makers have shown preference for a gradual conversion rather than a direct reform of the mental health system as a whole. To this end, a number of pilot-projects followed one another between 1995 and 2010. The therapeutic projects and the transversal consultation which form the focus of this paper can be distinguished from others such programmes primarily by their considerable scope. On the one hand, therapeutic projects are intended to encourage cooperation between professionals belonging to competing groups (including psychiatrists, general practitioners, social workers, nurses and home help), competing organizations (for instance, psychiatric hospitals and Initiative Sheltered Housing), and sectors (Health, Social, Justice, etc.). On the other hand, three kinds of experts are involved in the transversal consultations: professionals and practitioners, users' associations and scientific experts.

3. Therapeutic projects and transversal dialog: design features

The therapeutic projects and transversal consultation were launched in 2005 by the Minister of Public Health and Social Affairs. The therapeutic projects and transversal consultation were intended to complement one another in a framework of policy experimentation aimed at providing policy makers and practitioners with useful expertise before starting a complete reform of the sector. In practice, this experimentation started in 2007 and ended in 2010.

[2] The position of the NACH, composed of progressive professional elites, does not necessary reflect the position of each psychiatric hospitals, managed by boards of directors concerned with supporting the subsistence of their institutions.

[3] 7 ministers have discretionary decision-making power on issues related to mental health care. The Federal government has competencies relating mainly to residential cure and care aspects. Regional and community governments have political competencies relating to the 'non-cure' aspects of mental health care (prevention, welfare and social care) (Leys et al., 2010: 4).



3.1. Local level: the therapeutic projects

> *"Therapeutic projects are intended to implement an 'integrated health services model' in clearly defined catchment areas, providing services adapted to the needs of the patient and promoting his rehabilitation in society and guaranteeing continuity of care [. . .] The TP should aim at "complex and chronic" patients with psychiatric disorders, within a clearly identified age group (namely children and adolescents, adults, elderly), and/or a specific pathology (addiction or forensic psychiatry). The TP should consist of a minimum number and type of partners, operate in an explicitly motivated catchment area, and aim at giving needs-based care and guaranteeing continuity of care, through a developed model of collaboration"* (Leys et al., 2010: 5).

In practical terms, therapeutic projects are local projects intended to organize therapeutic consultations for selected patients. Therapeutic consultations are meetings gathering different professionals: general practitioners, psychiatrists, nurses, social workers, home help, and sometimes the patient concerned. Each consultation is aimed at creating or assessing care plans appropriate to the actual needs of the patient.

Public authorities invited outpatient services and psychiatric hospitals to develop therapeutic projects. In other words, these organizations were allowed, but not obliged, to take part in this experimentation. Nevertheless, authorities received many applications and eventually decided to finance 63 projects. The 63 therapeutic projects were distributed among the three Belgian administrative regions according to the target group they addressed (children and adolescents' general psychiatry, forensic, or addiction [15 therapeutic projects]; adults' general psychiatry, forensic, or addiction [38]; Elderly [10]).

These projects were compatible with the general objectives described above, and to the guidelines defined by the public authorities. These guidelines consisted of organizational principles which the projects were required to observe in order to receive financial support from the National Institute for Health and Disability Insurance (NIHDI). For example, each therapeutic project was required to involve at least 30 service users from the first year of the experiment onwards, to organize at least three consultations a year for each patient, and to develop predefined partnerships.[4]

[4] Each project should include as participants at least: a psychiatric hospital or a psychiatric unit, one of the "pilot projects" (home care or outreach), funded through Federal Public Service and a primary care partner (an association of general practitioners, Integrated Services Home Care (ISHC), Home Services (HS)) (Leys et al., 2010: 10).

Beyond these general characteristics, each project consisted of a specific arrangement, often reflecting the philosophy of the promoter as well as local resources and constraints (Vrancken et al., 2010). For instance, therapeutic projects promoted by psychiatric hospitals tended to focus more on medical aspects than therapeutic projects promoted by outpatient service, which instead tended to defend a social approach to mental health; therapeutic projects working on a large geographical area typically worked with many more partner organizations than projects working on small areas, etc.

The application for participating in the experiment was managed by a promoter; however, the practical organization of the project during the three years of experimentation was managed by a therapeutic project coordinator: a person choose by the promoter to organize the therapeutic consultations, and who became the spokesperson of the therapeutic project. As such, the therapeutic coordinator formed a link between the therapeutic projects and the second part of the experimentation: the transversal consultation.

3.2. Intermediate level: the transversal consultation

Transversal consultation is an intermediate instrument placed between local projects and public authorities. Authorities have termed this policy instrument transversal consultation[5] according to its objectives and the means used to achieve them. Firstly, ''*The aim of transversal consultation is to identify ways to organize mental care networks and circuits in their content and form, based on experimentations conducted in therapeutic projects, in order to bring a structural proposition for organizing such care networks and circuits*.'' (NACH, 2007: 4, free translation). This objective to provide authorities and professionals with a comprehensive knowledge about care networks and circuits underlies a consultation processes, ''*specifically and ideally formulated to allow new ideas to be argued, tested, upheld or dismissed in order to create a new policy to direct action*'' (Smith-Merry, Freeman, & Sturdy, 2009: 2).

Secondly, the transversal nature of the consultation refers to the political motivation to extrapolate transversal lessons from the heterogeneous whole formed by the 63 local projects. The recording of these outcomes was conceptualized in three ways, which formed the three parts of the transversal consultation. The first was the scientific portion (1), consisting of a quantitative and a qualitative assessment. The two others parts are the transversal projects (2a) and participation projects (2b), which took place in the empirical portion (2) of the transversal consultation.

(1) The scientific portion was led solely by the Belgian Health Care Knowledge Centre (KCE). The KCE was founded in 2002 to produce evidence-based studies ''*to advice policy makers when deciding in health care and health insurance. [. . .] The KCE is not itself involved in making decisions and certainly not in their implementation. Its role is to point the way to the best possible solutions. It does so in a context of optimal access to health care of high quality and taking into account increasing demand and budgetary limitations*.''[6]

The KCE carried out its scientific assessment of the therapeutic projects by utilizing two complementary approaches: interviewing the therapeutic project coordinators on organizational issues (qualitative analysis), and additionally asking them to complete specific scales measuring the effects of the monitoring of patients taking part in the local projects (quantitative analysis).

(2a) The MHCCP were responsible for the transversal projects. The objective of the transversal projects was to facilitate an exchange of learning between representatives of the therapeutic projects addressing the same target group. Thus the 63 therapeutic projects were distributed among 7 transversal projects corresponding to the 7 target groups addressed by the therapeutic projects: children and adolescents general psychiatry [referenced as TP1], forensic [TP2], addiction [TP3]; adults general psychiatry [TP4], forensic [TP5], addiction [TP6]; elderly [TP7].

Each MHCCP was responsible for organizing one transversal project. To that end, the MHCCP hired transversal coordinators, entrusted with the day-to-day management of the transversal projects. According to the rules established by the federal administration in charge of the regulation of the transversal project (The Federal Public Service), each transversal coordinator was required to organize a meeting to gather the therapeutic coordinators of all local projects addressing the same target group every three months for the duration of the

[5] ''Transversal consultation'' is the official translation for ''concertation transversale'', see Leys et al. (2010).

[6] See http://kce.fgov.be.

project. The intention of these meetings was for participants to share their local and practical experiences, to identify emerging best practice when working in networks and care circuits, and to identify any shortcomings of the mental health care system.

The final aim of the transversal projects was to provide policy makers with experience-based recommendations concerning all the target groups. Therefore transversal coordinators, who managed their transversal projects separately, were required to write their intermediate and final reports collaboratively.

(2b) The participation project was led by service users' associations, and was designed to collect best practice regarding service user participation in care. To that end, the associations were responsible for collecting examples of international best practice, as well as training (ex-)service users to enable them to participate in therapeutic consultation and in the transversal projects as experiential experts, in order to observe innovative practices in terms of participation. The associations were also responsible for summarizing their survey of international best practice and the observations made by experiential experts to make recommendations to policy makers.

3.3. The federal level

At the federal level, a special committee was created, composed of representatives of policy makers and administrative authorities supporting the therapeutic projects and the transversal consultation; of representatives of the MHCCP; of service users' associations; and of the KCE. This committee connected the decision-making forum with the therapeutics projects and the transversal consultation by facilitating the exchange of key information with the transversal coordinators.

4. Introduction to the case study and methodology

The case study analysed in detail in this paper relates to one of the transversal projects. This transversal project gathered the therapeutic coordinators of the local therapeutic projects which addressed the target group ''adults: general psychiatry''.

The following section provides a descriptive narrative of what happened during the meetings organized during the three years of this transversal project.

This narrative is based on fieldwork carried out by our research team for the Know&Pol European research between 2008 and 2010. This cluster was chosen for analysis in order to ensure a comprehensive data set. Indeed, a previous part of this European research involved analysis of two therapeutic projects addressed to the target group concerned in this transversal project (Vrancken et al., 2010).

The methodology for this study consisted of documentary analysis, semi-structured interviews, and observations. First, all the reports produced by the coordinator of this transversal project, including minutes, annual and final reports were examined. Secondly, semi-structured interviews with the coordinators and the participants in the transversal project were carried out. Thirdly, all meetings of this transversal project over the course of two years, between 2008 and 2010, were observed by members of the research team.

Additionally, cross referencing the three previous methods provides an analytical account of the process that has taken place within the transversal project. This analytical account, and the concepts around which it is organized, have been submitted to practitioners and other stakeholders in order to ensure their heuristic value. Indeed, the end users' seminars organized by the research team as part of the European research created repeated opportunities to share the results of the study.

4.1. Transversal project (adults: general psychiatry): a descriptive narrative

The narrative is divided in three parts, in order to highlight three significant periods regarding the development of the overall project process. These parts are not precisely defined by distinct time periods (indeed, from a temporal perspective, they overlap each other), but rather hold different meanings regarding the process development. This sense of difference is based on the concept of turning point (Abbott, 2001: 240–260), defined as any event that changes the parameters of a given situation or, from a more dynamic perspective, that causes the process to develop in a direction that one could not anticipate before this event occurred, and thereby changes the parameters of every subsequent situations.

Two turning points can be highlighted within the empirical material. The first was a protest letter sent by the participants of the transversal project to policy makers and administrative authorities. This turning point closed an initial period dominated by controversies about the administrative regulation of the local projects and the organization of the transversal consultation as a whole (A).

The period following the protest letter was dominated by stories of therapeutic projects as told by the project coordinators (B). This period then ended in another turning point: the announcement, by policy makers and administrative authorities, of their decision to stop financing the transversal consultation, although the therapeutic projects it intended to assess were still running.

This announcement opened a third and final period, which could be viewed as a period of regret due to the feeling shared by many participants in the transversal projects that the overarching project had not succeeded in producing recommendations reflecting the expertise acquired through the project process (C).

4.1.1. The period of controversies

Due to a lack of consensus between federal authorities, scientific experts from the KCE, and spokespersons for the MHCCP, the transversal projects started some nine months later than the therapeutic projects. Therefore, when the transversal project started, the therapeutic coordinators seized the opportunity to share the difficulties encountered at a local level during these first nine months.

Among these difficulties, three particular problems were rapidly highlighted: first, administrative logic did not always match professional logic (1); secondly, concerns of users' associations did not match with professional concerns (2); and thirdly, the scientific assessment made by the KCE did not fit with the experimental logic of the whole process (3).

> *The implementation timing was a real issue. The first transversal consultation meeting took place in December while projects had started in April [2007]. There were thus only two meetings the first year, and I think it did not help our mission. It was already jeopardized at the start. I remind that at the beginning, we did not have a communication mission, but a consultation mission. We spent our time informing projects about the INAMI's [NIHDI] rules and about the scales [KCE].*
>
> (Interview with a transversal coordinator, free translation).

(1) The contradiction between professional logic and the logic of administrative authorities was highlighted by therapeutic project coordinators because administrative regulation caused difficulties in the development of the local projects. A lack of communication between authorities and practitioners created serious misunderstandings about the rules that the therapeutic projects should follow. For example, when one project coordinator explained his difficulties in gathering three professional partners at each therapeutic consultation, others coordinators realized that they had interpreted the rule differently and, furthermore, that a few of them had deliberately circumvented this rule (indicating the three partners' presence, even though they did not directly participate in the therapeutic consultation).

Moreover, therapeutic coordinators underlined the friction between administrative constraints and day-to-day clinical requirements. Their position relied on three main arguments.

First, the obligation to diagnose patient according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) before entering the project is widely considered to be problematic in many respects: professionals need more time to make a reliable diagnosis; situations of some mentally ill patients who particularly need a multidisciplinary aftercare do not fit with the DSM classifications; and finally, social workers do not agree with this ''patients' labelling'' according to medico-psychiatric references.

Secondly, the case load imposed by the NIHDI (at least 30 patients from the first year of the experiment) threatened the most specific and perhaps the most innovative therapeutic projects (e.g. projects addressed to patients with multiple physical disabilities and psychiatric disorders) and led others to include patients for whom the project was not directly relevant.

Finally, the obligation to organize a therapeutic consultation for each patient every three month did not necessarily match with the clinical rhythm of the patient's case and encouraged the coordinators to schedule pointless meetings, while simultaneously preventing them from scheduling useful meetings according to the actual needs of the patient.

(2) The second issue relates to the tension between professional and service users' perspectives. Although the coordinators recognized service users as necessary partners in quality care, they expressed opposition to the latter's systematic involvement in transversal consultation. Indeed, they believed that such experiential experts are simply not concerned by many aspects of information sharing, especially that which goes beyond the strictly organizational themes and involves detailed medical considerations.

> *It is clear that mental health patients and users associations are key players in the ongoing reorganization of mental healthcare: at this regard, they will therefore be invited to take part in transversal dialog and share their thoughts, questions and arguments. They however have a distinct status than professional actors: it means they are not involved in all the professional experiences sharing and discussions.*
>
> (Consultation Minutes, 2007: 6, free translation).

(3) The third issue opposes the conflicting logics of experimentation and evaluation. The scientific analysis conducted by the KCE was criticized regarding its nature, purpose, and the tools used to support it. Therapeutic coordinators denounced a gap between the stated objectives of the KCE's work and its perceived purpose. Indeed, the scales used to measure patients' development (besides the fact that they contain questions considered an intolerable intrusions into the latter's privacy), suggests a desire to test the projects' performance, rather than to analyse and assess new organizational models.

Closing this period of controversies: the protest letter.

These three major issues gradually came together to form a clear opposition between the key players involved in the transversal projects (the empirical part of the consultation), who claimed an identity combining experimental logic and professional common sense, and the others stakeholders involved in the experiment: the NIHDI responsible for its regulation, the KCE for the scientific assessment, and users' associations for the participation project.

In almost the half of the transversal projects, the transversal coordinators felt unable to adequately facilitate the exchange of experience-based knowledge between the various therapeutic coordinators, due to the issues outlined above. The transversal coordinator therefore decided to summarize and formalize the concerns of the therapeutic coordinators by collectively writing a letter to the federal authorities.

> *Today, therapeutic projects are still in the experimentation phase: it is important to remind it, because it is essential to take time in order to test a new collective work system which has a significant impact on patients and the methods used to support them. The experimentation reveals however that this humble position was hard to maintain, either in 2008 or in 2007. Indeed, the system promoted by the INAMI and the SPF (federal authorities) provides field professionals with a low ability to adjust their practices to these new work methods. From the beginning, it imposes them non arguable results obligations – in particular to reach a case-load of thirty patients otherwise they will get no more funding – and not means obligations – which are typical of an experimental logic. The dialog frame rigidity leads us to think that formalization precedes experimentation for contractual partners!*
>
> (Consensus Note, 2009, Therapeutic Projects, experimentation versus formalization?: 4, free translation).

After having decided to write this protest letter, which became a consensus note under pressure from the MHCCP (in charge of the organization of the transversal projects) on the transversal coordinators (in charge of the day-to-day management of these projects), the latter informed the therapeutic coordinators of their desire to alter the methodology used:

> *During the meetings, we have been talking about a lot of things that are not under our responsibilities, but not so much about the therapeutic projects' practices themselves. That is why I suggest to rely on the same methodology that others transversal projects where it has been decided from the start to present two therapeutic projects at each meeting.*
>
> (Introduction to a transversal dialog meeting by the transversal coordinator, 2009, free translation).

4.1.2. The period of the therapeutic project stories

What are therapeutic consultations? Is the patient present and how does (s)he participate? What difficulties are inherent in bringing together professionals from different backgrounds, and what organizational innovations might they co-create? The therapeutic project stories highlight a number of questions such as these, and almost as many different answers according to which project is analysed, the context in which projects unfolded, and how the coordinators translated (Freeman, 2009) the administrative rules to succeed in making the project sustainable.

> *Each therapeutic project is born in a particular context, with specific partners, different routines and work cultures. . .We observe thus a great diversity between the projects, among others as the issue of the target groups and the organization of the therapeutic consultation are concerned. Moreover, we notice that next to these organizational differences, many projects need to work within a flexible framework. They have to remain free of giving different shapes to the therapeutic consultation as well as to the project coordination, according to the specific features and need, continuously changing, of the patients and the practitioners involved. Thus many projects also show an internal diversity.*
>
> (Transversal Consultation Report, 2010: 2, free translation).

The transversal coordinator of the project ''adults: general psychiatry'' promoted this diversity; further stating that other transversal coordinators have decided to rely on differing methodologies in order to deal with this variance:

> *For instance, in the transversal project x, the coordinator has imposed a particular framework, with precise questions, a good power point. . .: the parameters of the debates were well defined. But I have preferred a much more qualitative discussion because I taught that one can obtain much more information in this way, even if it requires a subsequent greater work, to select and summarize the relevant information. I wanted true debates, open discussions, even if it created difficulties and let the therapeutic coordinator free of sharing all their concerns; at least it was constructive.*
>
> (Interview with the transversal coordinator).

Eventually, by referencing one another, the therapeutic projects stories progressively revealed data elements that seem relevant to the political motivation to prepare a future reform. Indeed, as outlined in the following text box, these stories serve to highlight common benefits and issues, from both a structural and relational viewpoint, which could be considered either as sticking points, or as priorities for a future reform. Thus, among the extracts from the ''therapeutic projects stories'' presented below, gaps, as well as areas of professional resistance and instances of organizational learning are highlighted.

Therapeutic projects stories[7]

Therapeutic coordinator of project X1 *is highlighting the difficulties faced in home aid services involvement. It is not that these services do not participate to the project, but rather that they do not have enough resources to satisfy the demand. The main weakness that the coordinator identifies in his project is that he does not manage to open therapeutic consultations to more social actors (justice, social workers and so on. . .). According to coordinator this issue is related to medical secrecy that doctors, psychiatrists in particular, fear to share.*

Coordinator of project X2 *then speaks. She emphasizes the issues she is facing to involve doctors and psychiatrists, when they do not work in institutions. It is therefore the lack of independent professionals participation to the project that is highlighted.*

Coordinator of project X3 *highlights that the involvement of home aid in the rehabilitation process seems crucial. She has indeed already started a procedure to include them in the partners who sign the convention that is binding her project to the INAMI.*

[7] These extracts are from reports based on transversal dialog meetings observed by the research team.

*The last person to talk is **the coordinator of project X4**. Her project is different from the others as it addresses patients with mood disorders, behaviour disorders and mental disorders. The TP partially responds to patient's needs, but it does not manage to satisfy them totally because specialized services intended for this public are not always available or do not exist.*

4.1.3. The time for regrets

The end of the transversal consultation, including the transversal project ''adults: general psychiatry'', timed according to its originally intended lifespan (04/2010), revealed a general dissatisfaction from project participants. Indeed, the decision to discontinue funding for consultation at the end of the scheduled three years arguably defies the very logic of the device.

The project involved two levels of action: local therapeutic projects and transversal projects. Local projects served as a kind of laboratory for coordinators gathered in the transversal project, enabling them to produce evidence-based knowledge.

However, the administration responsible for the management of the local therapeutic projects – the NIHDI– decided to continue the experiment one year longer than originally planned.

It therefore seemed likely that the administration responsible for the organization of the transversal consultation – FPS – would, in response, likewise continue its involvement in the project; however the authorities decided to discontinue funding for the consultation as of the originally planned end date.

A short extension in funding was made possible, but was conditional on a change in project methodology. Both the decision not to extend funding further and in particular the condition laid for a possible short-term extension, augurs political and administrative authorities' dissatisfaction with the transversal projects' work.

That dissatisfaction was shared by transversal coordinators who stated that ''*we have not gone beyond the therapeutic project level; we wondered what the rules were, how we would move forward. . . But there was insufficient perspective, no real project that would result in real policy recommendations*.'' (Interview with the transversal coordinator, free translation).

Nevertheless, participants in the transversal projects also pointed out some positive effects that could sustain further changes in the mental health care organization. For instance, ''*It has enabled some hospitals to discover that there is a mental health service next door and that it is possible to work with it; it has opened the discussion with patients' associations, which is interesting – even though the debate is not over [. . .]*'' (Interview with a therapeutic coordinator, free translation).

Eventually, the presentation of a new policy programme called ''*Psy107*'' (05/2010) occurred simultaneously with the end of the transversal consultation, reinforcing stakeholders' dissatisfaction. The acronym *Psy107* refers to policy measures intended to kick-start the structural reform of mental health care in Belgium.[8] This move prompted a new round of questions: where did this reform come from? Were policymakers so unhappy with the transversal consultation experiment that they did not even want to hear about its conclusions? Did this signal the beginning of a reform despite the fact that the transversal project had neither completely ended nor produced the empirical recommendations ordered by policy makers?

5. Discussion

This discussion relies on the Sociology of Organizations (Crozier & Friedberg, 1992; Friedberg, 1997) and Sociology of Public Action (Commaille, 2004) to analyse the development of the transversal project ''adults: general psychiatry''. According to this theoretical framework, the analysis should encompass the viewpoints of the actors involved in the project's implementation, as well as their interactions with one another. On the one hand, the Sociology of Organizations emphasizes the importance of practices and interactions through which actors negotiate their cooperation. Indeed, this cooperation is not evidence but rather depends on the ability of strategic actors to reach compromises (Friedberg, 1997). On the other hand, Sociology of Public Action responds to the increasing complexity of state intervention by transposing the premises of the Sociology of Organization to the study of public policies

[8] Guide (2010) ''*Vers de meilleurs soins de santé mentale par la réalisation des réseaux et circuits de soins*'' (www.Psy107.be).

(Musselin, 2005). Consequently, instead of focusing on policy decision and outcome evaluations, this approach emphasizes the policy process, including the actual practices of actors involved in the implementation of policy programmes.

> *Examining a system of actors always means examining how it uses these [objects, techniques, and instruments] devices, that is, how it manipulates, defines, stabilizes, and, at the same time, transforms them. It is an effort to understand the investment that human actors have made in these objects and devices and the extent to which they consider them as a constraint or resource for action*. (Friedberg, 1997: 151)

As defined by the public action approaches (Commaille, 2004; Lascoumes & Le Galès, 2005), therapeutic projects and transversal consultation constitute a policy instrument: social conceptions are as important as technical features in their definition. First, therapeutic projects and transversal consultation are based on a particular conception of what quality mental health care should look like (community care), and of how such quality care should be provided (through mental health care networks); and these conceptions have significant implications regarding the power relations between professionals and institutions. Indeed, the idea of a network threatens the centrality of psychiatric hospitals; pluridisciplinary consultations threaten the autonomy of psychiatrists and encourage cooperation between medical and paramedical staff of psychiatric hospitals and social workers; transversal projects create interdependencies between policy makers and professionals, and require cooperation between independent knowledge producers (the MHCCP, users' associations and the KCE); and so on.

On the other hand, the description of the therapeutic projects and transversal consultation has highlighted a noteworthy organizational complexity. This instrument is multi-level, involving different parties and a range of interdisciplinary expertise, and implies simultaneous top-down regulation and bottom-up knowledge production. This organizational complexity reflects a trend in policy making to directly involve all the stakeholders in a given sector (Duran, 2010), either to provide the opportunity for stakeholders to express themselves, or to benefit from their respective expertise in building new models for forthcoming public action (Callon, Lascoumes, & Barthe, 2002). In the case study analysed here, the involvement of the MHCCP, users' associations and the KCE was a direct result of a political motivation to benefit from various expertise. However, the production of a comprehensive knowledge, integrating experience-based knowledge and scientific knowledge depends on cooperation between experience-based and scientific knowledge producers. Furthermore, the successful integration of experience-based knowledge depended on the ability of the transversal coordinator and the therapeutic coordinators to summarize and formalize their learning, enabling it to be successfully communicated to policy makers.

The questioning of power relations induced by the therapeutic projects and transversal consultation, and their organizational complexity, have had many impacts on the project process already described.

During the first period (the period of controversies), a conflict arose between "*logics of action that are at least divergent, if not contradictory, or to put it in a more neutral way, not spontaneously convergent.*" (Friedberg, 1997: 188).

The transversal project meetings quickly became a special forum for the collective expression of a conflict between the different logics of action involved in the transversal consultation. As previously observed, therapeutic coordinators' propensity to use the transversal project to communicate their dissatisfaction regarding the NIHDI regulation, the work of the KCE, and the users' associations was caused by the temporal gap between the start of the local therapeutic projects and the transversal project. This initial use of the transversal project for communication was also encouraged by the position of both the transversal project within the experimentation as a whole, and the MHCCP (responsible for organizing the transversal projects) within the existing mental health system. These two bodies have intermediary roles between practitioners and policy makers. Thus, while it was tempting for practitioners to use transversal dialog in the same way they used the MHCCP, it was also tempting for the platforms to endorse this role as it reflects their primary organizational concerns. For these reasons, the use of the transversal process for purposes other than those defined by policy makers undermined the consultation.

As a whole, the transversal consultation involved different logics of action held by various stakeholders: the scientific logic of the KCE, the professional logic of the transversal projects, the users' logic of the associations, and the administrative logic prevailing to the regulation of the therapeutic projects and transversal consultation. The simultaneous involvement of all these stakeholders in the transversal consultation was a direct result of the transversal consultation's objectives: to take advantage of complementary approaches in order to provide policy makers and professionals with a comprehensive range of expertise regarding mental health care networks.

In others words, the objective of transversal consultation required relatively autonomous actors to become interdependent for a set period of time and within a precise framework. This did not mean that each of these key stakeholders was encouraged to give up its specialism (professional, service user or scientific); on the contrary, each party was encouraged to utilize its area of specialism to improve the co-production of a comprehensive body knowledge about mental health care networks. Consequently, the mandate of the transversal consultation required key players to renegotiate their professional, service user, scientific or administrative goals in the light of a common goal to co-producing a comprehensive body of expertise. However, while cooperation, and thus co-production, depends on a bounded rationality, "*the preferences and the goals of actors are not fixed but rather are discovered and modified by action.*" (Friedberg, 1997: 29)

> Therefore, *"the central question is to understand the social process leading to the construction and organization of the competitive cooperation between a set of actors who are mutually dependant for the solution of a common problem [. . .] for the resolution of which they have to secure the cooperation of partners who are also potential rivals." (*Friedberg, 1997*: 122). The cooperation of actors around "problems" and their "solutions" is thus always sustained by power and dependence relations, . . .through which actors try to "sell" their behaviour to others at the best possible price, while "buying" the behaviour he needs from others at the least cost.*" (Friedberg, 1997: 120).

In the case study analysed in this paper, neither selling nor buying of behaviour was observed. Instead, the participants redefined the problem (and the goals) of the transversal consultation, within the limited context of their respective transversal projects. Faced with experts from the KCE claiming their scientific independence; users claiming their right to remain there (to participate in the transversal project); and administrative authorities relying on Universalist values; therapeutic coordinators claimed their professional identity, including the particularism it implies (Freidson, 1988). The action of the transversal project participants to defend their identity by pointing out what distinguishes them from others, rather than trying to find interests shared with others, resulted in serious consequences for the project process.

This is the reason why the protest letter (through which therapeutic and transversal coordinators asserted their professional identities) can be viewed as a significant turning point. From that point onwards, both sets of coordinators conceived of a common strategy to promote their local knowledge, despite the difficulties they faced when trying to summarize it.

This common strategy resulted in the sequence of therapeutic project stories that characterizes the second period of the project. During this period, therapeutic coordinator' narratives have followed one another, and each coordinator has emphasized the specific achievements and/or difficulties of his local project rather than trying to collectively assess transversal learning. Supported in this approach by the transversal coordinator, participants in the transversal project have produced in this way a kind of catalogue of singular stories that enhance professional particularism instead of suggesting transversal lessons.

It is worth noting that this strategy of particularism establishes the same logic of differentiation as that developed during the first period: by allowing therapeutic coordinators to tell their stories independently, the transversal coordinator has taken into account their need to be recognized in their singularity.

Moreover, the intermediary role of the transversal coordinator is crucial here. According to this role, he is indeed "*stakeholder of several action systems [in our case: the MHCCP hiring him, his transversal project and the political and administrative authorities awaiting the latters' outcome] that are interconnected with each other and who can therefore play an essential role of intermediate or translator between different or even opposite method.*" (Crozier & Friedberg, 1992: 86, free translation). As such, the intermediary actor has a margin of freedom to translate the mandate of transversal coordinator, and therefore his organizational concerns (as well as methodological preferences) may interfere with this translation (Freeman, 2009).

In this way, the coordinator of the transversal project analysed showed preference for a qualitative methodology in order to represent the diversity characterizing the local projects over a more quantitative methodology, predisposing their expertise to be communicated to the authorities. Conversely, as text box illustrates, the qualitative methodology of the therapeutic project stories required substantial additional work in order to collate transversal lessons and to formulate resultant policy recommendations. The transversal coordinator in the case study thus gradually generalized the stories he collected: his initial intermediary report essentially formed a review of the stories told in the course of his transversal project, while the second offered a thematic approach instead of a

project-by-project approach, and the third attempted to define the main organizational models or functions which the stories allowed him to capture.

However, the case study's transversal coordinator, along with some other transversal coordinators, managed to issue such transversal lessons only at the end of the three-year process. Consequently, the outline of the final report (the policy recommendations) co-produced by the transversal coordinators remained uncertain until the very end of the project, and during the intervening three years authorities had time to become tired of waiting for some outcomes from the process they were supporting. The decision was therefore taken to end the transversal process before the local, therapeutic projects.

This paper has already highlighted this decision to end the transversal consultation as a second turning point. Indeed, from this point onwards the participants in the transversal projects began to question their strategy, concerned that it would not result in political recognition of their experience-based knowledge. Nevertheless, as previously outlined, therapeutic and transversal coordinators linked other kind of effects to the process, relating more to changing relationships between key professional and institutional actors than with the production of a comprehensive body of knowledge. The transversal projects were thus perceived as useful by the participants, despite a perceived gap between the original objective (producing a comprehensive body of knowledge) and the actual outcome of the process.

6. Conclusion

The analysis of the transversal consultation process outlined in this paper suggests that this gap between the original objective and the perceived outcome remains, insofar as the issue of producing knowledge is distinct from any power struggles between those parties responsible for its production.

Firstly, this analysis has revealed that the social conception bore by the transversal consultation (of what quality mental health care should look like and of how such quality care should be provided) threatened power relations between the key institutional and professional actors in the existing system.

Secondly, in this context of questioning the reality of power sharing, these key stakeholders were given the opportunity to contribute to defining a new organizational model for the mental health care system.

Thirdly, this participation happened in a consultation characterized by a high level of organizational complexity, which resulted in a proliferation of intermediate levels and intermediate actors, likely to translate their mandate when trying to perform it.

Eventually, according to the identity of these parties (hired by MHCCP, which traditionally represents the interests of professional and institutional actors) and the aforementioned challenging of power relations, this translation was more likely to be oriented by one of the two systems with which the transversal coordinator has to interact: professional or political.

In this context, this paper has observed that key parties' strategic concerns overrode their concerns about the production of a comprehensive body of knowledge. Indeed, they grasped the opportunities provided by this complex organizational system to use the transversal project to defend their particular specialisms. By doing so, they also attempted to highlight the necessity of considering these specialisms in the design of a new organizational structure for the mental health care system.

This use of the consultation for the defence and promotion of professional interests resulted in the transversal coordinator's choice of a qualitative methodology, based on discussions rather than evaluation. Insofar as the issue of producing a comprehensive body of knowledge remains distinct from that of power struggles (as outlined above), this choice seems in somewhat illogical. Indeed, it resulted in a series of stories that fail to mesh with the kind of knowledge asked for by policy makers (formal knowledge easy to use in policy making). However, as the question of power was raised, it appears that in practice this choice allowed therapeutic coordinators to confront their experience-based and professional knowledge with other kinds of knowledge (and knowledge holders) during the initial portion of the consultation (the period of controversies). It also allowed the diversity of practices resulting from this experience-based knowledge during the second portion of the consultation (the period of therapeutic project stories) to be highlighted, demonstrating that therapeutic consultation may take many forms.

Consequently, the controversies and discussions encountered by the therapeutic coordinators within the transversal project have at least challenged the centrality of the professional knowledge and judgement they represent, both in practice and in policy (Freidson, 1988). Their therapeutic projects enabled professionals to experience new working conditions (questioning traditional professional practice) and the transversal consultation involved other knowledge

holders in order to provide policy makers with a comprehensive range of expertise regarding mental health care networks.

Ultimately, relying on a conception of cooperation between social actors which is dependent on the compromises reached through their interactions (Crozier & Friedberg, 1992; Friedberg, 1997) this analysis has shown that the transversal project failed to produce the required body of knowledge, but has nevertheless succeeded in arguing for a change in the power sharing which characterizes the mental health sector. By threatening the professional conviction of being more legitimate than other to decide of the best therapy for the patient on the one hand, and of the best means of organizing the mental health system on the other hand, the process laid the foundations of a new compromise (supported by a new power sharing) (Friedberg, 1997). In turn, this compromise which assumes the relevance of experience-based knowledge (hold by practitioners and service users) and scientific knowledge in the creation of mental health therapies and policies enables authorities to form the foundation of a new structure for the organization of the mental health system: the mental health networks and care circuits.

References

Abbott, A. (2001). *Time matters. On theory and methods*. The University of Chicago Press.

Callon, M., Lascoumes, P., & Barthe, Y. (2002). *Agir dans un monde incertain*. Paris: Le Seuil.

Commaille, J. (2004). Sociologie de l'action publique. In L. Boussaguet, S. Jacquot, & P. Ravinet (Eds.), *Dictionnaire des politiques publiques* (pp. 413–421). Paris: Sciences-Po Les Presses.

Crozier, M., & Friedberg, E. (1992). *L'acteur et le système: Les contraintes de l'action collective*. Paris: Seuil.

De Munck, J., Genard, J.-L., Kuty, O., Vrancken, D., Delgoffe, D., Donnay, J.-Y., et al. (2003). *Santé mentale et citoyenneté: les mutations d'un champ de l'action publique*. Gent: Academia Press.

Dunn, W. N., & Miller, D. Y. (2007). A critique of the New Public Management and the Neo-Weberian State: Advancing a critical theory of administrative reform. *Public Organization Review, 7*, 345–358.

Duran, P. (2010). *Penser l'action publique*. Paris: LGDJ.

Freeman, R. (2009). What's translation. *Evidence and Policy, 5*, 429–447.

Freidson, E. (1988). *Profession of medicine. A study of a Sociology of Applied Knowledge*. University of Chicago Press.

Friedberg, E. (1997). *Local orders. Dynamic of organized action*. London: JAI Press Inc.

Greve, C. (2010). Whatever happened to New Public Management? *The Danish Political Science Association meeting proceedings*.

Hood, C. (1991). A public management for all seasons? *Public Administration, 69*, 3–19.

Hood, C., & Peters, G. (2004). The middle ageing of New Public Management: Into the ages of paradox. *Journal of Public Administration Research and Theory, 14*, 267–282.

Hughes, O. E. (2003). *Public management & administration. An introduction*. Hampshire: Palgrave MacMillan.

Kosa, I., Maury, C., Mélotte, A., Mossé, P., Ozga, J., & Schoenaers, F. (2008). Knowledge and policy in education and health. Challenging State legitimacy in 8 European countries: Facts and artefacts. *Integrative report of the European Project "Know and Pol"*.

Lascoumes, P., & Le Galès, P. (2005). *Gouverner par les instruments*. Paris: Sciences-Po Les Presses.

Leys, M., Antoine, C., De Jaegere, V., & Schmitz, O. (2010). *Réformes dans l'organisation des soins de santé mentale : études d'évaluations des projets thérapeutiques*. KCE Report, 146B, Brussels.

Musselin, C. (2005). Sociologie de l'action organisée et analyses des politiques publiques: deux approches pour un même objet? *Revue Française de Science Politique, 55*, 51–71.

National Advisory Council for Hospitals. (1997). *Avis concernant l'organisation et le développement futurs des soins de santé mentale*. CNEH/D/115-3, Bruxelles.

National Advisory Council for Hospitals. (2007). *Avis partiels 2 et 3 «concertation transversale»: vers la définition de nouvelles modalités d'organisation des soins de santé mentale*. CNEH/D/PSY/285-2, Bruxelles.

Newman, J., & Clarke, J. (2009). *Publics, Politics and Power*. London, New Delhi: Sage Publications.

Osborne, S. P. (2006). The New Public Governance? *Public Administration Review, 8*, 377–387.

Pichault, F., & Schoenaers, F. (2003). HRM practices in a process of organisational change: A contextualist perspective. *Applied Psychology an International Review, 52*, 120–143.

Schoenaers, F., Thunus, S., & Cerfontaine, G. (2011). La santé mentale en Belgique: l'hôpital renégocié. *Sociologie et Santé, 34*, 55–72.

Smith-Merry, J., Freeman, R., & Sturdy, S. (2009). Towards a Mentally Flourishing Scotland: Consultation process as public action. *Knowledge & Policy*, Orientation 2, Public Action 1.

Vrancken, D., Schoenaers, F., & Thunus, S. (2010). Le champ de la santé mentale en Belgique à l'épreuve de la concertation. De l'innovation politique à la politique de l'innovation. *Knowledge & Policy*, Orientation 2, Public Action 2.