

# **The social and cognitive mapping of policy**

## **The health sector in Belgium**

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### **Orientation 1**

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## 1. Introduction

The objective of Orientation 1 is to draw up the social and cognitive mappings of the health sector in Belgium. The cognitive dimension aims at answering questions linked to knowledge: What do actors know? How do they use knowledge? How do they collect knowledge? The social dimension emphasises actors and their relationships in order to answer questions like: Who are the actors? What are their competences? What type of relationships exists among them?

The report of Orientation 1 is divided into three parts: a general description of the field, a detailed description of the three identified dimensions (Structure – Actors – Knowledge) and an analysis of the collected material.

The first part, 'A context shaped in history', presents the context of the nation/sector. We will start with a description of the general characteristics of the Belgian political system. We will then go on to describe the history of the Belgian health sector before focusing on the mental health sector. We will close this part by presenting the main actors working in the Walloon region and the scope of their competences.

The second part, 'Three dimensions', will provide a detailed description of the material collected following the structure proposed in the guidelines:

- Structure: this point deals with models of relationship within and between the bodies
- Actors: the second point deals with actors playing a specific role (influential actors, circulators, brokers, etc.) in the knowledge process.
- Knowledge

The last part is an attempt to analyse the material collected in the perspective of a possible shift in the public action management.

## 2. A context shaped in history

Belgium is a federal state divided into three linguistic communities and three geographical regions. Health competences are shared between those levels of power.

We will first briefly present some of the country's general characteristics and its political organisation. Second, we will proceed to a description of the Belgian health sector, showing a move towards patient-centred care. We will then focus on the mental health system since the subsequent directions will concentrate on this sub-field. We will retrace the history of the mental health sector in Belgium, underlining the evolution towards a care circuit and network based system. Finally, given the complexity of the Belgian institutional context<sup>1</sup>, a defined-territory approach seems relevant. We will then focus on the Walloon region where three power levels are involved in health matters. We will present the health sector and its main actors in the Walloon region.

### 2.1 General characteristics

Belgium is one of the most densely populated areas in Europe. Its 10,445,852 inhabitants<sup>2</sup> live in a land of 30,528 km<sup>2</sup> or 342 people per km<sup>2</sup>. The population is distributed among the regions as follow: the Flemish region - 6,043,161, the Walloon region - 3,395,942, and the Brussels Capital region - 1,006,749. In the 2006 Human Development Index,<sup>3</sup> Belgium ranks 13<sup>th</sup> in the world and 9<sup>th</sup> in Europe.

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). Each power level has its own Parliament with proportional representation and its own Government. Belgium is a complex and decentralized system as each level exerts its power independently within its scope of competences. There are, for example, seven Ministers who hold some health competences.

The Belgian political system is characterized by its influent pillarisation (Kuty, 2005). 'An influential aspect of Belgian society is the historically important 'pillarisation'. The political

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<sup>1</sup> See annexe 2

<sup>2</sup> Survey « Population et ménages. Population totale et belge », Direction general « Statistics and Economic Information », at the 01.01.2005

<sup>3</sup> <http://hdr.undp.org/hdr2006/statistics/>

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 sociopolitical 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 [...].<sup>4</sup>

## 2.2 History of the Belgian health sector

'The Belgian health system is based on the principles of equal freedom of choice, with a Bismarckian-type of compulsory health insurance, which covers the whole population and broad benefits package. Compulsory health insurance is combined with a system of health care delivery, based on independent medical practice, choice of physician and predominantly fee-for-service payment' (Corens, 2007). The Belgian health system is primarily funded through social security contributions and taxation. Public sector funding as a percentage of total expenditure on health care fluctuates around 70%.

'Belgian health care organization 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 organizations, etc. Not only do these stakeholders influence health care policy by traditional lobbying, they are also directly involved in the management of the system, mostly by membership on one or more of the executive councils or committees in the National sickness and Disability Insurance Institution (RIZIV-INAMI), and are represented in different advisory bodies' (Corens, 2007).

Belgium has followed a process of devolution which resulted in a transfer of responsibilities from the national level to the communities and regions and has become a federal state. Since In 1980, the Constitution was amended to specify that Communities order by decree, each within its territory, all *person-related* matters. The Institutional Reform Act of 8 August 1980<sup>5</sup> states that *person-related* matters include health policy and provision of assistance to people. Other matters remain federal competences.

Health competences are then shared among national and regional power levels, without taking into account municipal and provincial prerogatives. 'There is no medium or long-

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<sup>4</sup> [http://www.eurofound.europa.eu/eiro/country/belgium\\_2.htm](http://www.eurofound.europa.eu/eiro/country/belgium_2.htm)

<sup>5</sup> Institutional Reform Act of 8 August 1980. MB 15/08/1980

term coherent and global political project. There is no articulation between preventive and curative, there is no coordination between power levels' (Jadot, 2003).

During the 1980s and 1990s, the Belgian State's budgetary crisis brought into question the Welfare State's expansionist logic. The demographic evolution and the health cost increase required changes in how the health care system was managed. In 1994, the Minister of Social Affairs asks the National Council for Hospital Facilities for advice on cutting back and reconvertng hospital beds. It suggested 'to highlight qualitative objectives in terms of services rather than traditional quantitative characteristics like number of beds, occupancy rate and length of stay. The hospital is considered a tool for patients. It is defined contingent to target-groups and care programs oriented towards these target-groups rather than in terms of structure.'<sup>6</sup>

In 1998, the Minister for Consumer Protection, Public Health and Environment mandated a research project called 'Health care in Belgium. Challenges and opportunities', carried out by Dr. Jan Peeters. In the final report, the following proposals were formulated:

- Necessity of a global vision in health matters
- Necessity of a transparent process of priority choice in health and health care
- Necessity of coherency and efficiency in health care and optimization of the system

When commenting on this report, the Minister underlined that 'a public health policy must be centred on the patient [...].'

In an opinion of 10 July 2002, the 'programming and accreditation' section of the National Council for Hospital Facilities stated that needs in health care can no more be formulated as needs in isolated structural factors (buildings, equipment and activities) which number is calculated on the basis of population data. Generally, legislation based on this calculation is obsolete when published because technology evolves quickly. The National Council for Hospital Facilities suggested that programming, accreditation and financing mechanisms must follow the evolution of patient needs and technology progress.

'Although the Belgian health system has not undergone any major structural reforms over the past couple of decades, various measures have been taken mainly to improve the performance of the health system' (Corens 2007). It should also be noted that 'due to the fact that the Belgian health system is mainly built on a model of consensus and

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<sup>6</sup> <http://www.fnams.be/LOGINONE/levelone/homeone/nchp.htm>

concerted action that involves all stakeholders, rigorous reform options are unlikely. Reform policy has consisted mainly of tariff cuts, supply restrictions and increased cost sharing. [...] Only in recent years have attempts been made to introduce more prospective financing, evidence-based medicine and benchmarking with financial consequences' (Corens 2007).

### **2.3 History of the Belgian mental health sector**

The history of the mental health sector goes back to the nineteenth century. Deviant behaviour, and among them alienation and dementia, were sanctioned. The asylum exemplifies the State's will to isolate mentally ill patients from the rest of the population (Bartholomé and Vrancken, 2005).

'In 1948, the asylum's responsibility is transferred from the Ministry of Justice to the Ministry of Health, created in 1936. This competence transfer, highly symbolic, is the accomplishment of fifty years of State socialisation and the consecration of dementia medicalisation' (De Munck, Genard, Kuty, et. al, 2003). The State positioned itself as a 're-distributor and organiser of services' (Genard and Donnay 2002). In the mental health field, this new vision of the State's mission is incarnated in a will to promote just access to psychiatric care. The hospital figure supplants the asylum figure. 'Whereas asylum policies lay within social control, Welfare State public action aims to medicalize mental illness' (Genard and Donnay 2002).

The 1960s initiated a change in perspective when disseminating an ideal of emancipation within the mental health sector. The first institutionalisation forms of this movement are found, in 1975, in the legislative creation of the ambulatory sector.

The current structure of the mental health care sector is the direct result of two important reforms that took place in 1990 and 1999. Indeed, the 1990s appear to be innovative years in the mental health sector. The Belgian State's budgetary crisis brought into question the Welfare State's expansionist logic. In 1986, the Minister of Social Affairs put in place measures intended to reduce the costs of hospital psychiatry. In 1990, an important reform of the psychiatry sector came true. Its main goal is the 'de-hospitalisation' of psychiatric patients. Alternative reception facilities for mental health care were created: psychiatric nursing homes, sheltered accommodations.

'The diversification of supply and the dissemination of institutions [coming from a new public action model] provoke cooperation necessities [...] and regulating processes to

assure this coordination' (Genard and Donnay, 2002). Coordination and discussion places appear, like the Dialogue Platforms<sup>7</sup>.

The 'Psychiatry' working group of the National Council of Hospital Facilities has played an important innovative role in mental health policies. In 1997,<sup>8</sup> it suggested the adoption of new key-concepts: network, care circuits and target-groups. The objective is to centre care on the patient and to assure care continuity.

'The policy reform of 1999 included the following objectives: increasing intensive and specialised care in psychiatric hospitals, setting up cooperation between the intramural and extramural sectors, and shifting hospital and rest home beds to psychiatric nursing homes and places of sheltered accommodation' (Corens, 2007).

In March 2001, the Minister of Social Affairs and the Minister of Public Health wrote a political note entitled: 'Psyche: my latest concern? Mental health care: participation and coordination paths.' This note promotes a global vision of mental health and underlines the diversity of factors at stake (environment, relationships, psychic condition, etc.). A new vision of mental health care developed and the patient constituted the starting point.

In this new conception of mental health care, the vertical and institutional structure must make way for an integrated horizontal structure. This new structure is centred on target-groups which 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. For each of these groups, an adapted therapeutic approach should be developed. The Dialogue Platforms are central actors in the mental health care re-organisation.

As far as possible, patients receive the necessary care in their day-to-day lifestyle. The coordination should lead to a maximal ambulatory treatment. The accent is no longer on

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<sup>7</sup> As a result of the "Health roundtables [Tables rondes de la santé]" (at the federal and community levels) organised in 1989, Minister Busquin created in 1990 a new type of body: the "Concertation platform for Mental health", whose first mission is to ensure care network coordination by associating hospital and ambulatory sectors.

<sup>8</sup> "The year 1997 saw, at the initiative of large Flemish hospital institutions and pressure groups very active at the political level, federal projects of re-organisation of the care plans in psychiatry aiming to develop "care circuits and networks"." (MATOT, 2001)



psychiatry itself but on an integrated conception of mental health care. In order to test innovative practices, pilot-projects<sup>9</sup> were launched on diverse subjects.

In Belgium, the mental health sector is complex and several power levels are involved. A coherent policy in this field should be the subject of a *cooperative agreement* between the Federal State, the Regions and the Communities. Several Inter-ministerial Conferences in Public Health led to a *joined declaration* on a future mental health policy<sup>10</sup> but no official cooperative agreement was signed.

A task force was created to optimise the mental health care supply. The task force brings together representatives of all competent authorities. The task force's role focuses on patient needs and on care continuity. The objective is to initiate an organisational model based on care circuits and networks.

Negotiations within the task force led to an *agreement protocol* proposition. Nevertheless, the Inter-ministerial Conference in Public Health did not arrive at a consensus on this protocol.

In 2005, the Minister of Public Health, in a political note on mental health<sup>11</sup>, insisted on the care circuits and networks development. 'This care supply should take into consideration patient's needs. [...] For each target-group, a specific care supply and circuit should be defined. At an organizational level, this supply should translate into a network made of all practitioners involved. Target-groups should be comprised of patients having a chronic and complex mental disorder'.

Two new concepts appear: the *therapeutic project* and the *transversal dialogue*. The *therapeutic project* is a coordination organised around a patient, financed by the National Sickness and Disability Insurance Institution. All practitioners involved meet and coordinate their actions around the patient's needs. This local coordination objective is to create a new organisational structure. To do so, coordination at a higher level is necessary, it is then organised around a target-group (or sub-group if requested): the *transversal dialogue*.

At the federal level, pilot-projects often precede changes in legislation and management of the mental health care system.

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<sup>9</sup> For example, "intensive clinical treatment supply for inpatients with a view to an optimal re-socialisation" in 2001, "Implementation of a care coordinator function within Concertation platforms for Mental health concerning the treatment of people with addiction problems" in 2002.

<sup>10</sup> Joined statement of Minister of Public Health and Minister of Social Affairs on the policy to come on mental health care of 24 June 2002.

<sup>11</sup> Political note on mental health of Minister of Social Affairs and Public Health Rudy Demotte, May 2005.

## 2.4 The health sector in the Walloon region<sup>12</sup>

When considering the Walloon region, health competences are shared among the three power levels concerned on this territory: the Federal State, the Walloon Region and the French Community. For each level, we will present the scope of competences and the main actors working on that level.

### 2.4.1 *The Federal State*

The Federal State is responsible for:

- organic legislation
- financing of the operational costs of health care institutions when covered by such organic legislation
- basic rules for the planning of health care institutions
- basic rules for the financing of infrastructure and advanced medical care equipment, national accreditation standards
- conditions governing teaching hospitals
- compulsory social health and disability insurance as an integrated part of the social security system.

The Minister in charge is the Minister of Public Health and Social Affairs,<sup>13</sup> and his cabinet includes scientist and practitioners.

The Federal Public Service (FPS) Public Health, Food Chain Safety and Environment is the administrative department of the Minister.

The National Institute for Sickness and Disability Insurance (RIZIV-INAMI) is a public body accountable to the Minister and is responsible for the general organisation and financial management of the compulsory health insurance.

As regards health policy, four scientific institutions and agencies<sup>14</sup> are linked to the FPS and to the Minister:

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<sup>12</sup> See annexe 3

<sup>13</sup> The last elections of members of the federal Parliament were held in June 2007. Since then, a new Government has not yet been formed.

<sup>14</sup> Information on the three first institutions/agencies is taken from Corens, 2007

- The *Scientific Institute of Public Health* (WIV-ISSP) is a public institute. Its main tasks are health promotion and disease prevention by providing the federal and regional governments with knowledge based on scientific evidence. It conducts a health interview survey involving 10,000 respondents in order to evaluate the health status, lifestyle and use of health care services in Belgium.
- The *National Council for Hospital Facilities* (CNEH) comprises stakeholders from the hospital sector. It plays an important role in the formation of Belgian health care policy by advising the Minister of Social Affairs and Public Health on issues related to hospital planning, accreditation and financing.
- 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.
- The *Federal Pharmaceuticals and Health Products Agency* (FAGG-AFMP) has been in operation since January 2007. Its missions are to guarantee quality, safety and efficiency of medicines and activities linked to blood and cells, to supervise research and development, to deliver marketing authorisations and to collect and evaluate information in order to avoid negative effects for users (vigilance).

#### 2.4.2 The Walloon Region

As mentioned above, since 1980, the Communities order by decree, each within its territory, all *person-related* matters. The French Community<sup>15</sup> transferred in 1993 all its health policy competences to the Walloon Region except for health education and preventive medicine.

The Walloon Region is in charge of:

- As regards inpatient care policy:

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<sup>15</sup> Decree of 19 July 1993 allocating the exercise of some competences of the French Community to the Walloon region and the French community commission. MB 10/09/1993

- defining priorities with respect to investments for construction and heavy medical equipment
  - granting admission and subsidies for the establishment, conversion and equipment of services, as well as for heavy medical equipment
  - inspection, accreditation and closure of medical facilities
  - internal organisation and reception, to the extent that this does not affect operating expenses.
- As regards outpatient care policy:
- home care, including services for integrated home care, as well as individual care
  - rest homes for the elderly providing care
  - services for mental health care, including after-care

The Minister in charge is the Minister of Health, Social Action and Equal Opportunity.<sup>16</sup> He has a ministerial cabinet. The administrative department concerned by these matters is the 'Social Action and Health' General Directorate which has three Directorates: 'Social Action and Immigration', 'Senior Citizens and Family' and 'Health and Infrastructures'.

As regards health policy, three institutions and agencies play an important role:

- The objective of the *Walloon Institute for Mental Health (IWSM)* is to gather together field actors working in the mental health sector with a view to supporting a permanent thinking on mental health issues, fostering questioning mental health practices, participating in mental health promotion and working on ethical issues in the mental health sector. The IWSM constitutes a permanent cooperation and consultation body and a interdisciplinary research organism on mental health issues in Wallonia.
- The *Regional Council of Mental Health Services (CRSSM)* is an advisory board. It formulates opinions or issues recommendations about any question regarding mental health services (accreditation, legal disposals, etc.).

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<sup>16</sup> In July 2007, there was a change of Ministers. The previous Minister, Christiane Vienne (who was described in the file for phase 2 of orientation 1), was elected member of Parliament and left her Ministry. She was replaced by Paul Magnette.

- The *Walloon Agency for the Integration of Handicapped People* (AWIPH) is a public organism. It facilitates access to training and employment and offers financial interventions to support autonomy in daily routine. It accredits and allows credits to services which accommodate, employ and advise handicapped people.

### 2.4.3 The French Community

The French Community is responsible for health education, health promotion and preventive medicine. 'This includes different kinds of information and awareness campaigns, the organisation of medical screening, and control activities, like monitoring medical school, medical sports inspections and occupational health control. In the field of preventive health care, the Federal State remains responsible for national prophylactic measures, such as mandatory vaccination against poliomyelitis' (Corens, 2007).

The Minister in charge is the Minister of Health, Childhood and Youth Support. He has a ministerial cabinet. The administrative department responsible for these matters is the General Administrative Department of Health which is made up of six directorates.

As regards health policy, there is an important advisory board. The *Superior Council of Health Promotion* provides advice to the Minister and her administrative department on health promotion and preventive health care.

Mental health in the French part of Belgium, as a health sub-sector, is mostly under the competence of two power levels. The Walloon Region is in charge of the ambulatory sector, and in particular the mental health service organisation and subsidisation. The Federal State keeps its prerogatives in terms of social security and hospital sector. The French Community has only few competences in the mental health sector. The current Minister has focused his action on preventive medicine rather than health education.

In order to set the stage within which our research takes place, two aspects are essential: the historical and the institutional. We retraced the history of the health sector in Belgium, and more precisely the history of the mental health sector, underlining the evolution towards a care circuit and network based system.

Afterwards, and given the complexity of the Belgian institutional context, we proceeded to a territory-defined approach. We centred on the Walloon region where three power levels are concerned by health matters. We identified the main actors, their scope of competences and the main knowledge producers.

This contextualised introduction emphasises the complexity of the Belgian institutional and political context. The next part dedicated to the three dimensions (Structure – Actors – Knowledge) will rely on this introduction to go into greater detail to describe the sector.

### 3. Three dimensions

This section provides a detailed description of the material collected. The objective is to set the social and cognitive mappings. In order to achieve this, we have structured the presentation according to the following guidelines:

- Structures: this point deals with models of relationships within and between the bodies
- Actors: this second point deals with actors playing a specific role (influential actors, circulators, brokers, etc.) in the knowledge process.
- Knowledge

#### 3.1 Structures

As mentioned above, the mental health landscape in the Walloon region territory is segmented and competences are shared between the Walloon Region and the Federal State. Each power level organises its health policies independent of the other. We will proceed successively to the presentation of the organisational structure of these two power levels. We will then try to underline coordination attempts and initiatives.

##### 3.1.1 *The Walloon Region*

The health policy of the Walloon Region principally relates to outpatient mental health. The 'Health program' of the 'Social action and Health' General Directorate represents €64,400,000<sup>17</sup>, of which half is allocated to the 'Inspection and Control' Directorate (€31,713,000). In this Directorate budget, the financing of the Mental Health Services, whether they are private or public, represents 70.4% of the budget.

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<sup>17</sup> "Social action and Health" General Directorate 2005 activity report

“Inspection and Control” Directorate budget

	€	% of the budget
Mental health services of the public sector	7,759,000	24.5%
Mental health services of the private sector	14,580,000	46.0%
<b>Total Mental health services</b>	<b>22,339,000</b>	<b>70.4%</b>
Tele-reception centres	843,000	2.7%
Home care and services coordination centres	3,252,000	10.3%
Integrated health associations	1,343,000	4.2%
Intervention in social illness matters	355,000	1.1%
Mental health and fight against addiction	2,051,000	6.5%
Palliative cares	447,000	1.4%
Studies on health and mental health matters	540,000	1.7%
Studies on environmental health matters	199,000	0.6%
Financing of a research centre	195,000	0.6%
<b>Total Research</b>	<b>934,000</b>	<b>2.9%</b>
Diffusion of information related to health	24,000	0.1%
Financing of the « environment-health » scientific platform	125,000	0.4%
<b>Total</b>	<b>31,713,000</b>	<b>100.0%</b>

The financing of the Mental Health Services represents 35% of the Walloon Region health program expenditures.

The legislation<sup>18</sup> on the accreditation and allocation of Mental Health Services was modified in 2004. The main amendment was related to on the one hand the determination of the epidemiological anonymous information and data that Mental health services must send to the administrative department and, on the other the hand, the obligation to draft an annual activity report that had to be sent to the administrative department.

Obtaining and keeping the Mental Health Services accreditation is linked to the conditions stated in the Decree. Through this mechanism, the administrative department exerts control over the Mental Health Services because they have to answer for allocated subsidies.

At the Walloon Region level, the three main actors in the health sector are linked to the mental health sub-sector:

- the Walloon Minister of Health, Social Action and Equal Opportunities and his cabinet
- the administrative department at the Walloon Region level: the 'Inspection and Control' Directorate within the 'Social Action and Health' General Directorate.
- The Walloon Institute for Mental Health (IWSM) is the body appointed to produce knowledge in the mental health field.

We will concentrate on these three actors in addition to which a fourth plays a specific role as regards the Mental Health Services: the Regional Council of Mental Health Services.<sup>19</sup> This council constitutes the Walloon region's main advisory board in the mental health services sector. Its missions include formulating opinions on the mental health services programming, on accreditation, on modification of financing propositions and on legislative amendments.

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<sup>18</sup> Decree of 22 January 2004 of the Walloon Government amending the Decree of 7 November 1996 of the Walloon Government on the accreditation and allocation of Mental Health Services. MB 07-04-2004

<sup>19</sup> The council is composed of 18 members: a president, 4 representatives of the Organising powers, 3 representatives of the dialogue platforms, 2 representatives from psychiatry in mental health services, 2 representatives of psychiatric hospital physicians, 2 members of the personnel in the sector, a general practitioner, a representative of local powers and 2 representatives of associative sector.



The Walloon Institute for Mental Health is the body appointed in the Walloon region to produce knowledge. The Institute's creation, in 2002, rests on three points:

- guarantying an openness to all the actors active in the mental health field
- playing a role of interface for true dialogue in Wallonia
- carrying out expertise and research missions within the framework of a permanent observatory

The Institute is a not-for-profit organisation. Its governing board's composition<sup>20</sup> reflects this desire to be open to all the actors who are active in the mental health field in the Walloon region. Within the board, there are representatives of associations/federations of private and public organisations/institutions that are financed by the various power levels (Dialogue Platforms for the Federal, SOS teams for the French Community). 'For two years, the Minister's cabinet, the Institute and the administration have been working on a re-orientation of the Institute's missions. The objective is for regional financing to be used to support regional services in methodological and legislative matters.'<sup>21</sup>

Previously, research themes were chosen within the governing board according to the sector's priorities. Studies were carried out on themes like evaluation, accessibility, network practices and patient's rights. From then on, the Institute's missions were re-defined and its autonomy seemed to decline. 'We will be forced to work more as a partner of the politics and the administrative department. Presumably, there will be a greater listening to what we will produce but we will have a smaller breathing space.'<sup>22</sup>

This re-defining of the Institute's missions takes place at the same time as the change of Minister's political colour. The Institute was created under the leadership of an Ecolo Minister who fosters field actor autonomy. The re-defining occurred while a Socialist was Minister.

At the Walloon Region level, a model built on the hierarchical type of relationships seems to preside over the exchanges. As regards external relationships, few new actors have appeared these last few years in the mental health landscape. In the Institute's case, the will for openness and wide consultation showed at the time of its creation has been the

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<sup>20</sup> See the file dedicated to the Walloon Institute for Mental Health.

<sup>21</sup> 'A look at Mental Health Services' (Regards sur les Services de Santé mentale), Press release of 1 June 2007 of the Minister of Health, Social action and Equality of chances of the Walloon region.

<sup>22</sup> Quoted from an interview with a member of the Walloon Institute for Mental Health

object of a negotiation with the politics and the administration which led to redefining the Institute's missions.

Attempts at openness to field actors occur when faced with a certain strictness in the distribution of competences among the various public power levels.

The Walloon Minister of Health, Social Action and Equal Opportunities organised, from 1 May to 30 June 2006, an original consultation initiative<sup>23</sup> by means of an electronic forum. Mental Health Services users, workers, managers and collaborators were invited to participate in two *e-conferences* on the following themes: 'Working in Mental Health Services' and 'The Mental Health Service in its (Geographic and Institutional) Environment'.

Forty-seven hundred people visited the website and 315 people intervened on-line on diverse subjects: originality of their job in Mental Health Services, difficulties met during their treatment, etc. They also had the opportunity to communicate concrete propositions to improve the supply of care in the Walloon Region.

The whole sector was invited to a symposium in September, the *Assises* of Mental Health Services, focusing on three main topics raised during the virtual conference:

- Meeting all demands
- Working in networks
- Doing, thinking and functioning as a team

The objective of this meeting was to draw up proposals intended to optimise the supply of mental health care services.

In the aftermath of the *e-conferences* and the *Assises*, the Institute devoted the fourth issue of its 'Cahiers' to this matter under the title 'A look at Mental Health Services in Wallonia. Synthesis and perspectives of the *e.conferences* and the *Assises* of mental health services'. The Institute's quarterly review 'Confluences' is also devoted to this theme: 'Zoom in on Mental Health Services.'

The *Assises* organised in 2006 would influence the reshaping of the Decree of 1996. In June 2007, the Minister presented to the sector the forthcoming reform which aims to sustain and reinforce the Mental Health Services' anchoring and visibility within the care network and to increase the personnel.

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<sup>23</sup> In partnership with the 'Social action and Health' General Directorate, The Walloon Institute for Mental Health (IWSM), the Regional Council of Mental Health Services and the not-for-profit association 'Texto'.

Six main lines characterise the reform:<sup>24</sup>

1. Care accessibility for all Walloons
2. Focus on children
3. Automatic indexation of functioning costs
4. Clarification of the functions and creation of a link-function exerted by a member of the interdisciplinary team who will promote internal and external dialogues
5. Compulsory training for the personnel
6. Obligation to hand out a 'therapeutic project'<sup>25</sup> with the accreditation form.

Besides the Mental Health Services, the Walloon Region has two psychiatric hospitals<sup>26</sup> (the 'Marronniers' and the 'Chêne aux Haies'). A management contract is signed by the Walloon Government and the hospital governing board. An annual report evaluates the execution of the contract.

At the Walloon Region level, the emphasis is on procedures rather than on results. The hierarchical functioning seems to be one of the most distinguishing features of the Walloon Region organisation.

Recently, innovative initiatives have been taken:

- Organisation of the *e-conferences* and the *Assises* to be acquainted with the sector's priorities.
- The 2004 Decree which aims to increase the accountability of Mental Health Services by means of an activity report and a collection of epidemiological data.
- The project to reshape the 1996 Decree which introduces the presentation of a therapeutic project when requesting accreditation.

According to the Minister's Cabinet press release of the 1 June 2007, 'the mental health landscape in the Walloon Region is in an evolutionary phase and all the forthcoming

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<sup>24</sup> 'A look at Mental health services' (Regards sur les Services de Santé mentale), Press release of 1 June 2007 of the Minister of Health, Social Action and Equal opportunities of the Walloon region

<sup>25</sup> The therapeutic project does not have the same meaning as the therapeutic project at the federal level. It is for each Mental Health Service to describe its objectives, course of action and therapeutic approach.

<sup>26</sup> Decree of 6 April 1995 on the management of Walloon region psychiatric hospitals. MB 05-07-1995

changes confirm it. Other orientations come about, notably in terms of “care circuits and networks” and “care basins”.

### 3.1.2 *The Federal level*

Our fieldwork focused on the mental health sector, we will then try to illustrate the health sector functioning through this sub-sector as we did for the Walloon Region.

As a result of the research work carried out, we noticed that the administration plays a central role at the federal level, since many of the actors we met underlined: ‘politicians pass through, the administration stays.’

The mission of the Service of Psychosocial Health Care is:

- To develop an evidence-based policy, by means of pilot-projects and collaboration contracts
- To prepare the future policy by means of pilot-projects and drafting of legislation
- To set in motion support committees for research projects on mental health
- To develop recording and especially the ‘Minimal psychiatric data’ which is a file related to a given patient and completed by all care institutions concerned. It contains (i) international DSM IV data, (ii) local medical file information, (iii) information related to care and treatment. There is an electronic exportation to the administrative department via internet. The ‘Minimal psychiatric data’ must be recorded by psychiatric hospitals, psychiatric services of general hospitals, psychiatric nursing homes and sheltered accommodations.

The work of the Service of Psychosocial Health Care is mostly guided by an evidence-based policy development. Evidence-based policy is a ‘rigorous approach that gathers, critically appraises and uses high quality research evidence to inform policy making and profession practice’ which can be contrasted with ‘opinion-based policy, which relies heavily on either the selective use of evidence (e.g. on single studies irrespective of quality) or on the untested views of individuals or groups, often inspired by ideological standpoints, prejudices, or speculative conjecture’ (Davies, 2004). This type of policy is based on field experiences to determine good practices. Within this framework, pilot-projects constitute an evidence-based knowledge production storeroom. This kind of knowledge seems to be largely mobilised and favoured within the Service.

The politicians want to test, via diverse pilot-projects, the feasibility of a care model, based on patient needs and on continuity of care, before any generalisation of it. It is a model based on care circuits and networks. Each pilot-project is put in the framework of

an agreement between the administrative department and the operator who coordinate the pilot-project.

The pilot-projects are divided into target-groups in the entire Belgian territory. The 'Children and teenagers' target-group has four pilot-projects ('clinical intensive care for youth offenders with psychiatric disorders', etc.). The 'Adults' target-group has eight pilot-projects ('clinical intensive care for inpatients in order to re-socialize them', 'Psychiatric care for nursing home patients', 'Help-desk for first line practitioners in mental health', etc.). Each pilot-project covers a territory the size of which is defined by the project itself.

After the 2005 political note on mental health, the biggest theme which the Service of Psychosocial health care works on is also linked to care circuits and networks. The latest wide-ranging pilot-project relates to *therapeutic projects* and *transversal dialogue*. The *therapeutic project* is a coordination organised around a patient, financed by the National Sickness and Disability Insurance Institution. All practitioners concerned meet and coordinate their actions around the patient's needs. Eighty-two special pilot-projects have been selected to put in place this coordination. This local coordination objective is to create a new organizational structure. To do so, coordination at an upper level is necessary, it is then organised around a target-group (or sub-group if requested): the *transversal dialogue*.

At the Federal level, pilot-projects are an opportunity to test existing coordination practices before expanding it to legislation and management of the mental health care system.

A Support Committee was put in place. 'It gathers together data and propositions emanating from the *transversal dialogue*. The objective is to achieve, by this means, a structural proposition for a model based on care circuits and networks [...].'<sup>27</sup>

Two workgroups follow this wide-ranging project. The first one is the Insurance Committee's workshop. Its mission is to draw up organisational methods to introduce *therapeutic projects* and to define selection procedures and jury composition and to proceed to the project selection. The second is the 'Mixed-group' which is supervised by the Federal Public Service and aims to organise the *transversal dialogue*. These various initiatives reveal the politicians' concern for anchoring political decisions on field practices.

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<sup>27</sup> <http://www.therapeutischeprojecten.be>

The Federal Public Service works closely with various public agencies from two categories: advisory boards and scientific organs.

#### *Advisory boards*

The Federal Public Service is linked to some advisory boards which either offer opinions on future health care policy or control policy execution. Public power representatives and interest group representatives sit on these boards.

The *Hospital National Centre*, created within the Federal Public Service, is a federal advisory group on hospital policy (programming, financing and accreditation). It has two sections 'Programming and Accreditation' and 'Financing' and three workgroups 'Psychiatry', 'Rest and care homes' and 'University hospitals'.

The *Multipartite structure* is linked to the hospital policy. It was created by the Law of 22 August 2002.

The duty of the *Joint Commission practitioners-hospitals* is to identify problems in the practitioner-hospital relationships and to propose solutions to foster a fruitful collaboration.

Seven *Commissions* advise the Minister on specific issues: Telematics, Antibiotics, Patients' rights, Euthanasia, Abortion, *Commission de planification-offre médicale* and in-vitro embryo.

In the Belgian health care context, four *Federal platforms* are active in the following domains: coma, mental health care, palliative care and hospital hygiene. They include experts whose mandate is to evaluate the health care situation and to make improvement proposals. The Federal Platform on Mental Health Care is composed of county Dialogue Platform representatives, Minister and Federal Public Service representatives.

The mission of the *Committees* is to advise on specific topics and to inform the public. There are three committees: bioethics, medical pharmaceutical and breast-feeding.

Since 1999, *Doctors' colleges* have been created in various domains of hospital activity. Their objective is to promote quality in their respective speciality. The nomination of college members is generally guided by advice from scientific societies.

The large number of advisory boards reflects the very type of Belgian political system which is centred on consensus and on a substantial participation of the various civil society forces.

### *Scientific organs*

The Federal Public Service has also privileged relationships linked to knowledge with various organs.

The *Belgian Health Care Knowledge Centre*<sup>28</sup> is a federal agency created in 2002. Its objective is to collect and provide objective and scientific facts to support qualitatively the best health care achievement. It should also enable a transparent and effective assignment of Health Care Insurance means. The mandate given to the Belgian Health Care Knowledge Centre must lead to creating and maintaining a multidisciplinary team of high level experts, relying on an external network (within and outside Belgium). In the mental health sector, the Centre currently participates in research on 'Health services and therapeutic approaches for chronic and complex mental disorders'. The objective is to define the scientific guidelines for *therapeutic projects* (organisation, recording, etc.).

The *Scientific Institute of Public Health*<sup>29</sup> is a scientific institute of the Federal Belgian State. Its main mission is to conduct scientific research to support health policy. It also provides expertise in the field of public health. It carries out the Belgian Health survey by interviews. This large-scale survey is the main source of epidemiological data in the general population. A part of this survey is dedicated to mental health.

The *Superior Health Council* is the link between government policy and the scientific world in the field of public health. The council provides independent advice and recommendations to the Minister, at his specific request for information or on its own initiative. It is competent for all matters related to public health.

These scientific organs furnish statistical information on the health (or health problems) of the Belgian population and establish research reports on particular topics. The openness of authorities to numerous organs attests to a will to anchor political decisions on a scientific and political consensus.

In Belgium, we are witnessing a movement to empower users and families. In 2002, the Law on patient's rights<sup>30</sup> was passed. Fundamental patient's rights are listed that must be respected by all practitioners:

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<sup>28</sup> [www.kce.fgov.be](http://www.kce.fgov.be)

<sup>29</sup> [www.iph.fgov.be](http://www.iph.fgov.be)

<sup>30</sup> Law of 22 August 2002 relative to patient's rights. MB 26-09-2002

- The right to quality health care
- The right to free choice of practitioners
- The right to information
- The right to freely consent to any intervention
- The right to up-to-date medical records
- The right to protection of privacy
- The right to register a complaint to a mediation function. A Federal commission 'patient's rights' was created.

In the mental health field, a Royal Decree<sup>31</sup> imposes a mediation function which is carried out within the Dialogue Platforms.

### *3.1.3 Cross-level practices*

When an issue is at the cross-section of fields of competence of different levels of public power, dialogue bodies are put in place.

Within the framework of the Institutional Reform Act of 8 August 1980, a chapter is dedicated to dialogue and cooperation between the Federal State, the Regions and the Communities. Indeed, it mattered that agreements could be concluded, notably when they were related to the creation and management of joint services or institutions or the development of joint initiatives.

In order to promote dialogue and cooperation, specialised committees called 'Inter-ministerial Conferences' were established. They are composed of members of the Federal Government and of Region and/or Community Governments involved in the issue. A Public Health Inter-ministerial Conference brought together representatives of all Ministers<sup>32</sup> having health matters in their scope of competences.

The Mental Health task force is the workshop 'mental health' of the Public Health Inter-ministerial Conference. Its mission is to design a new mental health care concept which takes into consideration federal, region and community specificities. All competent authorities have seats on the task force.

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<sup>31</sup> Royal decree of 8 July 2003 amending the Royal decree of 10 July 1990 determining the accreditation norms for psychiatric institutions and services associations. MB 27-08-2003.

<sup>32</sup> In Belgium, there are 7 Ministers of Health. See annexe 2.



As regards setting up the pilot-projects *therapeutic projects* and *transversal dialogue*, a Support Committee has been created. It is composed of representatives of the seven Ministers concerned,<sup>33</sup> representatives of the Federal Public Service, and of various federal advisory boards<sup>34</sup> and patient and family organisations.

## 3.2 Actors

### 3.2.1 The Walloon Region

At the Walloon Region level, the administration controls the whole knowledge circulation process. On the one hand, its predominance is linked to the changes of Minister's political colour. From 1995 to 1999, the Walloon Health Minister's portfolio was held by a Socialist. In 1999, it passed into the hands of an Ecolo minister. In 2004, it returned to the Socialist party. With each change, the Minister who took office had first to take cognizance of the various matters. To do so, he relied on the administration and its deep experience of the field.

On the other hand, a hierarchical functioning dominates the whole relationship at the Walloon Region level. Thus, at the time of its creation, the Walloon Institute for Mental Health showed a will for openness towards all actors active in the mental health field in order to develop an integrated approach of mental health care. A few years later, the administrative and political authorities' reluctance to this openness led to a redefinition of the Institute's missions which will focus on Mental Health Services. 'The Minister's Cabinet, the Institute and the administration work on a re-orientation of the Institute's missions for two years. The objective is that regional financing is used to support regional services on methodological and legislative matters.'<sup>35</sup>

Moreover, the administration puts in place evaluation and control procedures. The various services financed by the Walloon Region must comply to these procedures by filling in forms and files sent by the administration.

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<sup>33</sup> Representatives of the Federal state, Flemish region, Walloon region, Brussels-Capital region, German community, French Communitarian Commission and Joint Communitarian Commission.

<sup>34</sup> Joint Commission practitioners-hospitals, Federal platform on mental health care, Hospital National Centre.

<sup>35</sup> 'A look at Mental health services' (Regards sur les Services de Santé mentale), Press release of 1 June 2007 of the Minister of Health, Social action and Equality of chances of the Walloon region.

The administration can be considered an 'influential actor', all the actors, whether they are political or field practitioners, systematically refer to the administration positively or negatively.

The administration also exerts a role of 'circulator' since it controls all the knowledge circulation and diffusion channels. Indeed, there is no real alternative to the administration's monopoly. Critics emerge but the actors' financial reliance on the Walloon Region allow little breathing space.

### 3.2.2 The Federal level

#### ***Influential actors***

At the federal level and when focusing on the mental health sector, two actors seem to benefit of an indisputable particular position: the Belgian Health Care Knowledge Centre and the World Health Organisation.

Within the framework of the last wide-ranging pilot-project at the federal level *therapeutic projects* and *transversal dialogue*, the Belgian Health Care Knowledge Centre is a central actor. It plays the role of expert and adviser to the authorities. It was mandated to complete research on various aspects related to the pilot-project and notably on dialogue added value evaluation modalities. It is supported by the Federal Public Service with which it forms a coalition which aims to impose a 'scientific vision' of the project. Nevertheless, the Centre asserts a total independence to its backers. The Centre is also omnipresent in the field actors' discourse but much more critically. The main criticism, which is relayed by the Dialogue Platforms on Mental Health Care, is related to the evaluation scales choice made by the Centre. Field actors contest this choice at different levels:

- From a practical point of view, the investment in terms of time and personnel to fill in the questionnaire is too great.
- Scientifically, the scales, which mostly come from the Anglo-Saxon world, have simply been translated. No validation procedure has been organised.
- At the therapeutic relationship level, introduction of evaluation practices might skew the patient/therapist relationship.

Another reproach is related to the relevance of the scale choice. The selected scales evaluate the patient whereas the starting objective was to evaluate the added value of the dialogue.

The World Health Organisation is omnipresent in written documents. Thus, the 2001 general political note started with 'Health is a total state of physical, mental and social well-being, and not merely the absence of disease. This is the definition of health of the World Health Organisation.' In the 2005 political note on mental health, the introduction starts with: ' "Without mental health and a sense of well-being, there is no real health" recently ended up the World Health Organisation after noticing that depression occupies the third place among illness and affection causes in Europe.' At the Federal Public Service level, the World Health Organisation is also presented as source of legitimisation of the evidence-based policy.

### **Circulators**

Circulators control important channels of knowledge diffusion within the sector. The Federal Public Service, and more particularly its Service of Psychosocial Health Care, constitutes a knot in the information circulation process. A website<sup>36</sup> presents information on health policy and care practitioners and offers various links to specialised websites.

When concentrating on the pilot-project *therapeutic projects* and *transversal dialogue*, there are two main sources of information. The National Institute for Sickness and Disability Insurance (RIZIV-INAMI) which is in charge of the *therapeutic projects* aspect has a website<sup>37</sup> on which all the general and technical information related to this topic can be found: 2005 political note, procedures for introducing a project, list of documents needed to sign a convention, link to the Support Committee website, etc. The Service of Psychosocial Health Care website gives a great deal of information on the *transversal dialogue* layer.

### **Brokers**

Brokers play a role in import-export and translation. Two actors seem to respond to these characteristics: the Service of Psychosocial Health Care and the Dialogue Platforms on Mental Health Care.

The Service of Psychosocial Health Care appears to be at the crossroads of different 'worlds'. Thus, it works with international bodies like the European Commission and the World Health Organisation. To proceed to international knowledge integration, workshops were set up. A group works on the Helsinki Declaration, developed by the World Medical Association. Another one was created following the first WHO European Ministerial Conference on Mental Health organised by the WHO Regional Office for Europe where the

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<sup>36</sup> <https://portal.health.fgov.be>

<sup>37</sup> [www.inami.fgov.be](http://www.inami.fgov.be)

Mental Health Declaration for Europe and its action plan were signed. Its mission is to draft an annual evaluation (swot analysis) of the implementation of the Declaration in Belgium.

On the whole Belgian territory, 13 Dialogue Platforms for Mental Health are active: 5 in the Flemish region, one in the Brussels-Capital region and 7 in the Walloon region. They play a relay role between field actors and political and administrative authorities. They transport practitioners' preoccupations and concerns to decision-making spheres and they relay information coming from administrative and political authorities to its members.

### **3.3 Knowledge**

#### *3.3.1 The Walloon Region*

At the Walloon Region level, knowledge mobilisation takes two directions. On the one hand, knowledge is produced, collected and mobilised with the purpose of evaluating the sector. On the other hand, administrative and political authorities want to know what the sector's priorities and expectations are. Actually, through these two main lines, the Walloon Region wishes to have a reliable picture of the mental health sector in order to rationalise financing, while taking account of the sector's demands, as far as possible.

#### ***Evaluation***

The question of evaluation appears to be thorny and to generate tensions between different stakeholders. The last issue of the Walloon Institute for Mental Health's review 'Confluences' devotes a folder to this theme: 'Evaluation for evolution'. The first article begins by stating: 'Evaluation is a subject that leaves no one indifferent in the mental health sector. In many cases, it provokes suspicion. [...] Yes, the practitioners of the mental health sector think it is legitimate to evaluate their practices but, yes, they fear evaluation' (Olivier, 2007).

The administrative department underlines the necessity of control and the resistance from the field actors (mostly the Mental Health Services): 'In this sector, they do not like evaluation. They say that they cannot be criticised by the patients or by any external actors.'<sup>38</sup> To evaluate the sector, the Walloon Region put in place three types of practices.

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<sup>38</sup> Quoted from an interview carried out with a member of the General Directorate of "Social Action and Health".

Firstly, there is an epidemiological survey carried out by the Catholic University of Louvain. The Mental Health Services must fill in a blue file for every new registration. This file contains administrative information, diagnosis data (based on the ICD 10) and care information. The recording and analysis of these data are underway and no research report has been published yet. 'The epidemiological data analysis which was missing in the sector until 2006 will be assured by the University's work and facilitated by the introduction of simplified coding file in 2008.'<sup>39</sup>

Secondly, since 2004 Mental Health Services must hand out an annual activity report which will be analysed. This report contains notably yellow files which relate to information regarding consultation (origin, nature, etc.) and to completed activities. These data should be analysed systematically. Nevertheless, the administration which is in charge to carry out this analysis cannot complete this mission because it does not have sufficient human resources. Activity reports are considered by the administration as a control tool even if the aggregation is not yet done. The registration constraints have been increased and imposed from then on a unique registration file.

Thirdly, a qualitative evaluation of each Mental Health Service is achieved. The inspector in charge of this qualitative inspection goes, theoretically, to each service at least once in a convention period (6 years, generally). She attends a team meeting and carries out a subjective evaluation to make a report that will be transmitted to the *Regional Council of Mental Health Services*.

The evaluation seems to be a priority for the authorities, which present it as a tool to control the use of public financing. Values of accountability, efficacy and transparency are attached to the evaluation process. Evaluation can therefore be conceived as a legitimate means to control subsidy allocation and as a means to control practices profitably.

Practitioners underline the difficulty to evaluate situations linked to human subjectivity. They criticise particularly the tools used to complete the evaluation. 'These tools are inappropriate for the mental health field.' (Olivier, 2007) The evaluation modalities used by public powers are based on objective data, such as diagnosis based on DSM IV and ICD 10. This type of evaluation does not point to the specificities of each situation. Nevertheless, practitioners do not criticise the necessity of evaluation.

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<sup>39</sup> 'A look at Mental Health Services' (Regards sur les Services de Santé mentale), Press release of 1 June 2007 of the Minister of Health, Social action and Equality of chances of the Walloon region.

### **Sector's priorities**

As regards the sector's priorities, the Walloon Minister of Health organised in May and June 2006 an original consultation initiative<sup>40</sup> by means of an electronic forum. Mental Health Services users, workers, managers and collaborators were invited to participate in two *e-conferences*. The website was visited by 4,700 people and 315 people intervened on-line on diverse subjects: originality of their job in mental health services, difficulties met during their treatment, etc. They also had the opportunity to communicate concrete proposals for improving supply of care in the Walloon Region. The whole sector was invited to a symposium in September, the *Assises* of Mental Health Services, focusing on three main topics raised during the virtual conference (receiving all demands, working in network and doing, thinking and functioning as a team). In the aftermath of the *e-conferences* and the *Assises*, the Walloon Institute for Mental Health devoted the fourth issue of its 'Cahiers' to this matter, under the title 'A look at the mental health services in Wallonia. Synthesis and perspectives of the *e.conferences* and the *Assises* of Mental Health Services'. The Institute's quarterly review 'Confluences' is also devoted to this theme: 'Zoom in on mental health services'. The *e-conferences* and the *Assises* would influence the reshaping of the Decree of 1996.

This type of field actors' consultation can be assimilated into a 'vertical translation of street-level knowledge'. Indeed, through these initiatives, stakeholders have the opportunity to tell the authorities about problems they encounter and about existing gaps, and to formulate proposals. From these suggestions and given the budgetary limits, authorities attempt to answer the difficulties encountered by the sector, notably by reshaping the Decree of 1996.

### **Research**

In 2005, the budget allocated, within the 'Inspection and Control' Directorate, to research was €934,000 (2.95 % of the Directorate's budget) of which €540,000 will be used for studies on health and mental health (1.7% of the Directorate's budget). Moreover, the budget allocated to the Walloon Institute for Mental Health was €215,000; this amount of money is not exclusively devoted to the research mission. Research work is performed by external actors through specific studies. There are three possibilities:

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<sup>40</sup> In partnership with the General Directorate of "Social action and Health", The Walloon Institute for Mental Health (IWSM), the Regional Council of Mental Health Services and the not-for-profit association 'Texto'.

- some studies are planned in the legislation
- a research centre or any other body makes an offer
- the politicians have a particular concern and wish to obtain data

The Walloon Institute for Mental Health is the only pro-active actor in the research field. Among its three missions, training, information and research, research is fundamental. 'For two years, we have been more focused on research'<sup>41</sup>. The Institute's researchers all come from social and human sciences disciplines, mostly sociology and psychology. Specifically, the Institute appoints physicians for help in specific medical knowledge.

The Walloon Region wants the Institute to be 'a support tool, a study provider but not unique because diversity is beneficial. [...] We want concrete results to give direction to field practices.'<sup>42</sup> Nevertheless, this diversity does not seem to be reflected in practices and research does not appear to be a priority for the Walloon Region.

### 3.3.2 The Federal level

At the federal level, various types of knowledge circulate through specific methods: expert knowledge, field-grounded knowledge, user knowledge and academic research. Some types of knowledge are contradictory and antagonistic.

#### **Expert knowledge**

Within the framework of the *therapeutic projects* and the *transversal dialogue*, the Belgian Health Care Knowledge Centre is mandated to carry out research on various aspects of this issue:

- What is the definition of complex chronic psychiatric patients?
- What are available relevant data on care and rehabilitation of identified target-groups, on services efficacy and on profitability?
- What are examples of good practices in terms of integrated rehabilitation care in other countries? What are the financing models for care in other countries?
- What should be the evaluation methods for the *therapeutic projects*? What tools should be used (degree of resocialisation, quality of life scales, symptom check list)?

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<sup>41</sup> Quoted from an interview of a member of the Walloon Institute for Mental Health

<sup>42</sup> Quoted from an interview of a member of the General Directorate of "Social action and Health"

The last point related to evaluation methods is linked to the authorities' desire to maintain control over practices. Values of accountability, efficacy and transparency are attached to this process.

### ***Field-grounded knowledge***

Tensions generated by the research led by the Knowledge Centre revealed field-grounded knowledge. This type of knowledge is being built from practices. During dialogue meetings organised by the Dialogue Platforms for Mental Health, actors working directly with patients meet, exchange and share know-how knowledge. The aim of these meetings is to know the supply of care, the means that are available, the ways to use these means and the gaps. The Dialogue Platforms gather this knowledge and transmit it to competent authorities (Federal state, Regions or Communities).

### ***User knowledge***

Within the framework of the *therapeutic projects* and the *transversal dialogue*, research on user empowerment has been launched. It aims to support user involvement at all levels: patient/carer relationship, care structures, politicians. [...] The project must allow patients' associations to reinforce themselves, to acquire new skills. In the end, it will be a question to build, working with scientists, models of user participation with a view to advising politicians.<sup>43</sup> This research will be performed collectively by five partners: the Interregional Association for Guidance and Health, three user and family associations and a research centre (Lucas).

Values of activation and autonomisation seem to appear behind this research project and a more general desire to integrate policies target in their conception process.

### ***Academic research***

Universities and research centres are solicited specifically for thematic research. They are selected on the basis of an invitation to tender. The problem is described as follows: 'Reports written by universities give very general conclusions and there is no translation of these conclusions into concrete recommendations for politicians. Researchers are too cautious and it is a shame.'<sup>44</sup>

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<sup>43</sup> Quoted from the participative research project "Therapeutic projects and transversal dialogue". Partners of the project: the Interregional association for guidance and health, three user and family associations and a research centre (Lucas).

<sup>44</sup> Quoted from an interview of a member of the Service of Psychosocial Health Care.



The aim in this descriptive part was to structure the material we collected during our fieldwork in order to set the social and cognitive mappings of the Belgian health field. We built our presentation around three dimensions – Structures, Actors, Knowledge.

The next part of the report is an attempt to make sense of all observations detailed in this section. We will try to give it an interpretative analysis through a perspective of a possible shift in the public action management.

## **4. Analysis**

The 1980s marked a turning point for the entire public service sector. The State and the various political bodies that make it up decided to centre part of their action on a reform of the public institutions and a rationalisation of the use of public monies from taxes collected from citizens. In this way, it is first and foremost the organisational structures themselves of the public action that will be changed. Thus, the new mechanisms to deal with the issues from the public arena will appear, starting from undiluted privatisation of certain services to reengineering work procedures within the public services passing through competition between public services and private sector companies.

About ten years on, a new configuration for dealing with the public problems appeared. Vrancken (2002) demonstrates for example that the Social State as we knew it until then would enter an 'activation' phase and take a 'contract' approach. Its activity of allocating resources to the weakest or most marginalised social categories would change direction noticeably. This rationalisation of public expenses entails a phenomenon of 'conditionality of aide' granted. In return for the allocation of a social advantage, the aided citizen should demonstrate an individual investment.

This rationalisation movement will involve all European public sectors and is the sign of a change in systems of reference for the State (Muller, 2000). At the beginning of the 1990s, we would witness the advent of the New Public Management based on two basic premises: public services should 'open up' (Pollitt, 1990; Nutt and Backoff, 1992) and listen to their users (perceived as their 'clients') on the one hand, and, on the other, should also combine their resources with a view to optimisation: source of the criteria of efficiency that signifies that the amount of means invested to fulfil the core missions, that is, the lowest possible (Loveridge, 1980). In the stride of these two founding elements, the issue of control of the performance of the public services and of transparency of their action also become central. From now on, we manage the government with the control of management, indicators and contracts which are signed with the users, the professionals and the administration.

In total, the State paradigm is noticeably changed since carrying out the public action, in its totality, is to date directed at new objectives, and a very powerful normative discourse in the matter is developing (Rondeaux and Schoenaers, 2001). All this appears to lead to a central hypothesis placing the emergence of a new method to manage the government that would co-exist with the more traditional method marked by Weberian bureaucracy. In this sense, a series of variables for running the State, at both macro and micro levels, are likely to be marked by substantial changes. As we will see, the health sector in general and the mental health sector in particular do not escape this general trend.

During the 1980s and 1990s, the Belgian State's budgetary crisis brought into question the Welfare State's expansionist reasoning. The demographic evolution and the health cost increase required changes in management in the health care system. In 1994, the Minister of Social Affairs asked the National Council for Hospital Facilities for an opinion on cutting back on and reconverting hospital beds. It suggested to 'highlight qualitative objectives in terms of services rather than traditional quantitative characteristics such as number of beds, occupancy rate and length of stay.'<sup>45</sup> In 1998, the Minister of Public health stressed that 'a public health policy must be centred on the patient [...]'.<sup>45</sup>

In an opinion of the 10 July 2002, the 'programming and accreditation' section of the National Council for Hospital Facilities stated that needs in health care can no longer be formulated as needs in isolated structural factors (buildings, equipment and activities). It suggested that programming, accreditation and financing mechanisms follow the evolution of patients' needs and technology progress.

The consensual feature of the Belgian political system is not favourable to radical changes in public affairs lead. 'Although the Belgian health system has not undergone any major structural reforms over the past couple of decades, various measures have been taken mainly to improve the performance of the health system [prospective financing, evidence-based medicine and benchmarking with financial consequences]' (Corens 2007). Nevertheless, a general trend aiming to rationalise health care costs fostered initiatives that were headed in this direction.

The mental health sector followed this global reasoning. The current structure of the mental health care sector is the direct result of two important reforms that took place in 1990 and 1999. In 1990, an important reform of the psychiatric sector came into being. Its primary goal was the 'dehospitalisation' of psychiatric patients. Alternative reception facilities for mental health care were created: psychiatric nursing homes and sheltered accommodations.

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<sup>45</sup> <http://www.fnams.be/LOGINONE/levelone/homeone/nchp.htm>

The 'Psychiatry' workgroup of the National Council of Hospital Facilities played an important innovative role in mental health policies. In 1997,<sup>46</sup> it suggested the adoption of new key-concepts: network, care circuits and target-groups. The idea of care circuits and networks functioning is largely shared in the mental health field and more particularly in the ambulatory sector where many local initiatives for collaboration and coordination were implemented. The need to reduce mental health care expenditures would lead to a reform of the concept of admission of patients. The objective became focusing care on patient, assuring care continuity and avoiding redundancy.

'The policy reform of 1999 included the following objectives: increasing intensive and specialized care in psychiatric hospitals, setting up cooperation between the intramural and extramural sectors, and shifting hospital and rest home beds to psychiatric nursing homes and places of sheltered accommodation' (Corens, 2007).

In March 2001, the Minister of Social Affairs and the Minister of Public Health wrote a political note which promoted a global vision of mental health and underlined the diversity of factors at stake. A new vision of mental health care developed and the patient constituted the starting point.

Since then, every measure taken by the public powers in mental health care matters has taken the same direction.

As mentioned above, the mental health landscape on the Walloon region is segmented and competences are shared between the Walloon Region and the Federal State. Each power level organises its health policies independent of the other.

The recent mutations in the public action field forebode the apparition and development of a new model of public action. To attest to this change, we will analyse public action evolution in the mental health field mobilising Lester M. Salamon's analysis grid (Salamon, 2002).

Starting with the American model, Salamon compares two models of public administration: the 'old' one – the Classic Public Administration - and the 'new' one – the New Governance. Given the shifts that occurred in the public approach to problem solving over the two last decades, Salamon suggests a new approach to public problem solving: the New Governance (Salamon, 2002). This notion of governance insists on the collaborative nature of the new way to understand public action. Nevertheless, 'the "New Governance" is not entirely novel. Rather it builds on a rich history of past thinking,

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<sup>46</sup> 'The year 1997 saw, at the initiative of large Flemish hospital institutions and pressure groups very active at the political level, federal projects of re-organisation of the care plans in psychiatry aiming to develop "care circuits and networks".' (MATOT J.-P., 2001)

changing emphases, and incorporating new elements, but without replacing all that has gone before.'

Salamon identifies five key concepts from which the transition from the old model to the new one can be characterised.

<b>Classic Public Administration</b>	<b>New Governance</b>
Agency and Programme	Tool
hierarchy	Network
Public vs. Private	Public + Private
Command and Control	Negotiation and Persuasion
Management Skills	Enablement Skills

*From Agency and Programme to Tool*

The New Governance paradigm relies on a 'shift in the "unit of analysis" in policy analysis and public administration from the public agency or the individual public program to the distinctive tools or instruments through which public purposes are pursued'. Tool choices involve a political dimension, they create or modify power relationships. Besides this political dimension, tool choices also lead to operational implications in public management. Salamon defines the tool of public action as 'an identifiable method through which collective action is structured to address a public problem'. In the European context, this point refers to the way by which the welfare state traditionally organises resource allocation through programming. The New Governance paradigm is characterised by a focus on tools which could be included in a more general proceduralisation movement.

*From hierarchy to Network*

Another characteristic feature of the new governance is the shift from hierarchical functioning to horizontal network. The State and its administration are no longer central actors, they are part of a network. They have to cope with a multitude of actors that have their own references and that are interdependent. 'Government gains important allies but loses the ability to exert complete control over the operation of its own programs.'

*From Public vs. Private to Public + Private*

The New Governance reveals a change in the relationship between the public and the private, both for-profit and not-for-profit, sectors. 'Collaboration replaces competition as the defining feature of sectoral relationships.' New partnerships are put in place. In the Belgian context, this distinction between public and private is not relevant because of its historically important 'pillarisation'. Each of the three pillars has a highly developed and segmented socio-political network. We will therefore analyse the collected information from the *pillarisation/de-pillarisation* angle rather than the public-private relationship angle.

*From Command and Control to Negotiation and Persuasion*

The New Governance emphasise a new approach to public management. 'Command and control are not the appropriate administrative approaches in the world of network relationships [...].' In a network made of interdependencies, the State is no longer in a position to impose its will on the others. It has to negotiate with its partners and persuade them to collaborate.

*From Management Skills to Enablement Skills*

'New Governance shifts the emphasis from management skills and the control of large bureaucratic organisations to enablement skills, the skills required to engage partners arrayed horizontally in networks, to bring stakeholders together for a common end in a situation of interdependence.' Salamon identifies three types of skills:

- *Activation skills*: New Governance requires the mobilisation and activation of all partners of the network. This role can be played by the State or any other actor.
- *Orchestration skills*: once the network is activated, it needs to be maintained dynamically.
- *Modulation skills*: 'the new governance requires the sensitive modulation of rewards and penalties in order to elicit the cooperative behaviour required from the interdependent players in a complex tool network.'

This movement from one model of public action to another was also interpreted as a slide from government to governance. 'The government concept is historical and its work is recognised as the direction and distribution of public goods and services. Government is viewed as an institution. [While] governance is contemporary, it suggests an interactive approach to problem solving using a variety of tools and models within a network of partnerships and envisions the role of government as a facilitator-power broker [...]' (Knepper, Sitren, Smith, 2006).

The idea of moving from one system to another seems to radicalise somewhat the transformations at work in the field of public action in Belgium. A perspective that favours the co-existence of two models seems closer to observable reality. This co-existence gives rise to many possibilities that will inevitably be crossed by tensions and that should begin with the necessary adjustments. Genard and Donnay emphasise this characteristic which seems particularly representative of the reasoning at work in the field of mental health. 'When the history of public policies in mental health is reconstructed, we should avoid adopting a concept of history as "discontinuist" for which the change was only run by radical leaps. These public policies instead constitute strata that succeed one another, are superimposed on one another and that interpenetrate. Responding to complex reasoning, each stratum refers to concepts of health, psychopathology, law, subjectivity, the state of therapeutic knowledge, and forms of organisations that correspond to reasoning of State intervention' (Genard and Donnay, 2002).

In the complex institutional context of Belgium, the Walloon Region and the Federal State operate according to their own organisational reasoning. The two levels of power constitute hybrid forms that combine the characteristics of the two models according to a configuration that belongs to that level alone. Nevertheless, the Walloon Region appears increasingly to have come from 'Classic Public Administration' while the Federal State appears to fall more within the New Governance paradigm. From concepts developed by Salamon, we will consider in turn these two levels of power. We will also attempt to integrate the elements connected to the knowledge when such seems enlightening.

#### **4.1 The Walloon Region**

Managing the issue of mental health at the Walloon Region level seems to fall mainly within 'Classic Public Administration'. Some recent initiatives nevertheless reveal a trend toward introducing practices that increasingly fall within the 'New Governance' model. To illustrate this, we will review the qualification parameters of each of the two models that appear to be reflected in the method of public administration implemented by the Walloon Region.

In the Walloon Region, the administration plays a key role and is the hub at the level of managing mental health. This kind of centralised organisation favours an approach that focuses on the *public agencies*. In fact, in a top-down reasoning, the administration of the Walloon Region establishes the rules according to which the various organisms under its authority operate and should be held to account. Nevertheless, the future Decree on Mental Health Services initiates a new method of management based on contract: to benefit from consent and subsidies, every Mental Health Services should enter a 'therapeutic project' describing its objectives, its lines of conduct and its therapeutic approach. Based on this project the Walloon Region and the Mental Health Services will

enter a contract. Nevertheless, the contract process does not replace existing power relationships. 'If the contract process produces in principle an effect of declaration, [...] it proves in reality to be very structured by classic hierarchies of means, by dissymmetries in the powers of initiative and by insidious forms of the representative's construction' (Gaudin, 1999).

One mode of *hierarchical* functioning appears largely to dominate all the relationships at the level of the Walloon Region. The authorities dominate the whole decision-making process and determine the framework in which the exchanges can take place. Thus, in the case of the Walloon Institute for Mental Health, the producer of accredited knowledge of the Walloon Region, the will to open it at its creation to be subject of negotiation with the politician and the administration that resulted in redefining and reframing the missions of the Institute that will focus on Mental Health Services. Independent research has only a very limited space. The practices of the network implemented by the Walloon Region are rare and few new actors have appeared in the last few years in the mental health landscape.

The practices in the Walloon Region appear to be clearly anchored in the classic practices of *command and control*. Thus, the evaluation appears to be a priority for the authorities who present it as a management tool for proper use of the allocated public monies. Different management practices have thus been implemented, the Mental Health Services should fill two kinds of forms: one intended for an epidemiological inquiry based on the ICD 10, the other aimed at evaluating information on consultation (origin of the steps, nature of the steps, ect.) and on the tasks performed. Moreover, a qualitative evaluation is performed by the intermediary of on-site inspection visits. The issue of the evaluation appears to be thorny and to generate tensions between the administration and the players in the field. In Belgium, the evaluation mechanisms are rare and are recorded in the 'technocratic' type of approach. 'The evaluation of public policies are developing very slowly [...]. The mechanism is directed at a management purpose and its degree of openness is completely limited to politico-administrative actors or to researchers from institutions close to the sponsor's partisan sphere of influence' (Jacob, 2005). At the same time as these classic practices, *consultation and negotiation* initiatives with the sector were implemented, like the *e-conferences* and the *Assises*, the objective of which was to discover the priorities of the sector. These meetings resulted in a project to revise the Decree governing Mental Health Services.

The manner in which the Walloon Region manages the mental health sector necessitates *management skills*: rigorous procedures were implemented. To benefit from the financial support of the Walloon Region, the actors in the field should abide by some legal conditions (status of the organisation, qualification of the personnel) and submit to direct management (evaluation, inspection).

The operation of the Walloon Region fulfils the principal features of the 'Classic Public Administration', although, as has been emphasised, the transformations are currently at work. Thus, when we study the *pillarisation* variable, it appears that the system of outpatient mental health care relies at once on the private and the public sectors and that regardless of the organising power of the organisation. A tendency to depillarise thus appears to be at work.

In sum, the operating method of the Walloon Region appears largely to be similar to the 'Classic Public Administration' model despite some initiatives that were closer to practical characteristics of the New Governance. The upkeep of a form of centralisation and the management practices connected to an operation of the hierarchical type leaves little place to the innovations connected to a new method of management of public affairs.

## 4.2 The Federal State

At the Federal State level, the New Governance paradigm appears better introduced. The many elements characteristic of this model are found in the method of operation at this level of power.

At the Federal State level, a desire to restructure the system of mental health care in terms of care networks and circuits has been shown since the 1990s. Many pilot-projects aimed at developing the practices of *network* on the complex stakes were implemented, they bring together the actors from different levels of power and the private sector. 'Governance asserts that public action relies upon the engagement of stakeholders, and communities to resolve complex and messy problems' (Knepper, Sitren, Smith, 2006). The networks and the resources that they mobilise appear as a solution to the problem of increase in health costs.

The *negotiation* procedures are omnipresent in the mental health sector. Many bodies for dialogue and opinion exist and are regularly called upon by politico-administrative authorities. The diversity of the members of these various bodies bear witness to the desire to anchor the policy decisions in a consensus that is at once scientific and political.

At the level of management of public affairs, the Federal State tries to meet the necessary *enablement skills* by implementing the coordination authorities at the levels both of initiation and of follow-up of the public action. Thus, the Dialogue Platforms play an *activation* and *orchestration* role in the framework of *therapeutic projects*. 'What is essential, in a reticular system, is connecting it to a number of reflexive mechanisms, among which one of the most obvious functions would be the assumption of coordination tasks' (Genard, 2003).



These parameters appear to attest to the domination of the New Governance model. Nevertheless, the resonance of the characteristics of the classic model, like the weight of the bureaucracy and the *pillarisation* of the sector, provokes the tensions between the operation methods of each of the models.

Thus, the administrative and political authorities would like to implement an evidence-based policy. This desire to implement new practices encounters a significant resistance in the field. As regards the pilot-project related to *therapeutic projects*, the evaluation procedures drawn up by a research centre create a discussion within the field of mental health not on the issue of the evaluation but on the method of this evaluation. The weight of the union between the policy of the administration and the research centre leave the actors little room to manoeuvre. This type of hierarchical management of public action falls under the classic model that is based on a *command and control* manner of doing.

The influence of the *pillarisation* within the hospital sector remains largely present. Nevertheless, the pilot-project monies used by the Federal seem to favour the collaboration at the level of the territory more than the traditional coordination based on the networks implemented by the pillars.

The Federal State appears to adopt some of the characteristics of the New Governance paradigm although the weight of the politico-administrative system remains important. This type of hybrid functioning could be classified as autonomy under surveillance, leaving the door open to any technocratic drift. Another striking element at the level of the Federal State is the opposition between the politico-administrative reasonings of action and the organisation schemes favoured by the professionals locally.

In conclusion, in an increasingly complex context of the field of public action, the existence of 'pure' models corresponding to the models described by Salamon does not seem capable of applying to reality. The tensions and contradictions inherent to the field of mental health prompt the development of hybrid forms combining the characteristics coming at once from the classic model and from the New Governance model. The strong segmentation of the field of mental health also allows, at the power levels concerned, adoption of the different configurations. Thus the Walloon Region remains anchored in a classic management model while the Federal State appears to have increasingly integrated the organisational characteristics of New Governance.

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## **Annexe 1: Sample and materials**

Minister of Health, Social action and Equality of chances and her Cabinet

Type of materials collected:

- website : <http://vienne.wallonie.be/site/>

Directorate of Inspection and Control

Within the Division of Health and Infrastructures within the Administrative department of Social action and Health

Type of materials collected:

- 2005 activity report
- the Director's curriculum vitae
- two interviews

Walloon Institute for Mental Health (IWSM)

Type of materials collected:

- website [www.iwsm.be](http://www.iwsm.be)
- review "Confluences" published by the IWSM
- an interview

Service of Psychosocial health cares

Within the Federal Public Service of Health, Food Safety and Environment

Type of materials collected:

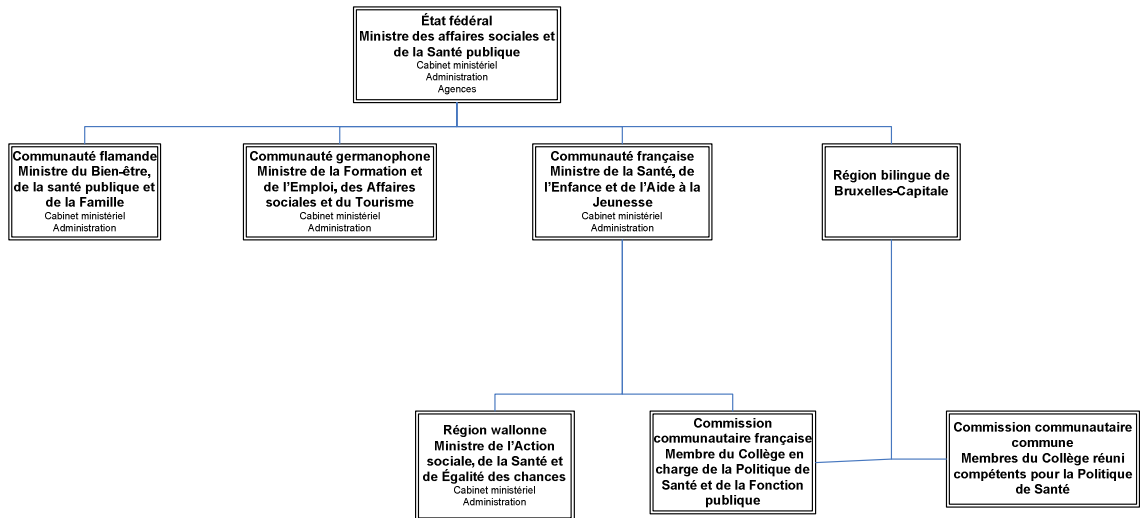
- website  
[https://portal.health.fgov.be/portal/page?\\_pageid=56,512828&\\_dad=portal&\\_sch\\_ema=PORTAL](https://portal.health.fgov.be/portal/page?_pageid=56,512828&_dad=portal&_sch_ema=PORTAL)
- the Director's curriculum vitae
- an interview
- websites of two knowledge producers: [www.iph.fgov.be](http://www.iph.fgov.be) and [www.kce.fgov.be](http://www.kce.fgov.be)

Dialogue Platform in Mental health in the Regions of the Centre and Charleroi

- website <http://www.pfrcc.com/hp/hp.htm>
- 2006 activity report
- two interviews
- Decree of 10 July 1990 fixing accreditation norms applicable to psychiatric institutions and services associations

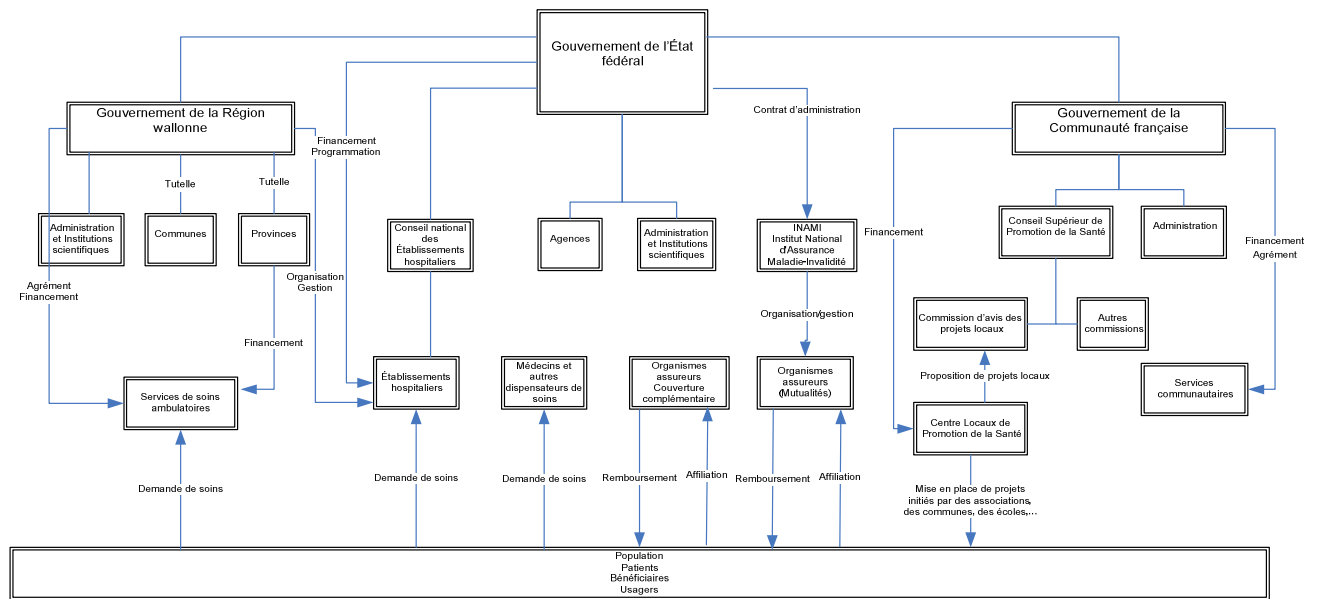
## Annexe 2: Health sector – Belgian institutional landscape

### Secteur de la Santé - Paysage institutionnel belge



**Annexe 3: Health sector in the Walloon region**

**Secteur de la Santé en Région wallonne**



#### **Annexe 4: File of the Minister of Health, Social action and Equal Opportunity**

Minister of Health, Social action and Equal Opportunity

Contingent on the selection of policies we have made for Orientations 2 and 3, it seems interesting to focus on the most important political authority in the Walloon region. We will describe the Minister of Health, Social action and Equality of chances.

Information sources that we have solicited are diverse. Number data and factual data on the Minister and her cabinet as an organisation are mostly found on the website<sup>47</sup>. Regarding the office holder's qualifications and experience, information is also coming from the website. Information linked to knowledge circulation arose from written documents (website).

We do not have information on the body's cognitive categories used to describe the sector. Indeed, an interview with a Minister's collaborator has been planned but cancelled several times.

#### 1. Body

##### 1.1. Organizational roles and missions

The Minister of Health, Social action and Equality of chances is in charge of the following subjects:

- Elderly people
- Handicapped people
- Precarious people
- Integration of foreign people
- Health

The Minister proceeds to the financing at to legislation creations or modifications on these subjects.

The « Contract for Walloons' future » passed the Government in 2005. It is meant to sustain a positive dynamic in Wallonia. The Minister presents her balance per themes after two years at the Walloon Government<sup>48</sup>. The principal facts are the following:

Actions	Budget
Elderly people: carrying out a society which gives value to elderly people	199 547 750 €
Handicapped people: handicapped people as integrated citizens	6 630 000 €
Precarious people: assisting precarious people	20 025 040 €
Foreigners' integration	2 428 000 €
Health	155 987 786 €
Total	384 618 576 €

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<sup>47</sup> <http://vienne.wallonie.be/site/>

<sup>48</sup> <http://vienne.wallonie.be/site/1sousprojecteurs.asp?DocID=589&v1ID=&RevID=&namePage=&pageParent=>



The health budget represents 40% of the overall budget. It can be divided into:

Actions	Budget
Amelioration of the medico-sanitary network	123 000 000 €
Centres of family planning	8 141 000 €
Mental health	24 323 736 €
Environmental health	523 050 €
Total	155 987 786 €

As we will focus in Orientations 2 and 3 on mental health sector, we will describe this sector into more details of this field. The Minister set up activities:

- Care offer in 56 mental health services (financing and accreditation): 23 104 000 €
- State of the art on the mental health services sector for the 10<sup>th</sup> anniversary of the decree on mental health services. Organization of two *e.symposiums* on "Work in mental health service" and on "The mental health service in its environment". 4700 visitors and 315 participants.
- New mental health service: 125 000 €
- New mental health team, specialised in networking: 48 000 €
- Specific subzidisation for computers: 36 736 €
- Finalisation of a State of the art of the care offer (hospital infrastructures and mental health services)
- Walloon Institute for mental health's financing: 215 000 €
- Mental health network: 10 000 €
- Facultative financing to institutions working in the mental health sector: 600 000 €

The Minister's team is composed as follow:

- Unit "Chief of staff": chief of staff and 2 secretaries
- Unit "Social action and Equality of chances": 8 collaborators and 1 secretary
- Unit "Health": 9 collaborators and 1 secretary
- Press unit: 2 collaborators
- Transversal units: 10 collaborators and 3 secretaries

## 1.2. Office holder

Name and rank: Christiane Vienne - Minister of Health, Social action and Equality of chances

### Formal qualifications:

Christiane Vienne holds a Master in social and economic political science, from the Catholic University of Louvain

### Professional experience:

- Since June 2004: Minister of Health, Social action and Equality of chances
- 2003 - 2004: Co-opted senator
- Member of the Committee of Finance and Economic affairs
- 2003: Assistant Director at the Cabinet of the Federal Minister of Public health
- 1997-2002: Federal secretary of the Christian Worker Movement.
- 1995-1997: City councilman
- 1992-1997 : Instructor in project management

Moreover, she is a member of several committees and has some administrator mandates in diverse companies.

## 2. Knowledge circulation

### 2.1. Formal relationships related to knowledge

Minister's formal relationships related to knowledge are linked to privileged knowledge producers.

It has to be said that most of the knowledge production is realised inside the administrative department. At the administrative department level, two types of studies are realised.

The first one concerns the mental health services which represent the Directorate's biggest mission, in terms of financing and administrative work. Each mental health service hands out an annual activity report to the Directorate. Data within those reports may be used in theory into two ways. A global quantitative analysis can be done on all reports. This work is meant to be realised by the Directorate itself. But this type of work is time consuming and it has not been achieved yet. Nevertheless, data from 2005 are currently analysed. The second type of analysis consists in a qualitative inspection of activity reports which can be done on pieces or on the premises.

The second type of studies concerns recording files. A recording file is filled in when a patient is coming for the first time in a mental health service. This record is realised through a standardised document which comprises administrative information, diagnosis data and care information. Those files are sent to the Directorate which delegates the epidemiologic data aggregation and utilisation to the Catholic University of Louvain, following an invitation to tender.

Besides, the IWSM is the main formal knowledge producer in the mental health sector in the French part of Belgium. Due to its financial dependency towards the administrative department, the IWSM is not really autonomous in its research work. As it has been said within the administrative department, "we want the Institute to be a tool to support policies." The administrative department gives clear directions to the Institute's research work.

Another knowledge producer is the *Research Centre for Social Defence*.

The third type of studies concerns specific problematics identified by the administrative department or by the politics. There is an invitation to tender for each study.

### 2.2. Knowledge production

The Minister put in place, in May and June 2006, an original initiative to consult the sector. Users of mental health services and practitioners were invited to participate to two *e.symposiums*.

4 700 people visit the website and 315 people intervened on-line on diverse subjects: originality of their job in mental health services, difficulties met during their treatment,... They also had the opportunity to communicate concrete propositions to improve care offer in the Walloon region.

The whole sector was invited in September 2006 to a study day, the *Assises* of mental health services, on the three main topics brought up from these virtual symposiums. The objective of this meeting was to elaborate propositions to optimize the mental health services' care offer.

As a result of the *e.symposiums* and the *Assises*, the Walloon Institute for mental health dedicated the fourth issue of its "copybook" to this problematic, under the title "Have a look on the mental health services in Wallonia. Synthesis and perspectives of the *e.symposiums* and the *Assises* of mental health services". This document is downloadable on the web<sup>49</sup>.

### 2.3. Research

Evaluation activities are realised (or meant to be realised) within the administrative department. On the contrary, research and study activities are delegated to external organisations or institutions. They are realised by various actors (the IWSM or any research centre), following an invitation to tender. Each time, a task book specifies what the objectives of the research are, how long will last the research,... There are three possibilities:

- Some studies are planned in the legislative texts
- A research centre or any other organisation has a project and submits it to the administrative department
- Politics have a particular concern and wish to obtain scientific information on it

### 2.4. International references

No international references are mentioned in documents or during interviews.

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<sup>49</sup> [http://assm.ecolloques.be/ebook\\_ASM4/ASM\\_4.html](http://assm.ecolloques.be/ebook_ASM4/ASM_4.html)

## Annexe 5: File of the Directorate of Inspection and Control

Directorate of Inspection and Control  
 Within the Division of Health and Infrastructures  
 Within the Administrative department of Social action and Health

Contingent on the selection of policies we have made for Orientations 2 and 3, it seems interesting to focus on the most concerned administrative department of the Walloon region. We think it is most relevant to describe into more details the "Directorate of Inspection and Control" rather than the entire administrative department.

Information sources that we have solicited are diverse. Number data and factual data on the Directorate as an organisation are mostly found in the 2005 activity report<sup>50</sup>. Regarding the office holder's qualifications and experience, information is coming from the curriculum vitae the Director sent us. Information linked to knowledge circulation arose from written documents (activity report, review,...) and from interviews realised with the Director and an inspector.

### 1. Body

#### 1.1. Organizational roles and missions

The Administrative department of Social action and Health's 2005 budget adds up to 252,9 millions € and is split up into:

	€ (millions)	% of department's budget
Health program	64,4	25,50%
Transverse policies in the socio-sanitary field	0,7	0,30%
Social action program	45,9	18,10%
Family and third age program	139,8	55,30%
Handicapped person program	2,1	0,80%
Total	252,9	100%

The Administrative department of Social action and Health is composed, beyond the Administrative department's pool, by three divisions:

- Division of Social action
- Division of Family and third age
- Division of Health and Infrastructures

Among those three divisions, the one which concerns us directly is the Division of Health and Infrastructures. This division allocates subventions to medico-social institution for constructing and fitting out. It is in charge to inspect and accredit general and psychiatric hospitals, hosting institutions and nursing homes. It accredits and allocates subventions to mental health services and to divers actions in the health field. It comprises four Directorates:

<sup>50</sup> <http://vienne.wallonie.be/files//pdf/DGASSrapportactivit%E9s05.pdf>

- Directorate of Infrastructures
- Directorate of Curative Health
- Directorate of Hygiene
- Directorate of Inspection and Control

The first three directorates do not concern us directly because mental health and ambulatory cares in particular are in the competences of the Directorate of Inspection and Control.

The Directorate of Inspection and Control is in charge of administrative and financial management of subjects linked to ambulatory extra-hospital health. Thus, it is competent for administrative and qualitative inspection of mental health services, home care services and addiction specialised services.

The inspection consist essentially in verifying if accreditation, functioning and financing requirements are, at all time, respected. It is also in charge to realise qualitative inspection.

Beyond accredited organisations, there are some institutions or associations which benefit, often within a recurrent framework. Thus, the Walloon Institute for Mental Health has an annual subvention of 215 000 € and the Unit of legal psycho-pathology has an annual subvention of 50 000 €.

Moreover, grants are also allocated to realise studies and researches, to support manifestations, symposiums, conferences, study days and publications on health matters in general and in mental health matters in particular.

Sixteen people are employed by the Directorate; some of them do not work full time.

Budget dedicated to the Directorate represents almost 50% of the Walloon budget dedicated to health program. In 2005, subventions were allocated to those types of organisations:

	€	% of the Directorate's budget
Mental health services from public sector	7.759.000	24,5%
Mental health services from private sector	14.580.000	46,0%
Distance reception centres	843.000	2,7%
Home care services	3.252.000	10,3%
Integrated health associations	1.343.000	4,2%
Intervention within social illness framework	355.000	1,1%
Mental health and struggle against drug addiction	2.051.000	6,5%
Palliative cares	447.000	1,4%
Studies in health and mental health matters	540.000	1,7%
Studies in environmental health matters	199.000	0,6%
Information diffusion	24.000	0,1%
Financing of a research centre	195.000	0,6%
Financing of a scientific platform 'health and environment'	125.000	0,4%
Total	31.713.000	100,0%

As we can see, the budget allocated to mental health services (from private and public sectors) represents more than 70% of the Directorate's budget.

#### 1.2. Office holder

Name and rank: Brigitte Bouton - Director

Formal qualifications:

Brigitte Bouton has a Master in archaeology and art history, obtained in 1985 at the Catholic University of Louvain.

Professional experience:

In 1985-1986, she worked in the archeology sector (dig, excavation, publication,...)

In 1987, she obtains a job in the administrative department of the French Community, more precisely in the Directorate of social action. She works in several services: documentation management, human resources service,...

From 1993 until 1999, she is detached to the Minister-President of the French Community's cabinet.

In 2000, she joins the Administrative department of Social action and Health, Division of Family and Third age.

In 2001, she replaces the Director of the Directorate of Inspection and Control who retires. In 2007, she is promoted at the rank of Director, until then she was Director ad interim.

## 2. Knowledge circulation

### 2.1. Formal relationships related to knowledge

The IWSM is the main formal knowledge producer in the mental health sector in the French part of Belgium. Due to its financial dependency towards the administrative department, the IWSM is not really autonomous in its research work. As it has been said within the administrative department, "we want the Institute to be a tool to support policies." The administrative department gives clear directions to the Institute's research work.

Another knowledge producer is also closely related to the administrative department, it is the *Research Centre for Social Defence* which benefits of an annual budget of 195 000 €.

The remaining budget (739 000 €) is dedicated to punctual studies which are ascribed to a research centre as a result of an invitation to tender.

### 2.2. Knowledge production

At the administrative department level, three types of studies are realised.

The first one concerns the mental health services which represent the Directorate's biggest mission, in terms of financing and administrative work. Each mental health service hands out an annual activity report to the Directorate. Data within those reports may be used in theory into two ways.

A global quantitative analysis can be done on all reports. The objective is to identify trends at the regional level in terms of epidemiology, accessibility, type of proposed consultations, work time distribution among activities,... This work is meant to be realised by the Directorate itself. But this type of work is time consuming and it has not been achieved yet. Nevertheless, data from 2005 are currently analysed. The second type of analysis consists in a qualitative inspection of activity reports which can be done on pieces or on the premises. Those study activities are linked to sector's evaluation.

The second type of studies concerns registration files. A register file is filled when a patient is coming for the first time in a mental health service. This registration is realised

through a standardised document which comprises administrative information, diagnosis data and care information. Those files are sent to the Directorate which delegates the epidemiologic data aggregation and utilisation to the Catholic University of Louvain, following an invitation to tender.

The third type of studies concerns specific problematics identified by the administrative department or by the politics. There is an invitation to tender for each study.

### 2.3. Research

Evaluation activities are realised (or meant to be realised) within the administrative department. On the contrary, research and study activities are delegated to external organisations or institutions. They are realised by various actors (the IWSM or any research centre), following an invitation to tender. Each time, a task book specifies what the objectives of the research are, how long will last the research,... There are three possibilities:

- Some studies are planned in the legislative texts
- A research centre or any other organisation has a project and submits it to the administrative department
- Politics have a particular concern and wish to obtain scientific information on it

Budget dedicated in 2005, within the Directorate, to research is of 934 000 € (2,95 % of the Directorate's budget). Moreover, budget allocated to the IWSM is of 215 000 €; this amount of money is not exclusively dedicated to research mission.

Another knowledge producer is also closely related to the administrative department, it is the *Research Centre for Social Defence* which benefits of an annual budget of 195 000 €.

The remaining budget (739 000 €) is dedicated to punctual studies which are ascribed to a research centre as a result of an invitation to tender.

### 2.4. International references

No international references are mentioned in documents or during interviews.

## 3. Sector

The principal characteristic of the sector (pointed by the Directorate) is the sector's resistance to any type of evaluation. Even if "there is various forms of evaluation, some criteria are objective. Moreover, there is services' auto-evaluation."<sup>51</sup>

At the Walloon region level, the question of evaluation seems thorny and generates tensions between the field actors and administrative department. The last issue of the review "Confluences" published by the IWSM dedicates a file to this theme: "Evaluate to develop". The first article begins in saying: "Evaluation is a subject that let no one indifferent in the mental health sector. In many cases, it provokes suspicion. [...] Yes, the practitioners of the mental health sector think it is legitimate to evaluate their practices but yes, they fear evaluation."<sup>52</sup>

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<sup>51</sup> Quoted from an interview realised with a member of the General Directorate of "Social action and Health"

<sup>52</sup> Olivier V., « De la subjectivité de l'homme à l'évaluation en santé mentale », in *Confluences* n°16, avril 2007

The administrative department underlines the necessity of control and the resistances coming from the field actors (mostly the mental health services): "In this sector, they do not like evaluation. They say that they can not be criticised by the patients nor by any external actors."<sup>53</sup> The activity reports are considered by the administrative department as a control tool. The registration constraints have been increased and impose from then on a unique registration file.

Practitioners underline the difficulty to evaluate situations linked to human subjectivity. They criticise particularly the tools used to realise the evaluation. "Those tools are inappropriate to the mental health field."<sup>54</sup> The evaluation modalities used by public powers are based on objective data, such as diagnosis based on DSM IV and ICD 10. This type of evaluation does not debrief each situation's specificities.

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<sup>53</sup> Quoted from an interview realised with a member of the General Directorate of "Social action and Health"

<sup>54</sup> Olivier V., *ibid.*



## **Annexe 6: File of the Walloon Institute for Mental Health (IWSM)**

Walloon Institute for Mental Health (IWSM)

Contingent on the selection of policies we have made for Orientations 2 and 3, it seems interesting to select the appointed knowledge producer of the Walloon region.

Information sources that we have solicited are diverse. Factual data on IWSM as an organisation are mostly found on the website<sup>55</sup>. Regarding the office holder's qualifications and experience, information is coming from the interview realised with the Institute's Director. Information linked to knowledge circulation arose from written documents (website, review,...) and from the interview realised with the Institute's Director.

### 1. Body

#### 1.1. Organizational roles and missions

##### Creation

The Institute was created in 2002. Its creation lies on three fundamental arguments:

- Opening towards all actors concerned by the mental health field. The Institute will give heed to associate various actors from the mental health sector in Wallonia: coordination platforms<sup>56</sup> (plateformes de concertation - PFC), Hospital Federation, Ambulatory Federation, First line services Federation, psycho-medico-social partners and users and families.
- Interface role for a real cooperation in Wallonia. The interface is considered as a relay to guarantee relations between field actors, with the population and with the authorities at all power levels. The IWSM will take initiatives in organising cooperations and participating to existing cooperations: official committees, field cooperations (at regional level but also at communitarian and federal levels)
- Expertise and research missions within the framework of a permanent observatory. Research work constitutes one of the central missions of the Institute. It leans on epidemiologic data and on a permanent observation of the field practices.

##### Object

The Institute has for object to gather together field actors working in the mental health sector with a view to support a permanent thinking on mental health problematics, to foster a questioning on mental health practices, to participate to mental health promotion and to work on ethical issues in the mental health sector.

The IWSM constitutes a permanent cooperation and consultation body and a interdisciplinary research organism on mental health issues in Wallonia.

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<sup>55</sup> [www.iwsm.be](http://www.iwsm.be)

<sup>56</sup> In Belgium, there are 13 Dialogue platforms (one per province). Their missions are to organise cooperation and consultation between all actors working in the mental health sector (hospitals, ambulatory organisations, users' associations,...) on a given geographical territory.

## Missions

To achieve its object, the IWSM has several missions which take three main directions:

- Research. The research mission's objectives are numerous: to increase understanding of specific problematics, to participate to the evaluation of the offer and demand of services, to underline guidelines for practices and to sustain thinking about mental health policy orientations. Concretely, several types of research are realised by the IWSM:
  - Thematic research groups on specific topics: network, childhood, elderly people, justice,... Those groups lean on field actors consultation
  - Epidemiologic research in collaboration with the administrative department
  - Public power-mandated researches
- Education. The objective is to develop new intervention modalities in a continuing education perspective. Education will then concern mental health professionals as well as first line actors, users and their family.
- Information. In a mental health perspective, the Institute fosters diffusion of accessible and adapted information on mental health issues and psychic disorders and towards population, users, field workers and politics. The information mission comprises:
  - Information on mental health services and institutions (contact information, proposed education,...) and orientation
  - Documentation centre: reviews, books, etc are made available
  - Information diffusion: fliers and publications, newsletter, scientific review,...

## General principles

On its website, the Institute describes itself as an independent organisation. It places itself besides ideological and theoretical debates and affirm its openness towards all actors whatever are their therapeutic approach, philosophical obedience,...

This openness is mirrored in its governing board's composition:

1. Structures hospitalières (Association Francophone d'Institutions de Santé, Confédération Belge des établissements privés de soins de santé, Association des Etablissements Publics de Soins, Fédération des Institutions Hospitalières)
2. Structures intermédiaires (Groupement des hôpitaux de jour psychiatriques, Fédération des intervenants en toxicomanie en RW, Fédération des Structures psycho-socio-thérapeutiques, Fédération Francophone des Initiatives d'Habitations Protégées)
3. Structures ambulatoires (Association des travailleurs de Santé Mentale Ambulatoire, Fédération des équipes SOS, Association des Pouvoirs Organisateurs de Services de Santé Mentale en Wallonie)
4. Plateformes de Concertation régionales
5. Familles et usagers
6. Structures psycho-médico-sociales et intervenants de 1ère ligne (Fédération wallonne des Maisons Médicales, Union des Fédérations Francophones d'Institutions de Protection de la Jeunesse et d'Aide aux Handicapés)
7. Ligue wallonne pour la santé mentale

Throughout our interviews, it appeared that the effective Institute's position is quite different from the description given on the website. The IWSM, the Minister and her cabinet and the administrative department are in negotiation to redefine the IWSM's missions.

The Institute's affirmed and claimed independence seems to be eroded. The Minister and the administrative department want the IWSM to concentrate on mental health services

which represent the biggest competences of the Walloon region in terms of budget and missions in the mental health sector. Moreover, the Walloon region is the Institute's unique financing source. For some civil servants of the administrative department, the IWSM must be a tool to improve practices. The Walloon region seems to proceed to a rationalisation of its budget.

## 1.2. Office holder

Name and rank: Christiane Bontemps – Director

Formal qualifications:

The office holder is sociologist. She obtained a "licence" in sociology from the University of Namur in 1977. In Belgium, a licence is equivalent to a master. The licence in sociology is a four year long study after secondary school.

Professional experience:

After her "licence" in sociology, she worked for a year in the education field as a teacher in psycho-sociology. Afterwards, she worked for four years at the University of Namur as a researcher. The research's theme was the social collective services and it was commissioned by the "federal scientific department" which is an administrative department. It was a research on user satisfaction degree in diverse types of social services.

Afterwards, she was employed as a researcher by the then League for mental health (Ligue pour la santé mentale) which was an association. She worked on an epidemiologic research in the mental health services which participate voluntary to this project. Within the league, study days and workshops were organised.

In 1996, the League still associated the Walloon league and the Brussel League. It became difficult to function as a whole because of the devolution. She has been the Director of the Walloon league since it took its independence.

In 2002, the Walloon Institute for Mental Health was created and is financed since 2003 by the Walloon region. The Institute replaces the League and is still a non-profit-making association.

## 2. Knowledge circulation

### 2.1. Formal relationships related to knowledge

Since its creation in 2002, the Institute is mostly related to the Walloon region which constitutes its unique financing source. The financing is made of functioning fares (200 000 €) and of publicly financed employment (10 within the Institute).

As we already mentioned it, the Walloon region wants to redefine the Institute's missions by restraining its action field to the mental health services. Previously, the research themes choice was made by the governing board contingently to the sector's concerns. Thus, studies were lead on evaluation, accessibility, network practices and patient's rights. "We will be forced to work more as a partner of the politic and the administrative department. Presumably, there will be a greater listening of what we will produce but we will have a smaller breathing space."<sup>57</sup>

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<sup>57</sup> Quoted from an interview realised with a member of the Walloon Institute for Mental Health

On its side, the Walloon region specifies its expectations: "We want the Institute to be a backing tool, a study provider but not unique because diversity is beneficial."<sup>58</sup>

The Institute is solicited by the Minister for direct missions (studies,...) but also for indirect consultation, such as participating to workshops (federal workshop on the Helsinki Chart).

The relationships between the Institute, on the one part, and the Minister and the administrative department, on the other part, seem tense. The Institute finds itself in a delicate position. Indeed, its financing has no recurrent framework and must be re-negotiated every year. The current negotiation should stabilize the relationship in another shape.

## 2.2. Knowledge production

The IWSM is the main formal knowledge producer in the mental health sector in the French part of Belgium.

The IWSM has three missions – education, information and research – which are under current redefinition. Among these, the research mission is fundamental. "Since the last two years, we are more focused on research."<sup>59</sup> The researchers of the Institute are all originally from human and social sciences, mostly psychology and sociology. The Institute appoints punctually support of medical practitioners for researches which necessitate specific medical knowledge.

Researches lead by the Institute focus on these four main themes: evaluation, accessibility, network practices and patient's rights. These themes were approved by the governing board. Research results are mostly diffused via the "Confluences" review<sup>60</sup> which has a quarterly publication. Each issue comprises a file dedicated to a specific problematic which represent two third of the issue and some general articles (1 to 3 pages) or articles that can not be included in the thematic file. The thematic file is composed of a dozen of short articles (1 to 3 pages) that can be divided into three categories. The first third is written by the Institute's researchers; the second third is written by researchers coming from universities or research centres; the last third is written by field professionals or users association representatives.

The last four issues of "Confluences" focused on these themes:

- N°13: Consent to cares in a constrained framework
- N°14: Zoom on mental health services
- N°15: Formalising network
- N°16: Evaluate to develop

Besides this publication, more detailed files and research reports are transmitted to the Minister and to the administrative department.

Another medium of diffusion is the Institute's monthly electronic newsletter.

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<sup>58</sup> Quoted from an interview realised with a member of the General Directorate of "Social action and Health"

<sup>59</sup> Quoted from an interview realised with a member of the Walloon Institute for Mental Health

<sup>60</sup> « Confluences » is a quarterly review published by the IWSM.

Previously, the Institute was relatively independent in the choice of themes, methodology and duration of the researches.

Since 2006, the Minister and the administrative department want to redefine the IWSM's missions and tasks. The IWSM's autonomy is restrained by this new definition of the research field but also by the demand of results coming from these two actors. Indeed, they want researches' data and conclusions to be useful in order to improve current practices.

The "Confluences" review is a medium of knowledge diffusion. This knowledge is coming from academics as well as from practitioners.

### 2.3. Research

The IWSM has three missions – education, information and research – which are under current redefinition. Among these, the research is fundamental. "Since the last two years, we are more focused on research."<sup>61</sup> The researchers of the Institute are all originally from human and social sciences, mostly psychology and sociology.

Since 2006, researches lead by the Institute focus exclusively on the Mental health services. It is due to the fact that the IWSM's missions are redefined by the politics and the administrative department. From then, researches are realised on topics like accessibility, evaluation,...

### 2.4. International references

The Institute's researches are not based on international references but its publications often mention international documents such as the Ottawa Charta.

## 3. Sector

The sector is presented by the IWSM in its diversity and complexity. The mental health field is immense. Moreover, in Belgium, competences are held by various actors and boundaries are not clear. It seems difficult to develop a consistent action plan which takes into consideration all factors influencing mental health.

Another problem is linked to visibility and stigmatisation. Mental disorders lead to suffering for concerned people. It is due to the unawareness of these disorder and their effects on various aspects of social life. "It can happen to anyone but it is not said enough..."<sup>62</sup>

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<sup>61</sup> Quoted from an interview realised with a member of the Walloon Institute for Mental Health

<sup>62</sup> Quoted from an interview realised with a member of the Walloon Institute for Mental Health

## Annexe 7: File of the Service of Psychosocial health cares

Service of Psychosocial health cares  
Within the Federal Public Service of Health, Food Safety and Environment

Contingent on the selection of policies we have made for Orientations 2 and 3, it seems interesting to focus on the most concerned administrative department of the Federal State. We think it is most relevant to describe into more details the "Service of Psychosocial health cares" rather than the entire administrative department.

Information sources that we have solicited are diverse. Number data and factual data on the Service as an organisation are mostly found on the website<sup>63</sup> and on document related to the service. Regarding the office holder's qualifications and experience, information is coming from the curriculum vitae the Director sent us. Information linked to knowledge circulation arose from written documents (website, internet,...) and from the interview realised with the Director.

### 1. Description of the body

#### 1.1. Organizational roles and missions

The Service of Psychosocial health cares is subdivided into four teams:

- Drugs
- Mental health
- Cultural mediation
- Recording: international survey, survey realised by the Scientific Institute of public health, Minimal psychiatric data,...

The Service of Psychosocial health cares has for mission:

- To develop an evidence-based policy, by the mean of pilot-projects and *therapeutic projects*
- To prepare the future policy by the mean of pilot-projects and legislation elaboration
- To set in motion support committees for research projects on mental health
- To develop recording and especially the "Minimal psychiatric data" which is a file related to a given patient and completed by all concerned care institutions. It contains (i) international DSM IV data, (ii) local medical file information, (iii) information related to cares and treatment. There is an electronic exportation towards the administrative department via internet.

The politics want to test, via diverse pilot-projects, the feasibility of a care model, based on patient's needs and on cares continuity, before eventually generalize it. It is a model based on care circuits and networks. Each pilot-project is put into the frame of a convention between the administrative department and the operator which coordinate the pilot-project. This document describes the following elements:

- General objectives of the project
- Operational objectives
- Mission execution
- Research protocol

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<sup>63</sup> [https://portal.health.fgov.be/portal/page?\\_pageid=56,512828&\\_dad=portal&\\_schema=PORTAL](https://portal.health.fgov.be/portal/page?_pageid=56,512828&_dad=portal&_schema=PORTAL)

The pilot-projects are divided into target-groups on the entire Belgian territory. The « Children and teenagers » target-group has four pilot-project (“clinical intensive cares for youth offenders with psychiatric disorders”, ...). The “Adults” target-group has eight pilot-projects (“clinical intensive care for intern patients in order to re-socialize them”, “Psychiatric cares for nursing home patients”, Help-desk for first line practitioners in mental health”,...).

After the 2005 political note on mental health, the biggest theme which the Service of Psychosocial health cares works on is also linked to care circuits and networks. There are *therapeutic projects*. Eighty-two special pilot-projects have been selected to put in place coordination around patient between practitioners. At a higher level, the target-group level, coordination is also organised: the *transversal coordination*.

## 1.2. Office holder

Name and rank: Pol Gerits – Director

### Qualifications:

MA (University of Leuven - Belgium), PhD (University of Leiden - The Netherlands) is experimental, clinical and health psychologist as well as behaviour therapist.

### Professional experiences:

At this moment he is manager of the department of psychosocial care service of the Federal Public Service of Health, Food Safety and Environment in Belgium where he is since 1998. He is member of the Pompidou Group and he is National Counter Part for the WHO - region Europe for Mental Health. He is following also the activities concerning mental health matters within the EC. He is specialised in health psychology, mental health and drugs related problems He has been widely published in a number of peer-reviewed journals and books. Finally, he is visiting professor at the faculty of psychology of the Free University of Brussels and at the faculty of medicine of the University of Antwerp.

## 2. Circulation of knowledge

### 2.1. Formal relationships related to knowledge

The Service of Psychosocial health cares has privileged relationships related to knowledge with various organisms.

The *Scientific Institute of Public Health*<sup>64</sup> is a scientific institute of the federal Belgian State. Its main mission is to conduct scientific researches in order to support health policy. It provides also expertise and public service in the field of public health. It realises the Health Belgian survey by interviews. This large-scale survey is the main epidemiologic data source in general population. A part of this survey is dedicated to mental health.

The *Belgian Health Care Knowledge Centre*<sup>65</sup> is a federal agency. It has for goal to collect and furnish objective and scientific facts to qualitatively support the best health care accomplishment. It should also enable a transparent and effective assignment of Health

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<sup>64</sup> [www.iph.fgov.be](http://www.iph.fgov.be)

<sup>65</sup> [www.kce.fgov.be](http://www.kce.fgov.be)

Care Insurance's means. In the mental health sector, the Centre currently participates to a research on « Health services and therapeutic approaches for chronic and complex mental disorders ». The objective is to define the scientific guidelines for *therapeutic projects* (organisation, recording,...).

The *Hospital National Centre* which is a federal advisory group, and particularly its workgroup "psychiatry", has played a crucial role in conception and setting up of a functioning model based on care circuits and networks.

Various workgroups have been set up:

- The Insurance committee's workshop has for mission to elaborate organizational modalities to introduce *therapeutic projects* and to define selection procedures and jury's constitution.
- The *therapeutic projects* Support committee gathers together data and propositions emanating from the *transversal coordination*. The objective is to achieve a structural proposition for a model based on care circuits and networks.
- The Mental health task force has for mission to elaborate a new concept of mental health care. This platform will formulate propositions for the Inter-ministerial Conference on public health.

Within the framework of an evidence-based policy development, all *therapeutic project* participants constitute privileged formal partners in respect to knowledge production and circulation.

## 2.2. Knowledge production

The Service of Psychosocial health cares' work is mostly guided around an evidence-based policy development. "Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values"<sup>66</sup>.

This type of policy is based on field experiences to determine good practices. Within this framework, pilot-projects and *therapeutic projects* constitute an evidence-based knowledge production stockroom. This kind of knowledge seems to be largely mobilised and privileged inside the Service.

Evidence-based policy development is influenced by Anglo-Saxon practices.

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<sup>66</sup> Sackett DL, Strauss SE, Richardson WS, Rosenberg W, Haynes RB. Evidence-Based Medicine. How to Practice and Teach EBM, 2nd ed. Edinburgh: Churchill-Livingstone; 2000



### 2.3. Research

Within the framework of the *therapeutic projects'* setting up, the *Belgian Health Care Knowledge Centre* has been solicited to realise a research on various aspects of this problematic:

- How to define chronic and complex mental disorders?
- What are the available data on treatment and re-socialisation of identified target-groups? What are the results of a network based model?
- What are the exemplars of good practices of integrated cares? What type of financing is used in these countries?
- How to evaluate *therapeutic projects*? What measurement tools are used (re-socialisation degree, quality of life scales, symptom check list)?

A participative research on users and families' empowerment will be launched in September 2007. How to implement empowerment in *therapeutic projects*? How to improve empowerment in future policies? This research will be realised collectively by five partners: the Interregional association for guidance and health, three users and families association and a research centre (Lucas).

Moreover, universities and research centres are punctually solicited for specific thematic researches. They are selected on the basis of an invitation to tender. The problem is that: "Reports written by universities give very general conclusions and there is no translation of these conclusions into concrete recommendations for politics. Researchers are too cautious and it is a shame."<sup>67</sup>

### 2.4. International references

Numerous international references are mobilised within the Service of Psychosocial health cares.

A workgroup has been set up on Helsinki Declaration<sup>68</sup> implications. The World Medical Association<sup>69</sup> has developed the Declaration of Helsinki as a Statement of ethical principles to provide guidance to physicians and other participants in medical research involving human subjects. Medical research involving human subjects includes research on identifiable human material or identifiable data.

During the first ministerial conference on mental health organised by the World Health Organization - Regional Office for Europe<sup>70</sup>, an action plan on mental health was signed by the 52 countries. It was the first occasion for ministers to agree on action on mental health as part of public health policy.

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<sup>67</sup> Quoted from an interview realised with a member of the Service of Psychosocial health cares

<sup>68</sup> <http://www.wma.net/e/policy/pdf/17c.pdf>

<sup>69</sup> [www.wma.net](http://www.wma.net)

<sup>70</sup> [www.euro.who.int](http://www.euro.who.int)

The action plan<sup>71</sup> is drawn up round 12 priority areas:

1. promotion of mental well-being
2. incorporation of mental health as a vital part of public health policy
3. reduction of stigma and discrimination
4. tailoring of services to different stages of life
5. prevention of mental ill health and suicide
6. access to good primary care
7. effective care in the community
8. partnerships across sectors
9. a competent workforce
10. effective information systems
11. adequate and fair funding
12. new evidence

Within this framework, a workgroup has been created in Belgium. Its mission is to realise an annual evaluation (swot analysis) of the Belgian practices.

Evidence-based policy development is clearly influenced by Anglo-Saxon practices.

Moreover, data recording related to patient's diagnosis is realised on the basis of the DSM IV.

### 3. Sector

Competences in mental health are divided among three care lines. Those care lines are under the guardianship of diverse public power levels or even of several at the same time. There is no guarantee of cares continuity or cares coherence.

The current trend is to promote coordination between actors under the guardianship of different power levels. This should lead to a new mental health cares programming model in terms of care circuits and networks. Pilot-projects and *therapeutic projects* have been initiated in this context and in the perspective of an evidence-based policy development. Nevertheless, the sector does not seem unanimously responsive to this new type of public management.

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<sup>71</sup> [http://www.euro.who.int/mediacentre/PR/2004/20041126\\_1?PrinterFriendly=1&](http://www.euro.who.int/mediacentre/PR/2004/20041126_1?PrinterFriendly=1&)

## **Annexe 8: File of the Plate-Forme de Concertation en Santé Mentale des Régions du Centre et de Charleroi**

Les Plates-Formes de Concertation en Santé Mentale sont des asbl agréées en tant qu'associations d'institutions et de services psychiatriques, comme défini par l'Arrêté Royal du 10 juillet 1990, modifié par les Arrêtés Royaux du 2 décembre 1998 et du 8 juillet 2003. A ce titre elles sont financées par le Service Public Fédéral Santé Publique, Sécurité de la Chaîne Alimentaire et Environnement (SPF SPSCAE) avec lequel elles ont signé une convention.

Sur l'ensemble du territoire belge, 13 Plates-formes de Concertation en Santé Mentale sont actives : 5 en Région flamande, une pour la région de Bruxelles-Capitale et 7 en Région wallonne. Chacune des Plates-formes couvre un territoire correspondant à la Province, à l'exception de deux provinces : le territoire de la province de Liège est réparti entre la PFC de Liège et la PFC germanophone, cette dernière couvrant le territoire de la Communauté germanophone, et le territoire de la province du Hainaut est divisé entre la PFC des Régions du Centre et de Charleroi et la PFC Picarde.

Les coûts de fonctionnement des PFC sont calculés sur base annuelle selon une formule particulière combinant une indemnité de base fixe par association et un montant variable en fonction du nombre d'habitants desservis par l'association.

Les Plates-Formes de Concertation en Santé Mentale ont pour but<sup>72</sup> :

1° d'organiser une concertation sur les besoins en matière d'équipements psychiatriques dans la région où sont situées les institutions et services membres de l'association;

2° de mener une concertation sur la répartition des tâches et la complémentarité en ce qui concerne l'offre de services, les activités et les groupes cibles, afin de mieux répondre aux besoins de la population et d'améliorer le niveau qualitatif des soins de santé.

3° de mener une concertation sur la collaboration possible et la répartition des tâches (en ce qui concerne les soins de santé mentale intégrés).

4° le cas échéant, de mener une concertation avec d'autres associations d'institutions et de services psychiatriques.

5° collaborer à une collecte de données et à l'exploitation de celles-ci, dans le cadre d'une étude nationale des besoins en matière des soins de santé mentale;

6° mener une concertation sur la politique à suivre concernant l'admission, la sortie et le transfert ainsi que la coordination de la politique médicale et psychosociale, sans préjudice des dispositions légales et réglementaires en vigueur.

Les activités de concertation d'une association se rapportent aux soins dispensés aux trois groupes cibles qui correspondent aux catégories d'âge suivantes :

- a) 0 - 18 ans,
- b) 19 - 65 ans;
- c) > 65 ans.

Au sein de l'association il est constitué, pour chacun de ces groupes cibles, un groupe de concertation. Ces groupes de concertation facilitent la création et le fonctionnement de réseaux

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<sup>72</sup> Decree of 10 July 1990 fixing accreditation norms applicable to psychiatric institutions and services association, Art 7

## 1. Description of the body

### 1.1. Organisational roles and missions

La Plate-Forme de Concertation en Santé Mentale des Régions du Centre et de Charleroi a été créée sous la forme d'une asbl le 16 février 2004, résultat de la fusion des Plates-Formes de Charleroi et du Centre qui existaient depuis 1992.

Son territoire d'action couvre les villes de Charleroi et de La Louvière ainsi qu'un territoire situé autour de celles-ci représentant une superficie de 1933,5 km<sup>2</sup>, soit une population de 729 564 habitants (au 1er janvier 2004).

La PFC compte 31 membres effectifs et un membre adhérent.

Membres effectifs :

- 6 services psychiatriques au sein d'hôpitaux généraux
- 2 hôpitaux psychiatriques
- 1 maison de soins psychiatriques
- 11 Services de Santé Mentale
- 4 initiatives d'habitations protégées
- 5 institutions conventionnées INAMI qui ont pour mission d'organiser une offre spécifique dans le cadre des soins de santé mentale
- 2 fédérations de médecins généralistes

Membre adhérent

- 1 association de parents de patients

En tant qu'asbl, la PFC dispose de deux organes de gestion. L'assemblée générale est l'organe souverain, elle se compose des représentants des membres effectifs et adhérent. Le conseil d'administration se compose comme l'AG, à l'exception du membre adhérent et des fédérations de médecins généralistes.

La PFC des Régions du Centre et de Charleroi entretient des relations privilégiées avec la PFC Picarde car elles opèrent toutes deux sur la Province du Hainaut, chacune sur son territoire. Une instance de concertation, l'Entre-Bureaux hennuyer, a été créée afin de favoriser un dialogue hennuyer.

En outre, certaines activités sont réalisées en collaboration par les deux PFC. Ainsi, le projet-pilote fédéral « Implémentation de la fonction de coordinateur de soins au sein des Plates-formes de concertation en soins de santé mentale, concernant le traitement de personnes présentant un problème lié aux substances » concerne l'ensemble de la Province, une convention de collaboration unit les deux plateformes. La PFCCC porte ce projet et a engagé une chercheuse dans ce cadre.

La seconde activité commune concerne « La médiation de plaintes ». Comme le prévoient la loi des droits du patient du 22 août 2002, les Plates-formes de concertation pour la Santé mentale ont pour mission de mettre à disposition de leurs institutions membres un service de médiation. Celui-ci offre un lieu de prise en charge des plaintes liées à la relation entre le prestataire de soins et le patient. Les deux PFC sont associées dans la gestion de cette fonction, la médiatrice a été engagée par la PFC Picarde.

## 1.2. Fonctionnement et organisation de la concertation

### Activités internes

La PFC organise des groupes de concertation selon le critère générationnel, comme prévu dans les textes législatifs :

- Commission pédopsychiatrie. Deux recherches ont été menées dans le cadre de ce groupe.
- Commission « adultes ». Ce groupe s'est subdivisé en plusieurs sous-groupes thématiques : « cas complexes et chroniques », « handicap mental et troubles psychologiques associés », « abus sexuel intra et extra familial », « alcool ».
- Commission « seniors ». « Le groupe s'est attelé à détecter les lacunes de l'offre de soins ainsi que les problèmes de collaboration entre services [...]. Suite à ces constats, le groupe a cherché une méthodologie afin d'améliorer le travail en réseau. »<sup>73</sup>

Parallèlement à ces groupes de concertation, la PFC mène un projet-pilote « implémentation de la fonction de coordinateur de soins au sein des PFC concernant le traitement de personnes présentant un problème lié aux substances ». Ce projet est mené conjointement avec la PFC Picarde car il concerne la province du Hainaut dans son ensemble.

Comme le prévoit la Loi sur les droits des patients<sup>74</sup>, la PFC, comme toutes les PFC, a pour mission de mettre en place une fonction de médiation.

En outre, dans le cadre du projet-pilote « projets thérapeutiques et concertation transversale », cinq projets ont été élaborés sur le territoire de la PFC.

Enfin, la PFC offre un soutien logistique à l'association Similes<sup>75</sup>

### Activités externes

En dehors des activités propres à la PFC, celle-ci organise ou participe à de nombreuses activités de concertation externes.

Au niveau hennuyer, la PFC participe à différentes activités :

- L'entre-bureaux
- Le groupe de travail hennuyer sur la fonction de médiation. Il réalise régulièrement un état des lieux du développement de cette mission.
- Le comité d'encadrement du projet pilote relatif à la fonction de coordinateur de soins.

La PFC participe également à l'Inter plates-formes Wallonie-Bruxelles-Communauté germanophone et à l'Inter plates-formes. Fédérale.

Dans le cadre du projet-pilote « projets thérapeutiques et concertation transversale », la PFC participe au Comité de pilotage du Comité d'accompagnement de ce projet.

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<sup>73</sup> Rapport d'activités 2006

<sup>74</sup> Loi du 22 août 2002 relative aux droits du patient. MB 26-09-2002

<sup>75</sup> Association de parents de patients.

En dehors de ces activités, la PFC exerce des fonctions de représentation ou de participations dans différentes instances de concertation comme la « Concertation assuétudes du Pays de Charleroi », d'autres associations locales ou encore l'Institut Wallon pour la Santé Mentale et le Conseil Régional des Services de Santé Mentale.

## **2. Knowledge**

### **2.1. Knowledge production.**

Concernant la production des savoirs, la PFC de Charleroi joue un rôle à deux niveaux.

Elle joue le rôle de relais entre les acteurs de terrain et les autorités politiques et administratives. Lors des réunions de concertations des différents groupes, les acteurs qui travaillent directement avec les patients échangent et partagent des savoirs-faire. L'objectif de ces réunions c'est de savoir quelle est l'offre de soins, quels sont les moyens que les autorités mettent à disposition du terrain et quelles sont les lacunes. La PFC rassemble ces savoirs, les met en forme et les transmet aux autorités (CF, RW et fédéral) sous forme de courrier officiel. « Il y a un savoir sur le terrain et on le fait remonter. »<sup>76</sup> La plupart du temps, la remontée de ces savoirs s'accompagne d'une demande de subsides supplémentaires. Ce rôle de relais peut également mais plus rarement se jouer dans l'autre sens. Le SPF a demandé à la PFC de faire des recommandations pour le prochain ministre pour ce qui concerne les soins relatifs aux assuétudes. « Ce qui est dommage, c'est qu'on a parfois l'impression qu'on nous consulte pour dire qu'on nous a consulté. Ca se fait avec des délais très courts, il faut répondre dans la semaine. »<sup>77</sup>

Parallèlement à ce double rôle de relais, la PFC participe activement à la production de savoirs. En ce moment, la PFC a deux recherches en cours bien que cela ne fasse pas partie de ses missions, « donc on doit faire attention pour notre agrément ». La première recherche concerne la pédopsychiatrie, la PFC a engagé l'IWSM sur fond propre pour faire un travail de répertoire intelligent et un travail d'analyse des collaborations. Le choix des informations reprises dans le répertoire a été réalisé en collaboration avec le terrain. Cette recherche a une durée de deux ans. Un colloque est organisé à l'occasion de la fin de la recherche pour diffuser les résultats au secteur. Dans un premier temps, le rapport reste la propriété de la PFC. La seconde recherche est financée en grosse partie par le Relais social de Charleroi et de La Louvière (lui-même financé par la RW) et est co-financée par la PFC. Cette recherche « Samenta » porte sur la prise en charge des problèmes de SM des SDF louviérois. L'objectif est de développer un réseau de prise en charge. Un rapport de recherche devrait être publié à la fin.

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<sup>76</sup> Extrait d'un entretien réalisé avec un membre de la PFC.

<sup>77</sup> Extrait d'un entretien réalisé avec un membre de la PFC.

## **2.2. Knowledge mobilisation.**

Les types de savoirs mobilisés au niveau de la PFC sont divers. D'une part, des savoirs organisationnels sont utilisés. L'objectif est de voir comment, en fonction des moyens disponibles, améliorer le service aux usagers ou de voir comment augmenter ces moyens. « Ca va jusqu'à des conseils pour adapter des décrets. » En général, les discussions se focalisent autour du manque de moyens, du manque de places, du manque d'infrastructures adaptées à des problèmes précis. D'autre part, des savoirs thérapeutiques sont mobilisés. Dans les différents groupes de travail, les intervenants échangent des conseils, partagent des pratiques, présentent des modalités particulières de prise en charge. « Evidemment, dans les groupes de travail, personne ne va dire : c'est notre façon de travailler la meilleure. »<sup>78</sup> Dans certains groupes, notamment dans le groupe « pédo-psychiatrie », les discussions s'organisent autour d'études de cas. Un intervenant présente une situation problématique et demande aux autres partenaires s'ils ont des solutions et quelles sont les ressources du réseau.

## **2.3. Knowledge circulation.**

Au niveau de la circulation des savoirs, la PFC

La PFC dispose d'un centre de documentation, bien que cela n'entre pas dans les conditions de son agrément. La coordinatrice de la PFC a parlé de cette initiative à l'ensemble des commissions et groupes de travail. Néanmoins, la documentation que renferme la bibliothèque n'est pas consultée.

La circulation de l'information entre les membres de la PFC se réalise principalement de manière informelle lors des réunions des différents groupes de travail.

Comme cela a été mentionné plus tôt, la PFC joue également un rôle d'interface entre les acteurs de terrain et les autorités administratives et politiques.

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<sup>78</sup> Extrait d'un entretien réalisé avec un membre de la PFC.