THE SYSTEM FOR ADDRESSING PERSONAL PROBLEMS
From Medicalisation to Socialisation:
Shifts in Belgian Mental Health and
Psychiatric Institutions

Sophie Thunus

Thesis directed by Frédéric Schoenaers, Professor of Sociology,
Institute of Human and Social Sciences, University of Liège
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MEMBERS OF THE JURY:

Frédéric Schoenaers	Professor of Sociology, Institute of Human and Social Sciences, University of Liège
Didier Demazière	CNRS Research Professor, Centre for Sociology of Organisations
Steve Sturdy	Professor of the Sociology of Medical Knowledge, University of Edinburgh
Richard Freeman	Professor of Social Science and Public Policy, University of Edinburgh
Erhard Friedberg	Professor emeritus of Sociology at Sciences Po Paris
François Pichault	Professor at HEC, Management School, University of Liège

To my grandparents,
Hélène and Maurice

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Preliminary Remark:
Quotes from books, policy and organisational documents, interviews and field observations have been translated from French to English by the author.

GLOSSARY

CMHS Community Mental Health Services are outpatient services involving multidisciplinary teams performing mental health prevention and promotion, demand reception, diagnosis and treatment functions, based on medical, psychological and social approaches.

FPS PH The Federal Service for Public Health, Food Chain Safety and Environment is the administrative department of the federal minister in charge of public health and social affairs.

IMC The Inter-Ministerial Conference is a public health policy committee composed of the federal, regional and community ministers in charge of mental health and psychiatric policies.

ISH The Sheltered Housing Initiatives are alternative housing facilities based on psychiatric rehabilitation principles and designed to help people in recovering social skills and autonomy.

KCE The Knowledge Centre for Health Expertise is a federal agency aimed at improving healthcare quality and facilitating a more efficient allocation of healthcare resources by assessing new technologies and stimulating changes in healthcare financing.

MHCDP The Mental Health Care Dialog Platforms are private non-profit associations of residential and non-residential psychiatric and mental health services designed to improve mental health care quality and continuity for definite target groups in their catchment areas, and to report the needs of their members to federal and regional public authorities.

MPS The Minimum Psychiatric Summary is an instrument designed to collect evidence on hospital care services, to serve as a basis to improve psychiatric hospitals' planning and financing. It was implemented in psychiatric hospitals and psychiatric wards of general hospitals in 1996, and in the sheltered housing initiatives and psychiatric nursing homes in1998.

NACH The National Advisory Council for Hospital Services is a federal advisory body containing three working groups: university hospitals; rest and care homes; and psychiatry. The psychiatry working group actively supported mental health policy making from 1996 to 2010.

NIHDI The National Institute for Health and Disability Insurance is a federal agency responsible for the general management of compulsory health insurance.

PNH The Psychiatric Nursing Homes are small and multidisciplinary structures offering permanent care for chronic and stabilized patients.

PRC The Psychiatric/Psycho-social Rehabilitation Centers are community services with a therapeutic intent, directed toward social and professional insertion and providing comprehensive rehabilitation plans based on different techniques including the use of practical aspects of daily life.

WHO World Health Organization

INTRODUCTION

This thesis tells the story of the Belgian system for addressing personal problems. The expression "personal problems" is borrowed from Abbott (1988). In a chapter devoted to *The Construction of the Personal Problems Jurisdiction* (idem, pp. 280-315) in the United States, Abbott related the building of "a cultural jurisdiction" through the gradual "shaping of undefined tasks into a series of adjacent jurisdictions" (idem, p.281). He explained how problems which were conceived as everyday life problems in the middle of the 19th century were successively redefined according to evangelical, neurological and psychic approaches respectively claimed by the Clergy, psychiatrists and psychotherapists.

Drawing on the assumption that public and expert conceptions of mental illness varied following changes in the society, medical knowledge, culture and beliefs (Rowe & Thompson, 2011), the expression "personal problems" involves an invitation to question the progressive synthesis of new knowledge and institutions, which succeeded in shaping personal problems in different ways over time. Accordingly, it appeared suitable to our intent to relate the development of the Belgian system for addressing personal problems by relying on a constructivist, comprehensive and processual approach to collective action.

By relating the gradual formation of the Belgian system for addressing personal problems this thesis accounts for the growth of interdependent professions and institutions involved in dealing with personal problems. In Belgium, personal problems have been labelled in different ways, from "madness" in the 19th century to "mental health" in the early 2000s. The concept has varied along with claims by social and professional movements to hold superior knowledge of personal problems. Such claims gave rise to intricate processes of negotiation, causing changes in social institutions framing collective action addressing personal problems. Meanwhile, successive institutional changes supported a gradual shift in the paradigm dominating the system, from medical and residential psychiatry to community and social psychiatry.

The story of the development of the Belgian system for addressing personal problems includes analyses of successive changes in the system. It starts with the entrance of personal problems into the public sphere during the first half of the 19th century. This "politisation" (R Freeman, 2012) of personal problems occurred following calls made by psychiatrists to medicalise personal problems, which at that time still fell under the judicial jurisdiction.

The story continues with the displacement of personal problems from the judicial to the public health jurisdiction, just after the Second World War. It relates the resulting growth of the system for addressing personal problems in the course of the 20th century. By relating past changes in the system, especially the first reform of psychiatry launched in 1974, the Busquin reform started in 1989, and the

therapeutic projects and the horizontal consultation, it highlights the progressive development of "linked ecologies" (A. Abbott, 2005) and a particular "system of concrete action" (Crozier & Friedberg, 1980) directing the change process unfolding in the system. Following this, and based on this conceptualisation of the system, the story focuses on the ongoing *Reform 107*. Reform 107 was designed to support a shift from a medical to a social conception of personal problems. By relying on three case studies proposing in-depth analyses of collective action at the institutional and local levels, it relates how Reform 107 was devised, and how it was translated into concrete practices through different local orders (Friedberg, 1997).

The story told in this thesis is based on a comprehensive (Weber, 2009) and processual (Corbin & Strauss, 2008) approach to collective action. We adopted this approach following successive enlargements of the scope of our research. The research process leading to this thesis is useful in understanding the progressive broadening of our research question. Our PhD project flowed from a European research project in which we participated from 2008 to the end of 2011. As a member of one of the two Belgian research teams involved in this project, we had the opportunity to carry out in-depth analyses of a policy initiative called the *Therapeutic Project and the Horizontal Consultation* (2005-2010). As the European project was coming to an end, Belgian policy makers launched a new reform of mental health care; Reform 107. We decided to devote our doctoral research to this new reform.

From the beginning of our research in the field of mental health in 2008 to the end of our doctoral research in 2011, our continuing fieldwork caused successive shifts in our research questions, which enlarged from the issue of organisational change in psychiatric institutions to the question of paradigm shift in the Belgian system for addressing personal problems. The following sections report four main shifts in our research questions, by relating them to changes in empirical reality on the one hand, and in the framework in which the research was carried out on the other.

From Psychiatric Institutions to Inter-organisational Networks

We started studying policy initiatives in the Belgian mental health care system in the framework of our master thesis, one year before working on the European research. At this time, the initiative of the therapeutic projects and the horizontal consultation was unfolding through seventy eight local pilot projects. It was designed to encourage multidisciplinary professional work and institutional partnerships through the testing of "therapeutic consultation". Therapeutic consultation took place in psychiatric institutions or mental health services participating in local pilots. It consisted of meetings between service users and different kinds of mental health professionals, including psychiatrists, GPs, social workers, psychologists, nurses and home care workers. One of these local pilots was promoted by an important psychiatric hospital located in the south-east of Belgium. Having met the coordinator

in charge of this pilot on the occasion of a research seminar organised at the University of Red city, we decided to analyse therapeutic consultation meeting taking place in this hospital.

At the beginning of the research, we intended to study the local implementation of the policy initiative by relying on the strategic approach to organised action, as defined by Crozier and Friedberg (1980; 1997). We started our fieldwork by wondering how local pilots were impacting on the organisation of work in the psychiatric hospital. Our observations of therapeutic consultations, complemented by interviews and documentary analyses, helped us to define the local order relevant to understanding the work of the pilot. This local order went beyond the organisational boundaries of the psychiatric hospital, to encompass local residential and non-residential institutions. These institutions, which were project partners, were already linked to one another in various ways, either through the involvement of key actors into several boards of governors or through joint participation in previous policy initiatives.

Those initial observations made it clear that change in psychiatric institutions was an inter-organisational issue. Granted, the psychiatric hospital was central to the inter-organisational local order, but the particularities of the pilot were not comprehensible without considering its formal and informal relationships with different kinds of services and institutions comprised in its organisational environment. Thus, our research questions first moved from analysing change in a single psychiatric institution to examining change in the relationships among different kinds of institutions belonging to the local organisational network. This first move appeared consistent with that made by organisational sociologists, i.e. from organisations as fixed entities to the organising of collective action.

The Emergence of Professional Issues

When we started our fieldwork, we devoted little attention to the issue of professions. However, our observations of the therapeutic consultations revealed that professional matters, including status, privileges, identities and knowledge, played an important role in structuring their interactions. Consequently, we decided to explore sociological works on professions, especially the work of Hughes (1963; 1971); the "process approach to professions" defined by Bucher and Strauss (1961); the Schatzman and Strauss' "sociology of psychiatry" (1966); the seminal work provide by Freidson on "the Profession of Medicine" (1988); and the Abbott's "System of Professions" (1988). These interactionist approaches to professions seemed particularly helpful in understanding two issues which were central to our research: those of heterogeneity and change in professional life. Indeed, empirical material collected by attending therapeutic consultations showed that mental health professionals belonging to the same professional group perceived new work procedures implemented through the pilots in different ways. However, since our Master's thesis was designed to carry out a strategic analysis of organisational change, we did not go deeper into the analysis of those issues at that stage of the research.

From Organisations to Public Action

Following this, our participation in the European research project gave us the opportunity to keep working on the policy initiative of the therapeutic projects and the horizontal consultation. This research had started two years before. It was devoted to the study of the interrelations between knowledge and policy in the fields of education and health. Entrusted with the analysis of this issue in the Belgian health sector, our research centre had decided to focus on mental health, especially the policy initiative of the therapeutic projects and the horizontal consultation.

In that framework, we analysed one more therapeutic project and the evaluation system associated with the initiative, termed the "horizontal consultation". The horizontal consultation denoted a very complex evaluation system involving representatives of mental health care providers, scientific experts and services user groups. Those actors claimed very different knowledge of mental health services, including evidence and experience-based knowledge, and they occupied very different positions in the system for addressing personal problems. While mental health care providers were powerful and traditional actors in the system, scientific experts and services user groups were participating in a mental health policy initiative for the first time. In spite of those differences, all of them were required to provide policy makers with proposals for the reorganisation of the system, based on their evaluation of the local pilots.

We analysed that device by relying on the two main analytical perspectives endorsed by the European consortium. The first was a "public action approach", which we understood as the enlargement of the premises of the sociology of organised action to the domain of public policies(Musselin, 2005). The second perspective was a processual and social approach to knowledge developed by Freeman and Sturdy (2014) in the framework of the European project. Our analyses of the horizontal consultation showed not only that the respective logics of action of those actors were relevant to the understanding of collective action, but that they were also interdependent (Friedberg, 1997) in producing knowledge of the working of therapeutic consultations. Thus, with a view account for the power struggles and negotiations caused by the collective drafting of policy proposals, we had to enlarge to scope of the research a third time, to include policy-makers, civil servants, different professional segments, mental health care providers, scientific experts and services user groups in the range of actors relevant to the understanding of change in the system.

Reform 107: Further Changes in the Belgian Mental Health System

At the outset of spring 2010, Belgian policy makers responsible for mental health and psychiatric policies launched a global reform of the system. This reform took place in the context shaped by the therapeutic projects and the horizontal consultation. That context was characterised by the collective disappointment of local actors in relation to the outcome of the therapeutic project and

the horizontal consultation. Indeed, disagreements and power struggles had significantly delayed the writing of the proposals, and local actors as well as scientific experts were convinced that they had missed an opportunity to position themselves as an obligatory passage point (Callon, 1986) in the reorganisation of the system.

The public event of May 2010 confirmed their feeling. The policy programme presented by policy makers, called the "Reform 107" with reference to an article of the Hospital Law, did not refer to their proposals. It nevertheless required local actors to take an active part in its implementation. The reform also entailed greater challenges. It was directed towards a complete shift in the institutional organisation of mental health care delivery, from a model based on hospital psychiatry to a model based on community psychiatry. This implied the creation of a flexible and responsive local mental health care network performing five care functions, ranging from early detection to socio-professional insertion. Given that policy objective, many actors coming from different fields of activities, including social work, employment, justice and health prevention, were expected to contribute to the reform. Moreover, knowing that the reform was likely to meet several impediments, policy makers and civil servants had devised the initiative in such a way as to enable local innovations, without making room for excessive appropriations. Such public management of local innovation implied that civil servants and the representatives of policy-makers were taking an active part in the process, through the continuing assessment of local initiatives. It follows that the new policy programme raised new analytical challenges relating to the simultaneous involvement of the political and professional ecologies (A. Abbott, 2005) in reorganising the system and their continuing interactions through multiple meetings taking place at the institutional and local levels.

Our first observations of that reform were realised between 2010 and 2011, when the European research was coming to its end. Our wish to continue our research led us to apply for a doctoral fellowship: not only was the new reform empirically and analytically challenging, but our master's thesis and the Know&Pol research had raised various analytical issues which had not been addressed through our previous research, particular those relating to change in professional systems. Consequently, we decided to define our doctoral project in such a way as to bring different approaches to organisations, professions and public action into a comprehensive framework, and to use that framework in analysing the ongoing Reform 107.

Back to the process

Exploratory fieldwork on Reform 107 confirmed the relevance of considering the simultaneous action of the political and professional ecologies. Therefore, we decided to carry out one case study focusing on policy making, in parallel with two additional case studies focusing on the implementation of the policy programme at a local level. Those case studies provided us with a detailed understanding of the workings of the change process at the federal and local levels. However, they also highlighted

particular aspects of the policy programme and local idiosyncrasies which were not comprehensible without considering the overall process of change in which Reform 107 was embedded.

Our commitment to understanding such particularities took us back to a longstanding process of change that gradually shaped the social and institutional organisation of the Belgian system for addressing personal problems. The system of concrete action that developed in the course of past changes in the system helped us to understand most local idiosyncrasies. Conversely, the particularities of the policy programme became comprehensible when related to policy learning (R Freeman, 2006) achieved through being involved in mental health policy making for several decades. Consequently, we decided to explore ongoing change in the system in connection with its past developments.

This decision implied seeking for the means to conceptualise the whole process, including past reforms and ongoing changes. In keeping with that objective, we improved our knowledge of the interactionist conception of social processes (Corbin & Strauss, 2008), which we related to the strategic approach to collective action defined by French organisational sociologists (Crozier & Friedberg, 1980; Friedberg, 1997). Drawing from those two perspectives on social action, we achieved a conception of the reform as part of an overarching process of change; that is, a sub-process of change which unfolded throughout continuing interactions between different kinds of actors coming from different worlds, but embedded into the same, enduring system of concrete action (Crozier & Friedberg, 1980).

A comprehensive and processual story of the development of the Belgian system for addressing personal problems

The analytical decisions taken in the course of the research process led us to propose a comprehensive and processual story of the development of the Belgian system for addressing personal problems. That story is not the only possible story of the system development; rather, it is a sociological account of past and ongoing changes in the system, which are intended to answer questions as to the meaning and social mechanisms underlying paradigm shift in the Belgian system for addressing personal problems. This account includes two parts; the first part focuses on past changes in the system, and the second part analyses ongoing changes taking place in response to Reform 107.

This first chapter is a methodological and theoretical chapter. It presents the comprehensive and processual approach employed in this thesis. First, it suggests combining the strategic approach to collective action proposed by Crozier and Friedberg (1980; 1997) with the interactionist approach to social processes (Blumer, 1986; Corbin & Strauss, 2008; A. L. Strauss, 1978). It argues that, in spite of differences relating to their understanding of the role of actors and the status of change in collective action, the combination of those two approaches offers opportunities to conceive of the processual,

ecological and strategic aspects of collective action. Six basic assumptions relating to how change unfolded in the Belgian system for addressing personal problems are then derived from those two approaches.

Following this, the chapter explores particular perspectives on professions (A. Abbott, 1988; Bucher & Strauss, 1961; Freidson, 1988; Hughes, 1963), organisations (Crozier & Friedberg, 1980; Friedberg, 1997; Thoenig & Crozier, 1975; Weick, 1976, 1995) and public policies, paying a particular attention to policy learning, social and process approaches to policy making (R Freeman, 2006, 2012; Hall, 1993; Radaelli, 1995). It stresses that past developments in those perspectives induced the gradual dismantling of the sociological subjects they focus on; respectively professions, organisations and policy making. Fourth, assuming a need to address the question of the social integration of social systems (Friedberg, 1997), it suggests mobilising the concepts of linked ecologies (as defined by Andrew Abbott (2005)) and that of concrete systems of action (as defined by Crozier and Friedberg (1980;1997)). These concepts are jointly used to "reassemble" (Latour, 2005) our understanding of the system for addressing personal problems.

Moreover, with a view to question the embeddedness of successive sequences of collective action into an overall change process, it suggests relying on the interactionist understanding of social processes (i.e. as consisting of successive sequences of action/interaction bringing about new conditions, which define the context in which further action/interaction take place).

Fifth, this chapter suggests complementing our framework with the phenomenology of embodied, inscribed and enacted knowledge (R Freeman & Sturdy, 2014). It argues that this phenomenology is particularly helpful in construing ongoing changes in the system, in a way consistent with the strategic and processual perspective underpinning our global methodological framework. The concepts of inscribed, embodied and enacted knowledge are finally used in structuring the empirical material collected through carrying out three cases studies presented in the second part of this thesis.

The second chapter presents the global context relevant to the Belgian system for addressing personal problems. It provides short explanations of the Belgian political, social and public health systems, before relating the interdependent growth of the fields of mental health and psychiatry and recent changes in international mental health policies and organisations, especially the World Health Organisation. By drawing from those pictures of the Belgian and international contexts, this chapter defines two contrasting "knowledge regimes" (Mangez & Delvaux, 2008), viewed as ideal-types comprising the main kinds of social regulations relevant to the understanding of collective action in the system.

The third chapter tells one possible story of past changes in the system. It relates the gradual building of the linked ecologies (including the residential, community and rehabilitation ecologies) through successive policy initiatives occurring in reaction to professional claims to hold superior knowledge of personal problems. The system of concrete action specific to the Belgian system for

addressing personal problems is progressively derived from focused analyses of past policy initiatives. In conclusion, it proposes to conceive of past initiatives as successive steps in moving toward a shift in the medical paradigm dominating the system, before suggesting a sociological conceptualisation of the system. Accordingly, the Belgian system for addressing personal problems is defined as a large social system composed of interrelated ecologies whose social integration in achieved though cross-regulation exerted by two coalitions of actors - the traditional and the reformist coalitions - with contrasting sociological properties. This conceptualisation finally supports the problematisation of the issue of change in the system as depending on the ability of proponents of a complete reform to remove cross-regulation from the ongoing change process, and to simultaneously ensure the continuing enactment of strategic resources specific to the reformist coalition.

In the second part of this thesis, ongoing changes in the system are analysed through three case studies, based on this grounded problematisation. The second part focuses on Reform 107, analysing how collective action unfolded through successive and interrelated sequences of collective action taking place at the institutional and local levels. A synchronic perspective is thus substituted for the diachronic perspective mobilised in the first part. It is composed of four chapters including one case study focusing on the creation of the policy guide launching Reform 107, two case study of the implementing of the reform at the local level, and a conclusive discussion.

The first case study relates the creation of the policy guide devising a new reform referred to as "Reform 107" hereafter. It starts by explaining the policy programme and the mental health care model inscribed in the guide, before presenting the individual trajectories of those who wrote the guide and the negotiation process which led to an agreement on Reform 107. It emphasises how knowledge embodied by the authors of the guide was brought together to create a new conception of change in the system for addressing personal problems, and how that conception was modified to fit in with different kinds of concerns expressed by policy makers and local actors in the course of the first enactments of the guide. Further enactments of the guide within local care systems are the focus of the two following case studies.

The second and third chapters relate the implementation of the guide in two local care systems with contrasting social and ecological configurations. They present in-depth analyses of the local life of the guide, from the moment when local actors decided to apply to participate in the reform, right through to the moment when the federal and local versions of the guide were put into practice. Accordingly, they relate the local "translation" (R Freeman, 2009) of the guide into exploratory projects designed to support the implementation of the reform, before analysing the enactment of those projects by front-line professionals. Based on these analyses, these chapters indicate meaningful changes in the social and ecological configuration of local care system and key analytical findings regarding the role of embodied and inscribed knowledge in collective action.

Fourth, the conclusive discussion involves: a brief reminder of the analytical and methodological decisions taken at the beginning of this work; a summary of key analytical findings

following from the first and second parts of the thesis; a schematic definition of the approach to change in collective action endorsed in this work; and a summary of key learnings achieved by using the phenomenology of inscribed, embodied and enacted knowledge to analyse ongoing changes in the system. Finally, a short conclusion highlights possible issues for further research, particularly that of studying meetings as particular settings where collective action is made up.

PART ONE – SETTING THE STAGE FOR CHANGE IN THE SYSTEM FOR ADDRESSING PERSONAL PROBLEMS

Chapter I – METHODOLOGY

INTRODUCTION

"The empirical world must forever be the central point of concern" (Blumer, 1986, p. 22). From the very beginning of this research project, we have attempted to "develop images and conceptions that can successfully handle and accommodate the resistance offered by the empirical world under study" (Idem, pp. 22-23). That objective has entailed going back and forth between the fieldwork, which unfolded over the entire time of the research, and sociological approaches to organisations (Crozier & Friedberg, 1980), professions (A. Abbott, 1988; Bucher & Strauss, 1961; Hughes, 1971), public policies (Hall, 1993; Muller, 2005) and social knowledge (R Freeman & Sturdy, 2014; Radaelli, 1995).

The methodological framework defined in this section suggests assembling concepts deriving from those sociological approaches, in a way suitable to the analytical problems that gradually emerged from our fieldwork. In reference to a "hypothetico-inductive approach" (Crozier & Friedberg, 1980; Friedberg, 1997), the gradual development of that framework and the analyses presented in the following chapters were nevertheless directed by a set of premises, which directed our attention to particular aspects of social reality.

> "Adopting a hypothetico-inductive approach, the organisational approach uses the experience of the actors … to reconstruct … the particular logic and properties of a local order …Therefore, priority goes to … the development of descriptive and interpretive models that fit the field … Of course, this discovery … does not obey a simple empiricism. Rather, it is structured by … a set of theoretical premises expressed in notions such as power, strategy, uncertainty and game…" (Friedberg, 1997, p. 218).

As explained in the general introduction, our research questions shifted from particular aspects of the Belgian mental health system, such as changes in psychiatric services and professions, to the process of change unfolding in this system over the course of several decades. We sought to understand this process, which seemed to be characterised by rapid and frequent changes in psychiatric and mental health services on the one hand, and by institutional stability on the other. This puzzling observation led us to considerably enlarge the scope of our research, considering the influence of different kinds of actors on the system's development, and the embeddedness of successive reforms

into a longstanding process of change characterised by a similar rhythm. The resulting approach can be defined as processual and comprehensive; it assumes that "correct causal interpretation of a concrete course of action is arrived at when the overt action and the motives have been both correctly apprehended and at the same time their relation become meaningfully comprehensible" (Weber, 2009, pp. 114-115).

The two main sociological paradigms on which our framework is based are interactionist sociology and the French sociology of organisations, as developed by Crozier and Friedberg (1980; 1997). Their strategic approach to organisations provided us with a "prior picture" setting "the selection and formulation of problems, the determination of what are the data; the kinds of relation sought for in data, and the forms in which propositions are cast" (Blumer, 1986, pp. 24-25). As explained in the general introduction, the application of interactionist sociology came later on in the process. Indeed, it is our interest in issues related to professional work that led us to the works of Hughes (1971); Freidson (1988); Bucher, Schatzman and Strauss (1961; 1968); and Abbott (1988; 2005).

We argue that, in spite of differences relating to their understanding of the role of actors/action, ideas/interests, and change in collective action, those two paradigms might complement one another in a way that enables meaningful analysis of a long and continuous process of change, without overlooking the obstacles and contingencies inherent to change processes. The four following aspects of the interactionist and strategic paradigms encouraged us to jointly use them in analysing such change processes.

First, although interactionists and organisational sociologists focus on different aspects of social reality (the former being primarily interested in actions/interactions continuously restructuring the meaning of things and social institutions, and the later in the role of strategic actors in shaping collective action in particular fields of activities), both are "essentially anti-deterministic" (Strauss, 1978, p. 16) perspectives, stressing the role of human agency in forming collective action and social institutions (Friedberg, 1997, pp. 141-144).

> "The organisational approach focuses on human and collective action, that is, on the actors who initiate this action, and thus implies a theory of that actor. This theory … assumes the existence of actors whose behaviour expresses intentions … and cannot in any case be entirely explained by prior factors …" (Friedberg, 1997, p. 141).

> "Among the emphases deep in the interactionist tradition are those on social process … At the same time, they have assumed that human beings are active creatures, shaping their environment and their futures but also facing the constraints bearing on their actions …" (Strauss, 1978, p. 14).

Second, interactionists and organisational sociologists consider actors and action as situated in a particular context. That context influences the course of action without determining it. Its influence is mediated by the perception of actors whose interactions and negotiations are, in turn, continuously reshaping the context. By endorsing "an intermediate position between a world of no constraint whatever … and a structurally deterministic world" (Strauss, 1978, p. 14), the two approaches stressed a dialectic movement between "actors and systems" (Crozier & Friedberg, 1980).

Third, interactionists and organisational sociologists have, at first glance, a different conception of the role of ideas and interests in directing collective action. For the interactionist, "human beings act toward things on the basis of the meaning that the things have for them" (Blumer, 1986, p. 2). By contrast, for organisational sociologists, how "strategic actors" (Crozier & Friedberg, 1980; Friedberg, 1997) behave in a given situation depends on the nature of their interest. However, proponents of the two approaches agree on heuristic and contingent understanding of meaning and interest; an understanding "which does not exclude any motivation a priori" (Friedberg, 1997, p. 154). The Weber's notion of "motive", defined as "a complex of subjective meaning which seems to the actor himself or to the observer an adequate ground for the conduct in question" (Weber, 2009) allows us to go beyond an apparent opposition between ideas and interests. Moreover, that concept reminds us of the need to consider both individuals' past experiences (which are liable to influence their perception of a situation) and the observed situation (outside which the individuals' motives do not exist).

Fourth, interactionists and organisational sociologists have different conceptions of change in collective action. For interactionists, change is an unending process through which the meaning of things and social institutions are continuously renegotiated: "Social organization, disorganization and reorganization were perpetual processes and groups were in perpetual turnover and transformation" (Abbott, 2009, pp. 400-401). By contrast, the strategic paradigm[1] stresses the problematic character of change processes. It assumes that change always meets resistance from pre-existing "local orders" (i.e. informal regulations), into which change must be integrated before impacting on collective action: "Change is not a question of deciding on a new structure, technique, or method, but rather of beginning … a collective process which makes possible the mobilisation and even the creation of resources. This leads to the institution of new games" (Crozier & Friedberg, 1980, p. 221). Thus, relying on the interactionist and strategic paradigms allow us to conceptualise change as a continuing but problematic process, inducing permanent renegotiations of prevailing local orders in the light of current stakes. On the whole, assembling the interactionist and strategic paradigms draws attention to the role of human agency in directing social interactions and calls for a situated understanding of

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[1] The issue of change requires distinguishing between the sociology of organisations developed by Michel Crozier and shift toward the collective action accomplished by Erhard Friedberg (1997, pp. 107-117). In contrast to Crozier, who conceived of organisations as definite social entities to be studied as such, Friedberg *dismantled* organisations (Dubois, 2014). Conceiving organisations as contingent and provisional local orders, Friedberg devoted more attention to the heterogeneity and discontinuity of collective action (Friedberg, 1997, pp. 125-131). This move brought the French sociology of organisations closer to the Chicago School, which conceived of organisations as "a gerund rather than a name, a process rather than a thing*"* (Abbott, 2009, p. 399).

individuals' "motives", including ideas and interests. In addition, it simultaneously enables us to transcend the analysis of particular local orders to focus on global change processes, including successive changes in different local orders, without underestimating the strategic aspects of either of those changes.

Most of the methodological concepts and sociological perspectives mobilised in this work derive from the interactionist and strategic paradigms. Some of them are global sociological perspectives, likely to apply to the analysis of different kinds of social systems, while others are specific to psychiatric and mental health systems. Their presentation is not exhaustive, but rather is limited to aspects relevant to the analysis of the system's development. The following sections focus on three sociological objects, professions, organisations and public policies, which gave rise to sub-fields of sociology: respectively the sociology of professions; the sociology of organisations; and the sociology of public action. These three approaches gradually moved from unified and stable conceptions of their object, to conceptions stressing their heterogeneous and unstable character[2]. At the outset of his book *Local orders, The Dynamics of Collective Action*, Friedberg (1997) used the expression the "dismantling of organisations" (p.13) to account for such movement in the domain of organisation studies. In this section, we suggest enlarging that idea of dismantling (which stresses the increased complexity of particular fields of activities without ignoring their social integration (idem, p.73)) to apply to the fields of professions and public policies. Accordingly, we will successively present the shifting conceptions of professions, organisations and public policies, as well as methodological concepts intended to deal with the resulting complex and unstable sociological objects.

To conclude the sections relating to the sociology professions and organisations, we will particularly emphasise two key concepts: respectively the concept of "linked ecologies" (A. Abbott, 2005) and that of "systems of concrete action" (Crozier & Friedberg, 1980). These concepts arguably provide opportunities to take the heterogeneity and contingency of social systems into account, without rendering the social world a disintegrated and undifferentiated whole. By bringing them together into a single framework, we thereby intend to account for the progressive growth, stabilisation and integration of the Belgian system for addressing personal problems, through successive ecological moves directed by cross-regulations involving contrasted coalitions of actors.

Moreover, by presenting shifting perspectives on policy making, we will pay a particular attention to conceptions of policy-making as learning. Those conceptions are especially consistent with the processual approach to collective action endorsed in this work. Viewing policy-making as learning allows us to explore the extent to which successive reforms "reverberate" (R Freeman, 2012) one another and the encompassing process of change of which they are a part. The concept of "paradigm shift" (Hall, 1993) will be used in analysing that encompassing process. In turn, viewing

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[2] Such developments did not only occur in the domains of professions, organisation and the state. As noticed by Dubois (2014), the same kind of dismantling happened with the notion of market.

policy-making as learning implies looking at the concrete practice of policy making and analysing how different kinds of knowledge and instruments are continuously reassembled to fit in with changing policy objectives. The phenomenology of embodied, inscribed, enacted knowledge in policy as defined by Freeman and Sturdy aids us in carrying out such analyses. We will thus present the phenomenology before explaining how it complements our global methodological framework by making it suitable to the analysis of ongoing change processes.

1.   PROFESSIONS: FROM COMMUNITY TO ECOLOGIES

> "Professionals profess. They profess to know better than other the nature of certain matters and to know better than their client what ails them or their affairs. This is the essence of the professional idea and the professional claim …" (Hughes, 1963, p. 656).

The first sociological approaches to professions developed in the early 1930s. They defined professions as homogeneous social communities whose members shared values, "a sense of identity" and "a common language" (Goode, 1957, p. 194). These approaches assumed the existence of "organised bodies of experts who applied esoteric knowledge to particular case" (Abbott, 1988, p. 4). They were designed to analyse established professions with "elaborated systems of instruction and training, together with entry by examination and other formal prerequisites" (idem); for instance medicine and law. These approaches, defined as "trait-based" (idem), focused on listing different characteristics of professions and highlighting their social function. Based on the postulate that "the professional man" was engaged "in performing services to his patient or client, or to impersonal values like the advancement of science" (Parsons, 1939, p. 458), they were consistent with the functionalist perspective dominating social theories at that time. In the domain of professions, this meant considering their technical competence and social authority as functional requirements:

> "The professional man … often exercises his authority over people who are … his superiors in social status, in intellectual attainments or in moral character. This is possible because the area of professional authority is limited to a particular technically defined sphere … Functionally specific competence is only one type of case in which functional specificity is an essential element of modern institutional patterns …" (Parsons, 1939, p. 460).

However, as social scientists were increasingly observing the internal diversity of professions, which contrasted with the image of a community, they suggested replacing the concept of professionalism with that of professionalisation (Wilensky, 1964). This move consisted in substituting "a natural process entailing a series of types" (Abbott, 1988, p. 5) for a list of properties defining professions. The concept of professionalisation allowed social scientists to account for internal diversity, which was viewed as a transitory state supposed to disappear as groups "gradually acquired all the marks of true professions" (idem, p.4), without questioning the social function of dominant

professions. In turn, this approach gave scientific justification to the fact that occupational groups of lower range remained outside the rewarding world of established professions.

New approaches to professions started developing in the early 1960s. Drawing from "a new political climate" (Abbott, 1988, p. 5), they directly questioned the dominance of established professions over occupational groups. In the meantime, they provided an alternative to "a model of professions which cannot account for variations in the institutional work of professional practice …" (Johnson, 1972, p. 90).

These approaches, developed by interactionist sociologists of the Chicago School, can be defined as constructivist. Among them, it is worth differentiating between: 1) critical theories, analysing professions as forms of occupational control (Johnson, 1972) and denouncing both "their monopoly over specific areas of the division of labour" (Larson, 1977, p. xiii) and the control they exerted over occupational workers and their clients (Freidson, 1988); and 2) "processual" or "emergent" approaches to professions (Demazière, 2011), which analysed "diversity and conflict of interests within a profession and their implication for change" (Bucher & Strauss, 1961). In the remainder of this section, we present the main sociological works issued from the second tradition.

1.1. Professions as Social Constructions

In the 1970s, when he started teaching at the Chicago School of Sociology, E. C. Hughes replaced the course entitled *Sociology of Professions* with a course entitled *Sociology of Work and Occupations* (Heath, 1984); a shift that denoted his conception of professions as social constructions. Drawing from George Simmel's work on identity and institutions, Hughes thought of professions as cultural forms emerging from and in social interactions (idem). Therefore, methodologically, Hughes' approach to profession meant a commitment to fieldwork, in-depth analysis and detailed descriptions of the concrete work and interaction of occupational workers of multiple kinds.

According to Hughes, every occupational group was seeking to obtain a "license" authorising its members to perform "certain activities which others may not, and to do so in exchange for money, goods or services" (1963). This licence included a wide range of specialised activities as well as limited number of technical acts. The license was completed by a "mandate", denoting social privileges associated with the license, including the right for professional men "to define what proper conduct of others is toward the matters concerned with their work". In a similar way to the license, the scope of the mandate varied from profession to profession. For example, in the case of medical doctors, it expanded to the right to define "the conditions of work of many kinds of people [and the] very nature of health and disease." License and mandate were built and transformed within work organisations and through social interactions. They were socially constructed marks of difference instead of natural properties or functional requirements. By looking at the license and mandate of professional groups as social constructions, Hughes stresses the social process through which certain

occupational groups obtain more privileged status than others. In that sense, "professions come near the top of the prestige rating of occupations …" (Hughes, 1963, p. 657).

1.2. **The Process Approach to Professions**

Following Hughes, Bucher and Strauss (1961) developed a "process approach" to professions. It was designed "to supplement or to provide an alternative to the prevailing functional model" (p. 326). They argued that a profession was not a homogeneous community, but rather a heterogeneous assemblage of segments bringing differences, if not conflicts, into professional groups. Professional segments were not mere groupings but organised identities with definite ideologies.

Professional segments claimed a particular sense of mission and conception of work. Depending on how they defined the problem they were addressing, segments used particular methodologies and developed different kinds of relationships with their clients. They also created particular circles of colleagueship whose membership was limited to those acknowledging the segment's identity and values. Circles might occasionally enlarge to alliances, meaning sustained relationships with neighbouring professions or occupations with which the segment's members had more in common "than with their own fellow professionals" (idem, p.330).

The concept of the professional segment thus emphasised diversity within professional groups. Bucher and Strauss opposed that empirical diversity to what they termed the "spurious unity" (idem, p. 331) of professions, which resulted from the work performed by professional associations. Professional associations were created by particular segments to perform two specific functions: a cultural work, directed to impose the segment's ideology to the entire profession; and a social work, which consisted in negotiating institutional arrangements providing the segment with privileged status. However, privileged positions were always provisional; following changes in their "conceptual and technical apparatus, in the institutional conditions of work, and in their relationships to other segments and occupations" (idem), "movement is forced upon segments" (idem, p. 332).

Accordingly, the process approach not only accounted for professional diversity and the decoupling between empirical diversity and public unity, but it made professional change a continuous and situated process, which had to be understood in relation to a changing environment, involving competing professional segments and particular socio-technical conditions. In this respect, it pioneered the systemic approach suggested by Abbott in 1988.

A few years later, the "Sociology of Psychiatry" suggested by Schatzman and Strauss (1966) took a step further by proposing that sociologists should "utilize a more inclusive framework, one which has to do with the relationship of a profession to social movements" (p.6):

"As a field of study, psychiatry does not end with histories of professions and professionals; it begins there. Within psychiatry proper we find many special 'worlds'. However, these worlds are continuous and interrelated with other and equally complex worlds. On the periphery and

further out are many publics which stand in many relationships to psychiatry …" (Schatzman & Strauss, 1966, p. 8).

According to the authors, psychiatry had to be analysed as a set of interrelated processes including interprofessional processes, professional processes, public processes, socio-cultural and institutional processes. First, interprofessional processes were viewed as occurring within organisations where professionals with different interests and ideas were continuously negotiating local orders enabling their concrete cooperation (Strauss & Baszanger, 1992, pp. 87-95). Second, professional processes referred to power struggles among professional segments seeking to impose their ideology and to gain institutional arrangements. Third, public processes concern not only "quasi-psychiatric persons" (idem) as medical practitioners but also professionals and laymen remote "from the psychiatric province" (idem, p.9). They emerged as "public" (Blumer, 1949) "around specific issues bearing upon psychiatry" (Schatzman & Strauss, 1966, p. 8). Public process implied questioning "who understands what about mental disturbances" (Schatzman & Strauss, 1966, p. 8). Fourth, socio-cultural processes entailed particular contextual conditions enacted by social movements and defining "what mentally-ills need and the types of institutions and practices" (idem, p.11) responding to their needs at particular time. Fifth, institutional processes meant both limits and opportunities for the emergence of new ideas which, in turn, meant change in institutions. They drew attention regarding the meaning of institutions to those enacting them and how repeated enactment caused changes in institutions.

Thus, the sociology of psychiatry moved from systems limited to occupational workers to comprehensive systems encompassing multiple publics playing an active part in professional change. In the meantime, it anticipated the "Linked Ecologies" defined by Abbott in 2005.

1.3. **Applied and Abstract Knowledge as Defining Features of Professional Groups**

Given the emphasis on interactions and work organisations, interactionist sociologists of professions produced detailed analysis of professions' and occupations' concrete practices, stressing their diversity and contingency (Champy, 2009; Heath, 1984). Their approach led to a relaxing of the concept of the profession, while remaining mindful of the specificities of the related social processes. Drawing from Hughes and followers, E. Freidson and A. Abbott proposed new conceptions of professions, considering both the professional diversity observed at the micro-level and the image of unity ensured by professional institutions.

In *Profession of Medicine – A Study of the Sociology of Applied Knowledge* (1988)*,* Freidson straightforwardly questioned the power of established professions, emphasising their right to control the work of paramedical professions and the asymmetry of information characterising the doctor-patient relationship. However, by proposing an analytical distinction aimed at making sense of the

decoupling between empirical diversity and institutional unity, Freidson did not limit his work to a sociological critique of the established professions as medicine and law. The distinction between "professional men", thinking and acting politically in the name of the profession as a whole, and the individual practitioner whose target "is not knowledge but action" (Freidson, 1988, p. 168), provided a heuristic means to account for diversity in concrete professional practices without ignoring the public discourse to which they relate. Thus, following Freidson, the defining feature of professions was not so much to hold specialised and abstract knowledge, but to *apply* it in a way suitable to particular work conditions, clientele and segmental ideology.

In *System of Professions – An Essay on the Division of expert Labor* (1988), Abbott equally distinguished between the workplace (characterised by changes, diversity and conflict), and the public and legal arena (characterised by unity and stability). By analysing the relationship between professions' abstract knowledge and concrete practices, he attempted to reconcile "historical continuity of professional appearances with the day-to-day discontinuities of professional reality" (Abbott, 1988, p. xii):

> "The present model arises, essentially, by extending the Hughes logic to its limits and focusing on jurisdictional interactions themselves. Interactionist students of professions have continued to threat the profession as the unit of analysis … I have gone one step further. Moreover, by treating jurisdiction not only in the work environment but also in the much more formal public and legal environments I have tried to handle what I regard as the classic problem of interactionism – its inability to explain the evident stability of many interactions over time ..." (Abbott, 1988, p. 112).

1.4. The System of Professions

The *System of Professions* (A. Abbott, 1988) started with the assumption that professional problems have both objective and subjective qualities. Professional problems are human problems amenable to expert knowledge. As human problems, they have more or less evident objective qualities. For instance, personal problems are typically associated with sadness and expressed through unusual behaviours. Their subjective qualities result from the application of professional knowledge to those objective qualities (idem, pp. 35-40). For instance, if a specialist considers that a patient's sadness results from overwork, (s)he will diagnose a burn out. That diagnosis means specific treatments, possibly leaving aside other aspects of the problem, for instance abuse of alcohol or family problems, which another specialist might have considered to diagnose the problem. Thus, following Hughes, Abbott emphasised how professions take "problems out of their particular settings and make them a part of some more universal order" (Hughes, 1963, p. 660).

Relying on that assumption, Abbott argued that the professional world had no empty location; there were neither tasks waiting to be claimed by occupational groups nor occupational groups *meant*

to deal with particular tasks. Instead, there existed relationships between groups and tasks; these were progressively built up, following attempts by occupational groups to define concrete problems in abstract terms. Occupational groups succeeding in such attempts made the coveted tasks their own jurisdiction, at the exclusion of competing occupations. As Abbott put it, "through this reshaping of objective facts by subjective means there emerge a fully defined tasks irreducibly mixing the real and the construct …" (Abbott, 1988, p. 57).

The concept of jurisdiction is thus central to the Abbot's system of professions (idem, p.59). A jurisdiction is the relationship between an occupational group and an area of tasks. It has cultural (knowledge) and social (institutions) dimensions. Knowledge is viewed as the means by which an occupational group acquires a particular position in the system, while institutions help it in securing that position over a given period of time. The jurisdiction is preferably exclusive. There are some means (such as delegation) for professional groups to share their jurisdiction with competing occupations, but their purpose is to control the profession's social and cognitive structure. Controlling their cognitive structure is, according to Abbott, decisive in relation to the ability of professions to protect their jurisdiction from external assaults.

To keep controlling their cognitive structure, professions need to find an "optimum abstraction" (idem, pp.105-108), involving a definition of their problems which is neither too far from, nor limited to, their objective and most visible aspects. If professional knowledge is too abstract, it becomes difficult for the profession to account for its relationship to particular problems. In that case, "abstractions are simply generalities without legitimacy" (idem, p.103). "But paradoxically, too little abstraction can make a jurisdiction weak as well. While clients appreciate the simple case that shows them how professional knowledge work, they will not treat as professional a skill whose knowledge is all obvious to them" (idem). Therefore, the optimum level of abstraction ensures professions keep their jurisdiction by remaining accountable to and trusted by their public. This level varies over time depending on changes in social and cultural knowledge, which influence how and what the public know about the issue in question.

The consequences of the Abbott's reasoning are threefold. First, in a way similar to professional segments, "professions constitute an interdependent system. A move by one inevitably affects the other" (idem, p. 86). It follows that professional change is better understood by focusing on the interactions between several professions than by separately studying their internal dynamics. Second, "no profession can stretch its jurisdiction infinitely. For the more diverse a set of jurisdictions, the more abstract must be the cognitive structure binding them together. But the more the binding idea, the more vulnerable they are to specialization within" (Abbott, 1988, p. 88). Therefore, change in a profession is viewed as the normal result of jurisdictional growth, instead of an abnormality in a profession's life course. Third, jurisdictional claims cannot be considered outside the system of professional relationships and the social context in which they take place. Being subject to external

judgement and possibly opposed by competing occupations, jurisdictional claims are preferably consistent with social values, technical conditions and the configuration of the professional system.

1.5. **The Linked Ecologies**

In his article *Linked Ecologies* (2005), Abbott argued that his *System of Professions* (1988) had underestimated the ability of other systems, or ecologies, to oppose professional projects. He explained he had made the same mistake as classical ecological theories, which assume the existence of a complex social system with fixed surroundings, as the state and the public were assumed to be in his earlier work.

The linked ecologies argument recognised the complexity of each ecology and its surroundings. In other words, the environment of ecologies consists of adjacent ecologies, encompassing interdependent groups competing for privileged positions. It follows that the success of a coalition of actors (such as a professional segment) in reaching its objective (e.g. obtaining professional licensing) related to the potential of building an alliance with coalitions of actors from an adjacent ecology, equally concerned with the issue at stake.

By reconceptualising "the social world as made of linked ecologies, each of which acts as (flexible) surrounds to each other" (idem, p.246), Abbott added a second layer of contingency to the understanding of social systems. However, he also insisted that social systems were not undetermined ones; although the ecological argument supposed emergent entities and changing alliances, it does not imply random social processes. As explained below, multiple ecologies mean multiple *differences* in the social world, and imply the need for social actors to negotiate means to accommodate those differences.

According to Abbott, ecologies include actors, locations and the relationships between the two. Actors, location and their relationships emerged from a process of collective defining, through which problems are recognised and conceptualised in specific ways. As Abbott put it:

> "Professional 'location' – a task like obesity or alcoholism – is not a location by virtue of having as set of abstract properties that position it in some abstract or cultural space in advance of social interaction, but by virtue of the fact that various professions have constituted certain sets of social, psychological, and biological phenomena as obesity or alcoholism in the process of fighting over the vast array of potential expert work in the society." (Abbott, 2005, p. 249)

Assuming that "tasks come first, then professions, then links" (idem, p. 248), the "intermediate account" suggested by Abbott[3] (idem, p. 245) supposes the reciprocal inscription of actors and location, which progressively gives rise to ecologies. In order to denote such relational processes,

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[3] Abbott contrasted the ecological theory, which he conceived as an intermediate account of social systems, with both the individualist account (considering social systems as "the additive result of individual phenomena"(p.245)), and the emergentist account (regarding social systems as constituting "an independent level whose fully social structure coerce individual phenomena" (idem)).

bringing about different kinds of relationships between actors and locations, Abbott suggested the concept of litigation. In the *Linked Ecologies*, he distinguished between three kinds of litigation, associated to three different actors: respectively the state ("bundles"); universities ("settlements"); and professions ("jurisdiction"). For the purpose of this work, we are not going to distinguish between jurisdiction, settlements and bundles, but instead will keep "the basic concept of an ecology made up of a set of actors, a set of locations and a set of links between them" (idem, p. 251). Moreover, in reference to *Things of Boundaries* (2001), where Abbott argued that "boundaries come first, then social entities", we will consider that actors seeking to claim jurisdiction over a set of tasks start by claiming a "difference" in the way they relate to that task. Following this, the types of actors, locations and the nature of the links between them will remain an empirical question.

The creation of ecology thus starts with actors claiming a different kind of relationship to a particular problem; for instance, the creation of social work started with occupational workers contending that they related in different and more appropriate ways to personal problems than psychiatrists, limiting the latter to medical aspects of care. But how do two or more ecologies converge to form an alliance at a particular time? According to Abbott (2005), ecological alliances imply that the concerned ecologies have the potential for contact. In turn, "the possibilities for contact and alliance are shaped by the internal character" (idem, p.253) and the "temporal structure" (idem, p.254) of the ecologies to be linked. The "internal character of ecologies relate to their "material form", which includes the "actor size, distribution and exclusiveness" (idem, p.253). The temporal structure relates to the respective rhythms of adjacent ecologies. Differences in material forms and "temporal grains" (idem, p. 264) are factors facilitating or hindering the potential for contact. For instance, two ecologies operating at different paces and composed of a small number of very exclusive actors have only few opportunities for developing longstanding alliances. However, similar ecological structures are not sufficient conditions for ecological alliances to arise. Ecological alliances lastly depend on an agreement of a strategy which is rewarding for two or more ecologies at the same time. Abbott used the concept of the "hinge" (idem, p. 255) to define such mutually rewarding strategies.

Although hinges are necessarily shared by linked ecologies, they do not have the same meaning for the different ecologies forming parts of an alliance. If we consider, for instance, an agreement on the reform of psychiatric institutions, we can easily agree that such reform means an opportunity to comply with international standards in the political ecology: this comprises a threat for the professional ecology of the psychiatrist and a success for the social movement calling for such reform over several decades. It is in fact essential that hinges hold different meanings to different ecologies; otherwise they would not be ecologies but undifferentiated groupings to which the meaning of things would be fundamentally uncertain. If this were the case, social action requiring cooperation would happen randomly, outside institutions stabilising the meaning of things for a limited period of time. In contrast to such a view of social processes as "undifferentiated flow" (idem, p.255), Abbott's

argument postulates a double contingency, asserting that "events within any particular ecology … are hostage in some sense to events in adjacent ecologies" (p.254).

1.6. **Conclusion**

By drawing on the sociological concepts presented in this section, we propose to consider professions as groups of occupational workers seeking to obtain a position in the national system to address personal problems. They base their claims on particular knowledge of the nature of personal problems. Their position in the system is stabilised insofar as they receive a license, ensuring them an exclusive relationship to those personal problems, which is preferably complemented by a mandate, allowing them to impose their ideology over competing occupations and adjacent ecologies. Moreover, by relying on the distinction between applied and abstract knowledge, we will distinguish between: 1) public discourses and formal structures formalising and institutionalising a relationship between an occupation and personal problems; and 2) concrete practices and social interactions, which vary depending on local contexts and individual preferences. At the level of individual practitioners, we will consider those variations as pragmatic adaptions to uncertainties inherent to collective action. At the level of the system, we will consider that differentiated enactments of professional license and mandate indicate an increasing gap between public discourse and concrete practices.

At the same time, professional groups will be conceived as embedded in linked ecologies whose internal developments determine, in part, their ability to succeed in their respective projects. We will assume that every attempt by an occupation to take over the system for addressing personal problems must necessarily give rise to a hinge, defined as a rewarding strategy in relation to a particular problem for two ecologies at the same time.

The linked ecologies argument will be essential to our analysis of the system development. First, this argument will allow us to explore how different and interrelated ecologies have developed in relation to the addressing of personal problems. Second, it will encourage us to pay attention to the conditions in which ecological alliances are achieved. Third, it will draw our attention to connections between ecological moves and changes in the global context, including particular social and technical conditions. Fourth, at a system level, it will enable us to understand the meaning of successive ecological moves in the context of a global-scale change process. Fifth, at the level of actors and coalitions of actors, it will allow us to account for the "difference" they claimed in relation to addressing personal problems, without reducing them to organisational and professional logics. In other words, it will give us the opportunity to show that actors and groups differentiate themselves by relying on various sites of difference that they assemble in particular ways depending on the situation they face.

2.   ORGANISATIONS

"We no longer need to focus attention on the organization as an object or well-defined social instrument. What is now in question is the study of the diffuse and omnipresent social processes by which the relationships between interdependent actors in a given field of action are channelled and regulated…" (Friedberg, 1997, pp. 114-115).

By describing "the dismantling of organisations", Friedberg encouraged the gradual questioning of the "classical model of organisations" (Friedberg, 1997, p. 17), especially the assumption that organisations are homogeneous entities with clear boundaries, and the notion that they are designed to achieve predefined and external objectives in a mechanistic fashion.

First, works on "individual and organisational rationalities" (Simon, 1972, p. 161) supported a shift from a view of organisations as simple means to achieve predefined objectives, to a conception of organisations as contexts of action (Friedberg, 1997). The idea of the context of action implies the possibility for different actors to enact organisational structures in different ways, depending on the situation, their perception of organisational objectives, and the means they have at their disposal to reach those objectives (idem). The concept of "bounded rationality" (Simon, 1972) and that of the "position and disposition effects" (Boudon, 1989) successively emphasised factors limiting and influencing actors' rationality. On one hand, the concept of bounded rationality stresses that rationality is always limited in some ways, relating to available information and the extent to which actors and organisations are able to consider and examine each piece of information available to them. On the other hand, position and disposition effects (Boudon, 1989) highlight the fact that the actors are socially situated: their rationality is continuously mediated by their position, "which makes them perceive the reality in one light rather than in another" (idem, p.73) and by past experiences, or *dispositions*, leading or allowing them "to interpret the same reality in different ways" (idem).

Second, representations of organisations as "loosely-coupled systems" (Weick, 1976) questioned their internal homogeneity and consistency. The idea of loosely-coupled systems emphasised that organisations are not able to impose their objectives (which are not endowed with any kind of superior legitimacy) over individual actors holding their own objectives, leading them to use different and often conflicting strategies. The potential for organisations to reach predefined objectives thus depends on limited and provisional meetings between multiple strategies used by actors in responding to each other's actions. The concrete working of organisations becomes, consequently, almost completely uncertain: "… the field for the game is round; there are several goals scattered haphazardly around the circular field; people can enter and leave the game whenever they want to, they can throw ball in whenever they want to, they can say 'that's my goal' whenever they want to … for as many goals as they want to …" (Weick, 1976, p. 1).

Third, Friedberg did not view the environment of organisations as stable, but rather as being continuously redefined through "reciprocal translation" (Friedberg, 1997, pp. 59-61), equally involving organisations and their environment. In contrast to the classical model, which postulated clear organisational boundaries defining an inside and an outside functioning independently from each other, this emergent conception viewed the organisational environment as being built up by organisations themselves, according to their changing perception of elements present in their environment. Their perception was mediated through particular relationships between members of the organisation and actors representing parts of their environment. Those actors could not perceive every aspect of the organisation and its environment, and the extent to which they agreed to share their perception with one another inevitably changed in the course of their interactions. The environment of organisations thus transformed in the course of interactions involving such "relay actors". Changing environments caused changes in organisations, through successive adaptations of their strategies, which, in turn, brought about further change in the environment.

Following that "complexification" (Friedberg, 1997, p. 73), organisations appear as contexts of action, enacted by actors or coalitions of actors pursuing their own interests and responding to each other by using multiple strategies, representing the most rational way they found to adapt themselves to a changing environment. Organisational objectives, structures and environment continuously changed and nothing remained, at first glance, to hold such a heterogeneous whole together.

Such an image of organisations raised the question of their permanence – Weick wondered "how can such a loose assemblage retain sufficient similarity and permanence across time that they can be recognized, labelled and dealt with?" (1976) – as well as the potential to "integrate behavior in collective structures" (Crozier & Friedberg, 1980, p. 48). The intermediate perspective suggested by Crozier and Friedberg helped to formulate a response to that question without returning to a "mechanistic model of functional determinism" (idem, p.121). This process involved both a strategic argument, relating to the integration of actors with conflicting interests at the organisational level, and a systemic argument, relating to the regulation of large-scale and inter-organisational systems through interdependent games.

2.1. **Local Orders**

Crozier and Friedberg (1980) conceived the formal structure and rules of organisations as necessarily incomplete. Crozier demonstrated that even very bureaucratic systems failed in their attempt to control every aspect of work and to eliminate unexpected events (Crozier, 1963). Later, Friedberg argued that formal structures and rules did not constitute a relevant factor in distinguishing between organisations and the hazier idea of "contexts of action" (Friedberg, 1992). Formal organisations always entailed "zones of uncertainties", representing opportunities for actors to develop informal regulations, or "local orders", directing the concrete functioning of organisations (Crozier & Friedberg, 1980). Local orders not only provided concrete regulation supporting the social integration

of divergent behaviours, but also defined relatively stable strategies accounting for organisational stability.

The collective building of local orders started with the emergence of a common problem whose solution was uncertain. Requiring the cooperation of individual actors with conflicting interests, such uncertain problems caused negotiations relating to the very conditions under which strategic actors agree to cooperate (Friedberg, 2009). Accordingly, as Crozier and Friedberg put it, collective action constitutes a concrete problem rather than a simple solution for collective problems (1980, p.15).

By negotiating the conditions of their collaboration, actors sought to impose a definition of the problem, defining a context in which they have appropriate resources to impose themselves as key actors. Depending on their respective power, defined as the capacity to act on a particular situation (Friedberg, 1997, p. 183), actors have more or less opportunity to impose their conception of the issue at stake. In this respect, the most powerful actors are relatively autonomous actors holding relevant expertise and information in relation to the problem at hand. By allowing them to endorse unpredictable behaviour, for instance by proposing an innovative solution to the problem at stake, their relative autonomy prevents such actors from being easily replaced by other actors.

Such negotiations typically resulted in a particular definition of the common problem, including a set of appropriate solutions, the respective role of the involved actors, and relationships and interdependencies between them in enacting those solutions. That division of work and the corresponding social configurations would not necessarily reflect the formal structures and rules of organisations. Instead, they consist of "local orders" (idem, p.119), directing the concrete functioning of organisations and defining a set of rewarding strategies and interdependent games of cooperation, opposition and avoidance.

Local orders are always provisional; they can be renegotiated following changes in the global context or immediate organisational environment. However, considering that they involve particular social configurations and divisions of work representing a satisfactory solution for the actors involved, local orders are generally resistant to change. Change in some aspects of the organisation or work instruments can be achieved insofar as new elements are incorporated into prevailing local orders (Muhlmann, 2001). More significant change, supposing totally different roles and social relationships, requires changes in the games underpinning local orders, and thus the renegotiation of the very definition of the problem shared by the involved actors (Crozier & Friedberg, 1980).

2.2. **The System of Concrete Action**

The concept of a "system of concrete action" denotes:

> the "… structures of collective action through which a context of action is organized, that is, through which local orders are established and kept in operation, and which allow actors to

stabilize, at least for a time, their negotiation and strategic interactions … (Friedberg, 1997, p. 74).

Crozier and Friedberg (1980) first applied this concept to the analysis of organisations. At the organisational level, the identification of a system of concrete action was the result of strategic analysis of a particular organisation or collective action. It consisted in highlighting recurrent strategies and games negotiated by the actors involved and directing the concrete functioning of collective action. This concept was useful in accounting for the maintenance of a particular social configuration over a certain period of time, in spite of changing organisational environment. The concept of game involves:

"… Concrete mechanisms which men use to structure and regularise their power relations, while leaving these relations –and themselves– free … It is the essential instrument of organised action. The game reconciles freedom and constraint. The player remains free but must, if he wants to gain, adopt a rational strategy which conforms to the nature of the game … The game is a human construct … like every construct, it remains contingent." (Crozier & Friedberg, 1980, p. 56)

Then, assuming that "organisations represent a sort of experimental model of the system effects" (1980, p.116), Crozier and Friedberg moved on to analyse larger and comprehensive systems viewed as "structured (i.e. non-natural) fields whose various elements behave in coordinated and interdependent manner" (idem). Starting with this assumption, the analysis of systems of action consisted of identifying both their constituent interdependent elements and the dominant games through which their interdependencies were regulated. In the remaining part of this section, we will explore the definition of systems of concrete action as both multi-input and open systems, before of explaining their meaning in relation to change processes.

Systems of concrete action are not limited to particular organisations. In reference to the analysis of renal dialysis services provided by Kuty (Kuty, 1994), Crozier and Friedberg (1980) argued that it was possible, while studying situations of collective action, to show that different types of regulations drawn from different systems were working together. For instance, in the hospital units studied by Kuty, the understanding of particular actions necessitated the consideration of both strategies specific to the prevailing local orders, and ideologies enacted by professional workers connected to different segments. Confronted with the "complex problem of analysing the interaction of several different systems of action" (idem, p.129), Crozier and Friedberg suggested considering them as "multi-input" systems (idem, p.146), crossed by several kinds of regulation and games (Thoenig & Crozier, 1975), alternatively decreasing and enhancing the ability of strategic actors to cope with a particular problem in the desired way.

This definition of the system of concrete action gives it an equivocal status in relation to change processes. On one hand, systems of concrete action stand for "precarious and problematic structures imposed on human action". They are not only socially constructed systems, resulting from the *rewording* of collective problems by strategic actors, but also open systems, likely to be adapted to changes in their environment. On the other hand, by entailing the systematic mediation of external changes through dominant games, systems of concrete action represent powerful means of reproducing the social configuration characterising a field of activities. Therefore, when thinking about how to succeed in conducting change processes in social systems, Crozier and Friedberg suggested viewing it as a "sociological problem", which had to be sorted out through the collective learning of new games. In so doing, they envisaged a move away from the conception of change as resulting from either unending power struggles or successive improvements in technical and organisational settings, to a view it as the transformation of a system of concrete action through the collective learning of new games.

From this perspective, change in organisational procedures and rules cannot support major modifications in the organisation of a particular field of activities. Major reorganisation rather implies a "systemic process", taking into account dominant games and strategies involved by the system of concrete action characterising that field. This entails the displacement of the zone of uncertainties on which that system is based, facilitating the emergence of competing regulations and conflicts, and eventually leading to a rewording of common problems and the learning of new games. As explained by Crozier and Friedberg, even if the concerned actors honestly think that they are supporting the system's reorganisation, irrespective of whether or not that reorganisation might "ask them too much" (idem, p.217) (for instance by threatening their professional autonomy) they will seek to "manipulate the change" (idem, p.218) in order to maintain or to reinforce the "zone of uncertainty under their control" (idem). In this case, change is "assimilated" by the system of concrete action, preserving its social organisation. Crozier and Friedberg thus argue that only the "learning - i.e. the discovery, creation and acquisition by the actors concerned - of new relational models, new modes of regulation and similar collective capacities" (p.221) helps to implement major change in social systems.

2.3. **Conclusion**

By relying on the strategic approach to organisations, we will conceive mental health and psychiatric services and institutions as contexts of action, enacted in different ways by different actors in different situations. This conception is consistent with the ecological approach defined in the previous section. In turn, we will consider that collective action grows in relation to common problems, requiring the cooperation of multiple actors with different interests, and possibly specialised knowledge of the problem at stake. We will also pay a particular attention to the relationship between negotiations through which actors collectively determine the conditions of their collaborations and changes in the definition of the original problem.

Moreover, by drawing on the concept of the system of concrete action we will seek to identify games (cross-) regulating the development of the Belgian system for addressing personal problems. We will use that concept in combination with that of linked ecologies, with the intent of providing detailed analyses of social regulations influencing ecological moves. By relying on the systemic argument, we will conceive of changes in linked ecologies (which Abbott viewed as depending on provisional convergence between ecological strategies) as a sociological problem, questioning the social configuration underpinning the ecological system and inducing changes in the definition of the associated problem.

3.   PUBLIC POLICIES

At the beginning of his article *The Role of Knowledge in the Policy Process,* Radaelli noticed that, following works such as Crozier and Friedberg in the domain of organisations, scholars started viewing public policy as a dynamic process (Radaelli, 1995). By demonstrating that policy processes, decisions and instruments were no more rational and homogeneous than other forms of collective action, organisational analyses of public administrations stimulated a move from public policies analysis to the sociology of public action. In French-speaking sociology, the expression "sociology of public action" denotes a comprehensive approach considering different levels of action, (from the very local to the international level) and taking into account various kinds of initiatives jointly supported by public institutions, social movements, and interest and professional groups (Commaille, 2004). In comparison to a public policies approaches, the sociology of public action first shifted the focus from policy programmes to the implementation of public policies (Lascoumes & Le Galès, 2007). Methodologically, that shift entailed moving from macro-analysis to the study of the micro-level interactions taking place in relation to public policies (Musselin, 2005). The sociology of public action then replaced a unified conception of the state by a heterogeneous conception, recognising that multiple actors with different strategies and views of the world were participating in the policy process. Consequently, policy decisions and instruments were increasingly conceived as the contingent and situated result of continuous negotiation processes involving those actors and concerning every aspects of policy making (Commaille, 2004; Lascoumes & Le Galès, 2007).

The global conception of policy making that resulted from the abovementioned works stressed its uncertain and fragmented character. Policy learning approaches in particular construed the uncertain and collective aspects of policy making – "men collectively wondering what to do" (Hall, 1993). They suggested viewing policy-making as "collective puzzling" (R. Freeman, 2006) through which policy makers, civil servants and the multiple actors involved in policy decision and implementation learned as much as they do. Additionally, policy learning approaches did not evacuate any kinds of consistency and permanency from the analysis of the formation of policy decision and instrument. Instead, they questioned: 1) how to integrate the multiple interests and ideas involved in the policy process into a global order framing collective action in a given field of activity for a given

period of time (Hall, 1993; Muller, 2005); and 2) how to explain that, in spite of the contingency of the policy processes, policy initiatives always "reverberated" (R Freeman, 2012), to various extents, past initiatives launched in the same policy field. The two approaches to policy-making presented in the remainder of this section are intended to simultaneously cope with the uncertainty and consistency characterising policy processes. The concept of "paradigm shift" (Hall, 1993) will provide us with means to relate the policy initiatives presented in the following chapter to the entire policy process to which they are connected. This will be complemented by the phenomenology of embodied, inscribed and enacted knowledge (R Freeman & Sturdy, 2014), which will help us to analyse how social ideas changed and sometimes stabilised through sequences of interactions involved by successive initiatives involved in the policy process.

3.1. **Policy Paradigm and Paradigm Shift**

Hall opens his article on policy paradigms and social learning by arguing that social learning theories were still "state-centric" (p. 276), that is, they did not consider that policy learning "may well be a process that is intimately affected by social development" (idem), and did not provide an "overarching image of the way in which ideas fit into the policy process or a clear conception of how those ideas might change" (idem). To account for the comprehensive and social aspects of policy processes, Hall suggested the concept of "policy paradigm", defined as comprehensive framework "that specifies not only the goals of policy and the kinds of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing" (idem, p.279). The role of policy paradigm thus consisted in framing the issues at stake in a particular policy sector at a particular time, and identifying what had to be done in response to those issues. In turn, shifting the prevailing paradigm did not imply a simple policy decision but rather a social process to collectively learn new ways of considering and responding to policy problems. Hall suggested analysing such processes by distinguishing between first, second and third order changes in policy-making. First and second order changes concerned only the settings of policy and policy instruments, without attempting to modify policy goals. These changes were consistent with a conception of policy-making as a centralised activity based on evidence and expert advice. They denoted "deliberate attempt to adjust the goals or techniques of policy in response to past experiences and new information" (idem, p.278). Third order change, conversely, put the emphasis on the role of ideologies and social relations in policy change.

The idea of third order change relied on the assumption that "the process whereby one policy paradigm comes to replace another is more sociological than scientific" (idem, p.279). It first drew attention to the role played by ideological considerations in paradigm shift. As argued by Hall, the coalition of actors that finally succeeds in imposing its view of the world does not necessarily have the most convincing and scientific arguments, but rather simply succeeds in attaining a powerful position in a policy field. Secondly, the third order change emphasised shifts in institutional and social organisations induced by paradigm shift. Endorsing a new conception of a particular policy problem

meant changing the division of work that developed in relation to that problem, and thus questioning the corresponding balance of power. Thirdly, it invites us to question the adequacy of the prevailing paradigm in relation to concrete activities unfolding in the related policy field. According to Hall, paradigm shifts are preceded by the development of practices and conceptions, which "are not fully comprehensible within the terms of the paradigms" (idem, p.280). Changes are then made in the prevailing paradigm, with a view to adapt it to the observed "anomalies" (idem). However, as Abbott remarked about professional abstractions, attempts to "stretch the terms of the paradigms … gradually undermine the intellectual coherence and precision of the original paradigm" (idem). They resulted in policy failures which progressively evidenced the need for major change in institutional and social organisation of the field. Such major changes induced social processes involving multiple kinds of actors. They ended when coalitions of actors advocating a new paradigm managed to "secure position of authority over policy making and are able to rearrange the organisation and the standard operating procedure of the policy process" (idem, p.281). Thus, the concept of paradigm shift made policy change a social process, involving competing ideologies, power struggles, and attempts to institutionalise particular social configurations. Accordingly, it will help us to analyse successive adaptations in the prevailing policy paradigm of the Belgian system for addressing personal problems, by relating them to power and ideological struggles caused by successive policy initiatives.

3.2. Knowledge in Policy: Embodied, Inscribed, Enacted

The phenomenology of embodied, inscribed, and enacted knowledge is intended to apply to knowledge in policy. It draws on previous studies of knowledge in policy, which resulted in a broadening of the concept of knowledge, a relaxing of the boundary between the domain of knowledge (science) and policy (power), and moving from a strictly cognitive to a practical conception of knowledge. The relativised conception of knowledge resulting from those moves will be essential to the analyses provided in the following chapters.

The first move implied endorsing a broad conception of knowledge:

"…not only expert opinions and social research, but also the transformation of expert ideas into the kind of knowledge actually used by political actors; a knowledge in which research, information held by public administration bureaux, and even opinions expressed by the mass media are all intertwined." (Radaelli, 1995, p. 164)

The second move entailed questioning the boundary between the sciences, as a domain where knowledge was made up, and public action as a domain where power was exerted. By emphasising "the contingent and relativistic character of knowledge" (Jasanoff, 1990, p. 164) and how it "nonetheless succeeds in acquiring and maintaining cognitive authority" (idem), social studies of science largely contributed to that move toward co-production of knowledge and policy. As Freeman and Sturdy (2014) put it, science "is often actively oriented toward policy and that the work of

scientific knowledge production and the work of policy, far from being distinct or separate often proceed simultaneously" (p.4).

The third move implied recognising that knowledge production is not just a cognitive activity, but it happens in practice through the making of policy decisions and instruments and by assembling pieces of knowledge with one another in meaningful and purposeful ways. By highlighting the practical aspects of knowledge production, such accounts resolutely questioned transcendentalist conceptions assuming the intrinsic value of particular kinds of knowledge, for instance scientific or professional knowledge. Thus, they will be helpful in understanding situations where a particular kind of knowledge is contested by actors stressing their lack of reliability or their excessive embeddedness in policy objectives. On the whole, the relativised conception of knowledge in policy resulting from these moves will be relevant to our attempt to analyse change in a global policy paradigm along with situated claims to hold better knowledge of addressing personal problems and to translate them into policy instruments supporting the generalisation of the corresponding ideology.

More specifically, the phenomenology of embodied, inscribed, and enacted knowledge involved an original perspective on knowledge in policy which will be very helpful in analysing changes in policy ideas as they happened through micro-level interactions. This phenomenology drew from the observation that, although it encompassed "a striking diversity of ideas about what counts as knowledge, what different kinds of knowledge they may be and how they are to be observed empirically" (R Freeman & Sturdy, 2014, p. 1), the literature relating to knowledge in policy was not really helpful in analysing the way in which knowledge proceeds through policy. By categorising knowledge according to its sources, function, content or the characteristics of those who produced and used it, that literature seemed better adapted to capture knowledge than to observe its progress through collective action. By contrast, the new phenomenology of knowledge is intended to the study of knowledge in motion:

> "We propose a new phenomenology of knowledge based not on who know what, how or why, but on the forms that knowledge may take. Drawing on a simple analogy with the three phases of matter –solid, liquid and gas – we argue that knowledge too exists in three phases, which we characterize as embodied, inscribed and enacted. Furthermore, just as matter may pass from one phase to another, so too can knowledge be transformed, through various kinds of action, between phases." (R. Freeman & Sturdy, 2014, p. 1).

3.2.1. *Inscribed Knowledge*

Inscribed knowledge is knowledge inscribed on material supports (such as measurement instruments or mental health facilities) or in documents (such as policy guides or international recommendations). Material supports are more or less permanent, stable and mobile. Mental health facilities, conceived as material expressions of particular knowledge of addressing personal problems,

are very stable but not very mobile. By contrast, policy documents are very mobile but less stable. It is easier to dissimulate, dismiss or even ignore documents than it is to alter facilities durably modifying the system's institutional landscape. On the whole, however, stability and mobility are the main characteristics of inscribed knowledge (R Freeman & Sturdy, 2014)

The stability of inscribed knowledge relates to its ability to fix meaning and to carry that meaning away from the situated actions/interactions from which it arose. Policy documents fix decisions agreed upon by multiple actors involved in policy making and transfer those decisions to those responsible for policy implementing. By increasing the ability of knowledge to shift through time and space (Harris, 1998), inscribment increases its efficacy. Policy documents have made it possible for a policy decision and its corresponding ideology to move from the arena of policy making to multiple local care systems and to be enacted in different places over a certain period of time. The two main properties of inscribed knowledge (stability and mobility) thus make sense in relation to its purpose of communicating knowledge to help or to lead people in doing particular things in particular ways.

a)   From Shared Power to Domination

For the purpose of this work, it is worth differentiating between two different uses of inscribed knowledge: 1) sharing knowledge with particular actors to enable them to perform particular activities, including activities leading to innovations potentially questioning the initial knowledge; and 2) transmitting knowledge to actors with the intention of instructing them to carry out an activities in a particular way. These two different uses of inscribed knowledge correspond to two different kinds of relationship between those who produce inscribed knowledge and those for whom it is intended.

In the first case, actors are involved in a power relationship (Friedberg, 1997) providing both parties with equal opportunities to use their resources to make the most of inscribed knowledge, according to their own objectives. Material support on which knowledge is inscribed then makes room for individual appropriations. The ideas of the "boundary object" (Star & Griesemer, 1989) and "loose concept*"* (Löwy, 1990) denoted material and conceptual instruments intended to be used in common by actors holding specialised knowledge of a particular issue. Their purpose is to make collective action possible without preventing the actors involved from relating to the issue at stake in specialised ways.

In the second case, those who produce a particular inscription expect those to whom it is directed to be passive. Their relationship moves from shared power to domination. As noticed by Shapin, the sometimes militarist and imperialistic expressions used by Latour indicate opportunities to use inscribed knowledge as means to exert domination over particular situations (Shapin, 1998). Knowledge inscribed on material supports for the purposes of domination has different characteristics to knowledge that makes room for appropriation and innovation. The following characteristic will enable us to understand the particularities of policy documents analysed in this work. First, inscribed

knowledge directed to exert control or domination must appear trustworthy to the target audience. Discursive registers, particular rhetorics, and places of exhibition (Gieryn, 2002) are used by knowledge producers to make inscribed knowledge appear trustworthy to its audiences. Second, inscribed knowledge must either set conditions or create a context in which it might be enacted in a way faithful to its underlying ideologies. One way to create such context consists of incorporating problematic aspects of the environment in which knowledge has to be enacted into the inscription. This can be achieved by including specific measures to deal with uncertainties specific to that environment and providing those responsible for the enactment with appropriate knowledge (J Law, 1986). Third, inscribed knowledge has to be visible, readable and understandable by its audience. Particular methods and artefacts (Latour, 1983) are employed to increase its scope or, conversely, to target particular groups of actors and to define their roles in relation to a given course of action. By combining these three aspects, those who produce inscribed knowledge attempt to make all the elements of a network, including actors, documents and environment, work together to support the generalisation of an underlying ideology (Harris, 1998; Law, 1986).

b)   Documents as Strategic Inscriptions

Documents are the most frequent types of inscriptions used in organisations and in collective and public action (Richard Freeman & Maybin, 2011; Richard Freeman, 2006; Riles, 2006; Rot & Demazière, 2014). The story told in this work will illustrate three important roles of documents. First, they bring previously separated resources together through textual references to multiple actors, events and others documents. In so doing, they create networks either supporting particular courses of action or, conversely, preventing them from happening (Richard Freeman & Maybin, 2011). Second, documents support collective reflection and action in relation to a particular issue (idem). By attempting to agree on a common definition of a shared issue and to find means to deal with it, the involved actors come to know about their respective and collective interests in relation to that issue. The need to agree on phrases precisely and accurately expressing collective interest without undermining particular, group-specific interests can often cause long and bitter negotiations (Riles, 2006). It follows that actors involved in negotiating a document are generally committed to ensuring the respect of their epistemic content (idem). Third, documents are used by actors to communicate their position in relation to the issue in question to other actors. The role of documents to communicate a particular conception of a given issue to other actors highlights the crucial need to find the right language that will make the issue interesting and meaningful to the targeted audiences (Richard Freeman & Maybin, 2011).

These three roles of documents encouraged us to investigate the creation and circulation of policy documents framing collective action in the Belgian system for addressing personal problems. The in-depth analysis of policy documents provided in the second part of this work will highlight their strategic role in collective action.

3.2.2. *Embodied Knowledge*

"Embodied knowledge is the knowledge held by human actors and employed and expressed by them as they go about their activities in the world. " (R. Freeman & Sturdy, 2014, p. 8).

Embodied knowledge refers to past experiences informing actors' behaviour in a particular situation. Embodied knowledge is both procedural knowledge ("know how") and factual knowledge ("know that*")* (Collins, 2010)[4]. It particularly stresses the importance of individual past experiences in helping actors to make sense of situations (Smith-Merry, 2014). We insist that we view these experiences– for example, in running an organisation, holding a meeting, or chairing a conference – as requiring the active participation of the involved actors[5]. Accordingly, knowing that an actor belongs to a given organisation or profession does not necessarily infer how (s)he might behave in a particular situation. For instance, knowing that an actor has been trained as psychiatrist is not sufficient knowledge to predict how (s)he may behave in relation to reforms directed toward socialising psychiatry. In contrast, knowing that a psychiatrist chose to train in the United Sates rather than in Belgium, or that (s)he decided to work in community centres instead of psychiatric hospitals, does help in understanding his/her strategy in relation to the reform. Thus, it seems possible to relate the concept of embodied knowledge to that of disposition effect, and to jointly use these two factors in attempting to understand firstly the strategies used by individuals "as they go about their activities in the world" (R. Freeman & Sturdy, 2014, p. 8) and, in turn, the impact of embodied knowledge on collective action.

Freeman and Sturdy argued that the role of embodied knowledge was, at first glance, less powerful than that of inscribed knowledge in directing particular courses of action. Since it is not separable from human actors; embodied knowledge "is only mobile to the extent that living human bodies are mobile" (idem, p.10). That is, embodied knowledge can be used in collective action only to the extent that the actors embodying it participate in that collective action. It follows that the inclusion/exclusion of actors embodying particular knowledge in/from collective action can represent an important challenge for those involved. Moreover, assuming that embodied knowledge is not separable from the human beings holding and expressing it implies the assumption that it is less stable than inscribed knowledge. As emphasised by the concept of enacted knowledge below, the way in which actors enact knowledge depends of their perception of their situation. Finally, although embodied knowledge is less mobile and stable than inscribed knowledge, we assume it to be essential in determining the extent to which actors are able or willing to put inscribed knowledge into practice.

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[4] Noticing that procedural and factual knowledge were generally expressed together, Freeman and Sturdy (2014) suggested going beyond the distinction of "know-how", often conceived as tacit knowledge, and "know-that", defined as verbal knowledge.

[5] The need for the active participation of actors in embodying knowledge allows the differentiation of the concept of embodied knowledge from sociological concepts, especially the concept of habitus, which are not necessarily consistent with the strategic approach to collective action endorsed in this work.

As argued by Smith-Merry (2014), actors need embodied knowledge to make sense of particular inscriptions, and then to enact it properly.

3.2.3. *Enacted Knowledge*

"In the absence of action, knowledge remains latent: thoughts unspoken, skills not exercised, texts unread and instruments unused are indistinguishable from ignorance or nonsense. It is only when they are enacted that embodied or inscribed knowledge acquire meaning and significance." (R. Freeman & Sturdy, 2014, p. 12)

Inscribed knowledge involves a predetermined script for actors to follow (Akrich, 2010). However, without the intervention of actors prepared to enact it, the roles, ideas and projects inscribed in documents remain latent: inscribed knowledge is realised or unrealised only by being confronted with empirical realities (idem, p.3). Assuming that enacted knowledge is not separable from the action through which it occurs means recognising its uncertain, collective and situated character. As suggested by Freeman and Sturdy (2014), "embodied and inscribed knowledge provide resources for action, and may constrain what action is possible, but they do not determine unequivocally what form that action will take" (p.13).

Enacted knowledge depends initially upon how actors perceive a situation. Actors do not enact the same knowledge in the same way under different conditions; for instance whether they perceive a situation as a threatening or improving their position in relation to their common problem. Enacted knowledge is collective and situated: it changes in the course of interactions, as actors become aware of their respective resources in relation to a common problem. Thus, it is inseparable from pre-existing social regulation and from new roles and relationships negotiated through those interactions. In this respect, just as we previously drew a parallel between embodied knowledge and disposition effects, we propose to relate enacted knowledge to "position effects" (Boudon, 1989), inducing different perceptions of a given situation according to the position of the involved actors in relation to the problem at stake. Third, enacted knowledge is *transient*; "it endures only as long as the enactment itself" (R Freeman & Sturdy, 2014, p. 13). Elements of enacted knowledge can be written down in documents, but such inscribment is necessarily incomplete and subjective. Moreover, although enacted knowledge can be embodied by some participants, it will never be enacted again exactly the same way.

3.3. **Conclusion**

By drawing on public action approaches and social learning theories, we will consider policy and decision-making in the system for addressing personal problems as practical activities, involving multiple actors and consisting of assembling and combining different kinds of embodied and inscribed knowledge, as a means of reaching changing policy goals. Successive policy reforms in the system

will be conceived as attempts to improve its concrete functioning, and thus the ability of the actors of the system to collectively deal with personal problems. The concept of paradigm shift will enable us to situate changes in the dominant conception of personal problems - and the associated policy reforms - in relation to an overarching change process directed to the improvement of the system's effectiveness. In turn, the phenomenology of embodied, inscribed and enacted knowledge will provide us with the means to analyse the way in which policy ideas gradually change through social interactions.

4.   METHODS

This section first presents a precise definition of the research object: i.e. the limits of the system of action studied in this work; identifying the public issue in response to which that system took shape; identifying the actors involved in that system; exploring which kinds of inscribed, embodied and enacted knowledge are mobilised in its developments; identifying the context relevant to the understanding of the system; and pinpointing the temporal scope within which the development of the system is analysed. We then outline the methods used to collect empirical data, before presenting the analytical parts of this work, including chapters relating to the global context and past changes in the system, and chapters focusing on ongoing changes in the system.

4.1. Limits and Composition of the System

The system of action studied in this work is the Belgian mental health and psychiatric system. The first analytical chapter (chapter 3), which relates past changes in the system, focuses on policy reforms concerning the entire mental health and psychiatric system considered in the three regions of the country (Flemish, Walloon and Brussels). Following this, the second and third analytical chapters, which relate to recent and ongoing changes, focus on only that part of the system devoted to "adults-general psychiatry" and limited to the Walloon Region. This narrowing of the scope of the analysis resulted from our methodological decision to gradually move from documentary and general analyses to in-depth analyses based on documentary sources, observations and interviews (see below).

The system is composed of subfields of psychiatry, specifically residential psychiatry, community psychiatry and psychiatric rehabilitation, which developed in an interdependent fashion over a period of more than fifty years. Every subfield corresponds to a particular social system encompassing particular professional groups, knowledge and institutions. Those systems are conceived as interconnected to the extent that they developed in relation to the same collective issue.

4.1.1. *The Problem*

In accordance with the postulates of the sociology of organisations, we assume that collective action results from the existence of common problems requiring the cooperation of multiple actors pursuing different interests (Friedberg, 1997). The common problem focused on in the following story

is the need for dealing collectively with personal problems. By borrowing from Abbott (1988), we define personal problems as professional problems with objective and subjective qualities. Changes in the definition of personal problems, from "madness" to "mental health", are conceived as the result of a cultural work, through which occupational groups seek to obtain a position, or jurisdiction, in the system.

4.1.2. *The Actors of the System*

Actors are human, empirical and strategic. We assume, following Crozier and Friedberg (1980; 1997), that only human actors are capable of action. Objects can hinder or enhance human action, but they make sense only as they are engaged by human actors. Suggesting that actors are empirical simply means that the actors who play a role in our story are those who influenced the course of collective action in the system. Moreover, actors are viewed as strategic to the extent that they have "good reasons" (Friedberg, 1997) to act the way they do. As previously explained, their good reasons make sense in relation to "situation effects", including position and disposition effects (Boudon, 1989).

In concrete terms, the main types of actors playing a part in our story as individual actors are: policy makers; civil servants; professionals and occupational workers including social workers, GPs, psychiatrists, nurses, psychologists and educational therapists; managers of psychiatric institutions and mental health services; network coordinators; and services users. Alongside individual actors, groups of actors and institutions playing a part in our story are: professional associations and federations; advisory councils as the National Council for Hospital Facilities (NACH), federal departments (Federal Public Service Public Health - Psychosocial Department) and agencies (National Institute for Health and Disability Insurance-NIHDI); non-profit associations; and services users' groups.

4.1.3. *Knowledge in the System*

By relying on the phenomenology of embodied, inscribed and enacted knowledge, we conceive of knowledge as consisting of all means of "informing and directing action in a ways that make it meaningful and purposeful" (R. Freeman & Sturdy, 2014, p. 12). This includes ideas, conceptions, pieces of information, learning, instruments, documents, and data referred to by actors seeking to express or to defend their position in relation to collective action. We distinguish between inscribed, embodied and enacted knowledge.

The main forms of inscribed knowledge circulating in the system are the following: mental health and psychiatric services and institutions; organisational models, for instance the model of care circuits and networks; clinical model and tools, for instance therapeutic consultation and individual care plans; assessment tools such as data registration systems; communication tools including websites, help desks and documents. These documents are policy documents, for instance: policy guides and interministerial declarations; professional documents as the advisory notes produced by the

National Advisory Council for Hospital Facilities (NACH); organisational documents such as network conventions and meeting minutes; and formal documents used to apply for the development of pilot projects in the framework of particular policy programmes.

The main kinds of embodied knowledge involved in the system are the following: professional knowledge acquired by training; practice-based professional knowledge; procedural and factual knowledge acquired through involvement in meetings regarding change processes or resulting from membership of professional federations; knowledge of alternative models/practices in mental health acquired by visiting European mental health systems or by being involved in international organisations as the World Health Organisation; and policy, professional and managerial learning by key actors involved in the successive policy reforms of the system.

Inscribed and embodied knowledge are enacted on the occasion of conferences, public information events, and multiple meetings including meetings of the inter-ministerial conference, task forces, think tanks, steering committees, network committees, function committees and subject groups created in the framework of different policy initiatives.

4.2. **The Context**

We assume that context is relevant to our understanding of collective action. The successive sequences of collective action described in the following chapters occur "neither in a social vacuum nor in a homogeneous, unified social field, but rather in a social universe divided up by competition and […] a host of heterogeneous local regulations" (Crozier & Friedberg, 1980, p. 164). In reference to Crozier and Friedberg (1980) and Strauss (1978), we distinguish between the global and immediate contexts. The global context is outlined in the following chapter. It includes several dimensions (specifically professional, political and institutional dimensions), and several levels of action (specifically the international, national and regional levels). The ideal-types[6] suggested at the end of the first section of the following chapter summarise the most important dimensions of the global context.

In contrast to the global context, the immediate context of action directly results from and impacts on collective action in the system. That context started taking shape with the first law on Belgian psychiatry in 1850, and has continued to develop along with the successive policy initiatives described in this work (see "temporal scope" below). Every policy initiative is thus viewed as redefining the context, or setting new conditions (Corbin & Strauss, 2008), prevailing to further changes in the system. Past and recent policy initiatives which shaped the context (relevant to the understanding of ongoing changes) are analysed in chapter 3. The ideal-types suggested at the end of the chapter 3summarise the main dimensions of the context resulting from past changes, before using

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[6] Although they are based on in-depth analyses of the empirical reality, ideal-types do not provide exhaustive descriptions of the studied social systems. Instead, they are as abstract and general concepts summarising a typical course of action in those social systems (Weber, 2009).

them to define a grounded problematisation of the issue of change in the Belgian system for addressing personal problems.

4.3. Temporal Scope

The system's development is conceptualised as a longstanding process starting in the nineteenth century and currently unfolding through a global reform of Belgian psychiatry called "Psy107". The starting point is the public recognition, in 1850, of a need to deal collectively with personal problems. Following this, the process entailed several policy initiatives (conceived as "sub-processes" (Corbin & Strauss, 2008)) through which the system gradually acquired its present social and institutional configuration. Those sub-processes include: first, the stabilisation of medical and residential psychiatry through a set of policy measures taken during the sixties; second, the stabilisation of community psychiatry through a reform of psychiatry launched in the first half of the seventies; third, the development of psychiatric rehabilitation through a reform started in 1989; fourth, the setting and testing of new work conditions through a policy experimentation that unfolded between 2005 and 2010; and fifth, a reform directed towards the socialisation of psychiatry, which started in 2010.

Every sub-process is defined as consisting of "sequences of action/interaction" (idem), which set new conditions, or a new context, prevailing to further sub-processes unfolding in the system. Interactions unfolding within a defined sub-process are uncertain and contingent. Therefore, they are likely to give new directions to the global change process. However, successive sub-processes are characterised by a similar "rhythm" (idem), indicating their embeddedness in an overarching process, and resulting from "cross-regulations" (Thoenig & Crozier, 1975) exerted by dominant games.

4.4. Data Collection

Various methods were used to collect the empirical data analysed in the three main analytical parts of this work, including the analysis of past, recent and ongoing changes in the system. In brief, these methods include documentary analysis, semi-structured interviews and direct observation. By combining these methods and carrying out our fieldwork within a four years period, from 2010 to 2014, we approached a comprehensive and processual understanding of the system's development.

4.4.1. *Data Collection - Past Changes in the System*

Past changes in the system were analysed on the basis of documentary sources, including secondary sources[7] and policy, institutional, organisational and legal documents. The main documents used in analysing policy measures taken in the 1960s, the reform launched by the public health minister De Saeger in 1974, and the Busquin reform started in 1989, are listed following the reference list at the end of this work. We complemented these documentary sources, as far as possible, with

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[7] For instance: (Boffa, 2001; De Munck et al., 2003; Hermans et al., 2012; Orenbuch, 1981; Verhaegen, 1987).

press articles (listed following the references) and interviews (n=3) with actors involved in devising and/or implementing those past initiatives.

4.4.2. *Data Collection - Recent Changes in the System*

Recent changes in the system were analysed by relying on empirical material collected in the framework of the European Research project *Knowledge and Policy*[8], which was conducted between 2008 and 2010. It focused on the policy initiative of the "Therapeutic Project and the Horizontal Consultation". The project involved in-depth analyses of different instances of the therapeutic consultations taking place at a local level, and of cross-project discussion and scientific evaluation that took place in the framework of the horizontal consultation. These analyses were based on documentary analysis; semi-structured interviews with mental health professionals, managers of mental health and psychiatric services, civil servants, policy makers and representatives of services users groups (n= 23); and direct observations of the meetings taking place at the local level (therapeutic consultations, n=12) and at the horizontal level (cross-project discussions, n=7).

4.4.3. *Data Collection - Ongoing Changes in the System*

The analysis of ongoing change was based on three case studies, defined as in-depth analyses of particular instances of collective action developing in relation to the reform 107 (Diefenbach, 2009; Tight, 2010). The sampling was purposive, based on the problematisation of change resulting from the analysis of past policy initiatives. Our case studies were intended to explore different aspects of collective action, especially the drawing up of the policy guide defining the reform 107 (case study 1) and the local appropriation of that document by actors running local psychiatric and mental healthcare services and institutions, as well as professional and occupational workers (case studies 2 and 3).

a)   Case Study 1: "A Small Guide for a Big Reform"

The first case study concerns the level of policy making. It relies on semi-structured interviews and direct observations realised within the period between May 2010 and October 2014. Semi-structured interviews were with actors involved in the writing of the policy guide and the follow-up of the reform, including directors of federal and regional public health departments, federal and regional public health policy advisers and coordinators. We met with the federal coordinator of the reform several times between January 2012 and February 2014. The first three interviews focused on the making of the policy guide. The main issues broached through the six following interviews were: his appraisal of the local implementation of the reform; the means employed by the jury to ensure that local projects developed in the expected direction; political issues raised by the reform; and recurring oppositions between federal and local actors. These interviews combined with documentary analyses

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[8] The specific results of that research have been presented in research reports and scientific articles published in the framework of the European project (See for instance, Schoenaers, Cerfontaine, & Thunus, 2011; Thunus, 2008; Thunus & Schoenaers, 2012; Vrancken, Schoenaers, & Cerfonatine, 2010; Vrancken, Schoenaers, & Thunus, 2010)

and direct observations of events that took place at the Federal Public Services Public Health. Direct observations and documentary analysis allowed us to understand how the policy programme and the related strategies described by the federal coordinator were put into practice and inscribed in documents intended for local actors. The following table provides details about data collection.

Semi-structured interviews N=15	2012/01/09	Federal coordinator
	2012/02/06	Federal coordinator
	2012/03/19	Federal coordinator
	2012/04/05	Federal coordinator
	2012/05/16	Federal coordinator
	2012/06/07	Federal coordinator
	2012/06/22	Federal coordinator
	2013/02/04	Federal coordinator
	2013/02/08	Director of the federal psychosocial department, FPS PH
	2013/03/14	Regional mental health policy adviser
	2013/03/14	Civil servant responsible for hospital accreditation, regional social action and health department
	2013/12	Coordinator of the participation Project
	2014/02/18	Director of the regional social action and health department
	2014/02/21	Federal Coordinator
	2014/10	Coordinator of the participation project
Direct Observation N=3	2010/05/21	Public Information Meeting
	2012/01/16	Meeting at the FPS PH with a Canadian expert
	2010/10	Conference on the project participation
Documentary analysis	-	*Guide towards better mental healthcare by the realization of care circuits and networks*
	-	Conventions between the FPS PH and psychiatric hospitals (conventions relating to the financing of networks coordinators, running costs and medical function)
	-	Research reports produced by the research teams responsible for the scientific assessment of the reform
	-	Activity reports of the Participation Project
	-	Documents published on the website of the reform (www.psy107.be) and reporting decisions made by the jury, the Inter-Ministerial Conference (IMC) and the jury, news about the reform, and announcing events (kick-of, training session, conference) taking place at the FPS PH

Table 1 – Data Collection Case Study 1

b)   Case Study 2 and 3: Two Contrasting Local Versions of the Guide

The second and third case studies present two contrasting instances of the local implementation of reform 107. They rely on empirical material collected through semi-structured interviews and direct observations during the period from May 2010 to October 2014. Semi-structured interviews and observations were combined with documentary analysis.

In both cases, we analysed documents resulting from the development of the local exploratory projects that grew up in relation to the reform, including: the application documents defining the project (leading values, networks partners, organisational structure and communication tools); minutes of the meetings of the network and functions committees created in relation to the projects; annual reports produced by network coordinators; and new papers and articles concerning the projects.

Semi-structured interviews were conducted with the heads and head doctors of local psychiatric and mental health services and institutions at the origin of the projects, and with the network

coordinators. We interviewed network coordinators and heads of psychiatric hospitals promoting the two projects covered by the case studies several times, to learn about their appraisal of the development of their projects and the reform in general.

Direct observations focused on meetings of three kinds of committees created in the framework of the projects: steering, network and functions committees. Generally, those committees involved front-line professionals and a network coordinator. However, the specific composition and objectives of those committees varied depending on the project. Details about the kinds of actors involved in those committees are thus provided in the chapters devoted to those case studies.

As mentioned above, the sampling was purposive. The two local care systems involved in those projects have very different sociological, geographical and socio-demographical properties. Their sociological properties were defined in relation to the conceptualisation of the system proposed at the end of the Part One. Sociological, geographical and socio-demographical properties defining the cases are specified in the introduction to Part Two. The two projects were respectively renamed "REST" and "FUL".

The two following tables provide details about data collection:

Semi-structured interviews September 2010- July 2014. N= 16	2010/09/14	First local coordinator of the REST project
	2011/04/27	Head of the Peter Brothers Psychiatric Hospital
	2011/07/12	First local coordinator of the REST project
	2011/11/28	Psychiatrist (general hospital)
	2011/12/14	First local coordinator of the REST project
	2012/01/06	Temporary head, Wood Hospital
	2012/01/13	First local coordinator of the REST project Local coordinator
	2012/01/26	Head of the Peter Brothers Psychiatric Hospital
	2012/01/19	Psychiatrist-head doctor, Wood Hospital
	2012/05/22	Psychiatrist-head doctor, Peter Brothers Psychiatric Hospital
	2012/06/06	Coordinator of the guidance platform
	2013/02	Head of the Wood Hospital
	2013/08	Third local coordinator (3) of the REST project
	2013/10	First and second local coordinators of the REST project
	2014/01/15	Coordinators of the care circuits for inmates
	2014/07/04	Third local coordinator of the REST project
Direct observation September 2011- October 2014 N= 20	2011/09/14	Information meeting with local powers of the German speaking community and local care providers (n*=10) n*: number of participants in the meeting
	2011/11/09	Steering committee (n=18)
	2011/11/16	Function committee (F5) (n=10)
	2011/11/18	Function committee (F3) (n=9)
	2011/11/30	Meeting with French and German speaking Psychiatric Home Care teams (n= 5)
	2011/12/08	Meeting with the working group on practices of networking (n=15)
	2011/12/14	Meeting with key actors at the Wood Hospital (n=10)
	2012/01/12	Steering committee (n=12)
	2012/02/09	Steering committee (n=12)
	2012/03/14	Steering committee (n=12)
	2012/04/25	Steering committee (n=15)
	2012/06/20	Steering committee (n= 12)
	2012/12/19	Steering committee with the second network coordinator of the REST project and the federal coordinator (n=19)
	2013/09/04	Steering committee with the network coordinator 3 (n=18)

	2013/09/25	Meeting of the working group psychosocial rehabilitation centre
	2013/11/20	Steering committee (n=19)
	2014/01/15	Steering committee (attended by the coordinator of the care circuits for inmates) (n=)
	2014/01/30	Function committee 5 (n=9)
	2014/03/19	Network committee (n=19)
	2014/09/30	Network committee (n=19)
Documentary analysis	-	*Project intended to the conclusion of an agreement in the framework of the article 107 of the Law on Hospitals and Care Establishments*
	-	Minutes of the steering and function committees
	-	Newspaper articles

Table 2 – Data Collection Case Study 2

Semi-structured interviews October 2011-April 2012. N= 11	2011/10/18	Local Coordinator of the FUL project
	2011/10/26	Local Coordinator of the FUL project
	2011/11/22	Head doctor of the PRIPH (PRIvate Psychiatric Hospital)
	2011/11/28	Head doctor of the "Club" (non-profit associations holding different kinds of community and rehabilitation mental health services)
	2011/12/01	
	2011/12/07	Head doctor PEmergency (Psychiatric Emergency services of a public general hospital)
	2011/12/28	Head of the PUPH (Public Psychiatric Hospital)
	2012/01/10	Local Coordinator of the FUL project
	2012/02/20	Assistant manager running a community mental health centre included in the inter-organisational network of the "Association"
	2012/02/21	Head doctor of the PUHP
	2012/03/21	Psychiatric nurse-manager-mobile team PUPH
	2012/04/19	Local coordinator of the FUL project
Participant observation August 2011-April 2012. N= 23	2011/08/19	General meeting (n=90)
	2012/01/17	Meeting with the scientific research teams (n=10)
	2012/01/23	Function committee (2) (n=26)
	2012/01/24	Function committee (4) (n=10)
	2012/01/24	Function committee (1) (n=30)
	2012/01/25	Function committee (5) (n=16)
	2012/02/02	Function committee (3) (n=25)
	2012/02/10	Function committee (2) (n=24)
	2012/02/15	Function committee (5) (n=15)
	2012/02/27	Function committee (4) (n=11)
	2012/02/29	Meeting with federal project manager (training)
	2012/03/02	Function committee (3) (n=12)
	2012/03/05	Function committee (1) (n=34)
	2012/03/07	Function committee (3) (n=23)
	2012/03/23	Function committee (2) (n=12)
	2012/04/16	Function committee (4) (n=x)
	2012/04/17	Function committee (1) (n=x)
	2012/04/18	Function committee (5) (n=14)
	2012/04/23	Function committee (2) (n=14)
	2012/05/14	Function committee (4) (n=7)
	2012/06/18	Function committee (3) (n=15)
	2012/06/19	Function committee (1) (n=12)
	2012/06/25	Function committee (4) (n=10)
Focus Group N= 2	March 13th 2012	Mobile team for acute treatments: psychiatrist, psychologists, social workers, psychiatric nurses
	April 16th 2012	Mobile team for acute treatments: psychiatrist, psychologists, social workers, psychiatric nurses
Documentary	-	*Proposal for the constitution of a care network in the Red City*

analysis	-	*Position paper of the association of head doctors of French-speaking psychiatric hospitals on the function of psychiatric hospitals in relation the reform of care circuits*, September 2010.
	-	2008 Annual report of the Intercommunal association "PRIPH".
	-	Minutes of the steering and function committees
	-	Newspaper articles

Table 3 – Data Collection Case Study 3

c)   <u>Case Study Design</u>

The three case studies have been organised according to our methodological framework. The figure below provides an overview. Every case study involves three steps: (1) setting the conditions that preceded and led to the development of a project (either the policy programme or exploratory project); (2) analysing the document in which that project was recorded; and (3) attending to successive and interrelated sequences of interactions through which the documents were enacted.

First, setting the conditions for the development of a project entails an awareness of local ecological and social conditions that resulted from past changes in the system, embodied and inscribed knowledge specific to local care systems concerning the case studies, and the individual trajectories of actors involved in the writing/enactment of the project. Second, the analysis of documents, including the policy guide (case study 1), and two proposals for local exploratory projects (case studies 2 and 3) consists of describing their content and explaining key aspects of their development. The development of the guide is construed as a practical activity involving assembling social and structural conditions set up by past changes in the system with inscribed and embodied knowledge held by the authors of the policy guide, according to the policy objective of socialising psychiatry. The drawing up of the two proposals for the exploratory project is construed as the translation of the policy guide in two different local systems for addressing personal problems. It relates how local versions of the policy guide had been conceived of, by relying on the document and local particularities. Third, the analysis of sequences of interactions through which documents were enacted is composed of two parts: the initial enactments relate to the very first interactions (through which a particular project was confronted with empirical realities); while the main enactment itself relates to collective reflection intended to translate the documents into concrete practice at a local level. On the whole, by following the policy guide through successive sequences of interactions which occurred in response to the call for projects, we aim to highlight the different kinds of new inscriptions caused by its circulation, as well as the changes in the social configuration deriving from its successive enactments.

	CONDITIONS	INSCRIPTIONS	INTERACTIONS	
Federal Level Case study 1	□ Embodied and inscribed knowledge deriving form past changes in the system (case studies 1-6) □ Individual trajectories and recent moves of actors involved in the writing of the Guide □ Setting of the Task Force and the Think Tank	Policy guide: Towards bettered mental health care by the realization of care network and circuits	□ Public information meeting (2010/05/21) □ Call for projects □ Selection procee □ Meeting of the jury □ Meeting of the IMC	
Local care system Case study 2	□ Embodied and inscribed knwoledge held by the network coordinator; head and head doctor of the promoter psychiatric hospital □ The Guide	**"REST PROJECT"** Project intended to the conclusion of an agreement in the framework of the article 107 of the Law on Hospitals and Care Establishments Version 1&2 Addendum	Initial enactments (management): meeting with the jury, steering committee, local interessment process Enactments (management/front-lines professionals): network committee and committees of functions	□ Network convention □ PRC □ Guidance Platform □ Change in the social configuation
Local care system Case study 3	□ Embodied and inscribed knowledge held by the PRIPH and PUPH coalitions/network coordinator □ Initial PRIPH project □ Initial PUPH project □ The Guide	**"FUL PROJECT"** Proposal for the constitution of a care network in the area of Red	Initial enactments (management): meeting with the jury ans with scientific research teams Enactments (front-lines professionals): network committee and committees of functions	□ Network convention □ Operational defintions of the 5 function □ Individual cara plan □ Mapping of the network □ Local orders (function committees)

Figure 1 – Cases Studies Part 2: Overview

5. REASSEMBLING THE BELGIAN SYSTEM FOR ADDRESSING PERSONAL PROBLEMS

The three sections devoted to professions, organisations and public policies stressed successive moves from separated social entities to diffuse social processes, through which different systems of action constitute themselves in relation to particular problems. Following these moves, organisations were conceived of as contexts of action, professions as segmented social systems, and public policies as provisional and negotiated responses to collective problems. Social systems resulting from those displacements have no clear boundaries. Their concrete functioning entails to engage in relationships with adjacent systems of action. Relational processes involved in the activities of social systems result from their interdependency in relation to collective problems. In turn, they draw attention to a need to recognise that the problems addressed by social systems- including policy, organisational and professional problems - are not in fact distinct problems, but rather collective problems with different dimensions or subjective qualities. At the level of collective action, those dimensions are never completely separated.

Recent works in the sociology of professions and public action contend that the failure of bureaucratic systems in addressing public problems has resulted precisely from a fragmented management of public problems, which has led to handing responsibility for particular dimensions of public problems to specialised and separated entities (Duran & Le Bianic, 2008). Moreover, general sociological and philosophical works (i.e. Beck, 1992; Toulmin, 1992) have joined in suggesting that public problems flowing from the development of modern societies are manifold and intricate in nature, calling for comprehensive and integrated approaches. In the meantime, in the field of public administration, scholars conceptualised those problems as "wicked problems", before of suggesting a set of "post new public management" instruments appropriate to deal with the growth of uncertain situations related to those problems (Roberts, 2000; Termeer, Dewulf, Breeman, & Stiller, 2013).

As highlighted in the following chapter (which is devoted to changes in the global context) these observations were reflected by changes in psychiatric and mental health policies of countries members of the Organisation for Economic Co-operation and Development (OCED), (among others) through attempts to develop regional, interprofessional and integrated mental healthcare networks (Fleury & Mercier, 2002). Recent and ongoing changes in Belgian mental health policies have also reflected this trend (De Munck et al., 2003). As emphasised in chapter 3, they assumed the need to go beyond professional and institutional boundaries to think collectively and globally about how to deal with personal problems. However, in a way similar to other policy programmes implemented in most OECD-countries, Belgian mental health policies overestimated their ability to impose an external rationality, i.e. that "wicked problems" are better addressed through interprofessional and inter-organisational networks rather than social systems dealing with mental health problems (Bercot, 2006; Robelet, Serré, & Bourgueil, 2005). As argued by organisational sociologists, social cooperation is not

a solution to collective problems but a sociological problem, which must be collectively reflected on before finding a solution. That sociological problem is all the more important since the mental health system is deeply embedded in Belgian institutions, involving strong social regulations. Moreover, mental health policies did not pay enough attention to the fact that relativising professional and organisational boundaries does not mean creating undifferentiated social actors. Instead, increased moves of multiple actors across professional and organisational boundaries make sense only to the extent they that have something special, a difference, to bring to collective action.

The methodological framework outlined in this chapter intends to deal with such analytical challenges, raised by manifold and diffuse empirical problems and social processes. By involving broad conceptions of professions, organisations and public policies, it will enable us to comprehensively understand collective action in the system for addressing personal problems. Moreover, by relying on basic assumptions borrowed from the interactionist and strategic paradigms, it will allow us to consider both processual and systemic dimensions of collective action, including the continuing change process in which successive moves in the system are embedded, and the particular challenges associated with local orders developing in relation to either of these moves.

More specifically, by bringing together the strategic and linked ecologies arguments, the methodological framework will allow us to consider how differentiated social systems have been built up within the Belgian system for addressing personal problems, without overlooking the issue of their social integration. First, postulating linked ecologies in the system for addressing personal problems allows us to observe the arising of social systems following claims to hold better knowledge of personal problems. Consequently, it also enables us to understand the contrasted ideologies involved in different ecologies. Second, insofar as linked ecologies are identified and defined, they help in reassembling (Latour, 2005) the system around relational (ecologies are defined are specific relationships between actors and location) but explicit markers; advocating a new relationship involves claims for public recognition. In turn, linked ecologies provide a means to observe how actors connect "sites of differences" (A. Abbott, 2001) together to support a particular position, instead of limiting their "good reasons" (Friedberg, 1997) to organisational or professional logics. Third, on the whole, identifying ecological configurations enables us to map the system at particular time, on the basis of meaningful but flexible boundaries. Additionally, complementing the linked ecologies argument with the systemic argument allows us to stress that ecological developments are not just a story of events. Changes in linked ecologies are not fortuitous: they depend on collective action, involving negotiations which are at least partly regulated by local strategies and dominant games. Otherwise stated, ecological alliances and changes do not simply happen, they are negotiated by multiple actors advocating different ideologies and pursuing different interests.

Finally, assembling the interactionist and strategic paradigms allows us to connect changes in the balance of power between the system's actors with changes in the meaning of personal problems. Insofar as the overall process of change is concerned, the concept of paradigm shift enables us to

account for such changes and to situate them in relation to the global policy objective of completely reorganising the system. Insofar as particular sequences of collective action are concerned, the phenomenology of embodied, inscribed and enacted knowledge gives the means to construe changes in social ideas, as they happened within collective action and strategic negotiations. The phenomenology thus completes the methodological framework just summarised, by making it appropriate to the in-depth analyses of ongoing changes as well as for overall analysis of past changes.

The phenomenology appears particularly consistent with our framework for the following reasons. First, it insists on the embeddedness of knowledge production in social process and systems. Knowledge production does not happen in a social vacuum: on the one hand, the concept of embodied and inscribed knowledge reminds us that actors themselves bring something to knowledge production, stressing the role played by *"particular disposition"* in informing collective action; on the other hand, the concept of enacted knowledge reminds us that dispositions are always renegotiated in the light of the particular position of actors in collective action. Second, given the emphasis put on the collective and uncertain nature of enactment, the phenomenology encourages a focusing on collective action through which dominant ideas and the associated division of works are gradually changed. By inviting us to relativise the ability of particular actors and instruments to determine the course of the change process, this view offers a means to distance ourselves from a one-way account of innovation such as those suggested by scholars at the origin of the Action Network Theory (Callon, 1986; Latour, 2005). With this phenomenology, we are able to follow actors and instruments through "n-ways" translations (Star & Griesemer, 1989); that is, a sequence of interaction though which different kinds of knowledge are collectively discussed and negotiated. Meanwhile, it allows us to retain insights given by the Action Network Theory (ANT) into the study of innovation, and especially the very production of knowledge, devices and instruments. Third, by involving the assumption that moves - moving peoples and moving documents - are essential to changes in social ideas, the phenomenology invites us to follow actors (and documents) into collective action by moving across institutional boundaries, along different levels of action, and through the change process.

The methodological framework defined in this chapter supports the overall analyses of past and recent changes in the Belgian system for addressing personal problems provided in the third and fourth chapters. It also supports in-depth analyses of ongoing changes provided in the second part of this work. Following the analysis of past changes, it will help us in identifying and defining the linked ecologies and systems of concrete action that developed in response to personal problems, before of problematising the issue of change in the system. Following the presentation of case studies focusing on ongoing changes, it will allow us to explain how change in collective action concretely happens in the system, and to situate ongoing change in relation to the concept of paradigm shift. The final discussion will summarise empirical findings and how our framework improved our ability to cope with the sociological analysis of a complex change process   .

Chapter II – **THE GLOBAL CONTEXT FOR PERSONAL PROBLEMS**

INTRODUCTION

This chapter introduces the global context of the Belgian system for addressing personal problems. It first summarises the Belgian context by explaining the organisation of Belgian society according to ideological pillars and the political structure of the state. Second, it presents the Belgian public health system, including recent changes and current debates relating to compulsory health insurance and hospital systems. Third, it briefly outlines the institutional landscape of the Belgian system for addressing personal problems, which is more deeply analysed in the following chapter. Fourth, it delineates the global context by specifying the limits and the composition of the system we are talking about – is it limited to psychiatry or enlarged to mental health? Are psychiatry and mental health two different things? What are their differences and how could we understand their particular relationships? Fifth, by relying on those preliminary remarks, it indicates international developments which are particularly relevant to the story told in this work. It specifies the global orientations followed by OECD mental health and psychiatric policies during the last decades, before evoking the activities of the World Health Organisation and the European Commission in relation to mental health. To conclude, it defines two particular "knowledge regimes"[9] (Mangez & Delvaux, 2008), summarising the kinds of institutional arrangements and uses of knowledge observed at the international and national levels.

1.   WELCOME TO BELGIUM

Belgium is a northwest European country of 30,528 square meters with a population of 10,839,905 million people in 2010. The density of population averages 349 per square kilometre. It is a tri-lingual country. More than a half of the Belgian population (59 %) speaks Dutch, while the other part speaks French, except for less than one percent of German speakers.

Belgium has been recognised as an independent state by European powers since the London Conference in 1830. Leopold of Saxe-Coburg-Gotha, the first king of Belgium, was enthroned on the 21st of July 1830. The Belgian Constitution established a constitutional parliamentary monarchy. It compelled kings of Belgium to take an oath before the two houses of parliament by swearing to observe the Constitution. The king has almost no political power but exercises some influence on policy decisions by consulting with federal ministers.

The political system is a parliamentary system composed of the Chamber of Representatives and the Senate. Both are elected every four years, by universal suffrage and on the basis of linguistic

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[9] According to Mangez and Delvaux, "the knowledge regime hypothesis claims that national contexts are still relevant contexts for understanding how knowledge is constructed, used, or not used and situate in relation to policy making. … [It] should not be understood as a strictly cognitive hypothesis. Its point is rather to identify possible relations between political and institutional arrangements, cultural traditions and knowledge utilisation …" (2008, p. 110-111).

communities, respectively. The federal government is the executive power, with mandates formed through the Chamber of Representatives. It participates in the legislative power only by submitting bills to the federal parliament. Bills approved by the federal parliament must be signed by the federal government and the King before of gaining force of law.

Federal government tends to be a majority government composed multi-party coalition. Alongside it's balanced bicameralism, federalism, decentralisation, and electoral rules based on proportional representation, multiparty coalitions make the Belgian political system a "prototype of a consensual model" (Troupin, Steen, & Stroobants, 2013, p. 6).

1.1. **The Origins of a Pillarised Society**

"Belgium has often been described as a consociational democracy derived from a sharply pillarized society. The fact that segments (pillars) are denominational means that they are based on beliefs and values. Historically, they separated two communities promoting distinct values, looking at the world in distinct ways and thinking of their place in the world differently too. They only agree to live together on the basis of a pact according to which each community would be given equal rights to organize its own collective life. Today, each pillar gathers an extensive network of functional organizations providing a wide range of services. Within each pillar, one can find education services … ,healthcare services, health insurance, hospitals, trade union, youth organizations and political parties …" (Mangez & Delvaux, 2008, p. 115).

The Pillarised society (Rokkan, 1977; Vanderstraeten, 2002) and associated "pragmatic culture" (Kuty, 2006, p. 185) originated from the period preceding Belgian independence. Following the Vienna Conference in 1815, Belgian provinces were united with the Netherlands. William I, the king of Netherlands, then passed a "fundamental law". Among other provisions, that Law recognised all religious beliefs and stated that the king must be member the Reformed Church. The King also exercised executive power alone, while he shared the legislative power with the General State. Policy measures taken over the following years on the basis of this law challenged the interests of the two main social forces existing in the Belgian provinces: the Catholics and the liberals. Catholics were strongly opposed to the organisation of social institutions such as schools and public care by the state. For their part, liberals remarked that, in spite of the rapid industrial growth of the south of Belgian provinces (which significantly increased the national wealth) Belgian representatives were excluded from governing the Netherlands. It is in that context that the "pragmatic culture" started to develop, making previously unthinkable alliances worthwhile solutions (Kuty, 2006).

The pragmatic culture was pioneered by the archbishop of Malines in 1817. Being obliged to take the oath before the fundamental law, which established the principle of religious freedom contested by the Catholic Church, he decided to take the oath under the condition of distinguishing civil from religious tolerance. That pragmatic decision inspired the "monstrous alliances" (idem,

p.189) initiated by the Catholics at the end of 1820s. Feeling excessively threatened by the policy of the Netherlands, the Catholics then distinguished their political interest (which consisted in allying with the liberals to push the Orange Regime out the Belgian Provinces) from their religious values, which were fundamentally opposed to liberal ideas. The liberals were also willing to make important concessions to take over industrial cities of the south Belgian provinces. The resultant liberal-Catholic agreement on the Belgian Constitution meant the birth of the "consensualism" (Kuty, 2006, p. 187).

Belgian consensualism was inscribed in the Constitution, which simultaneously ensured liberal ideals by giving primacy to the legislative over the executive power, and the Catholic requirement to maintain control over social institutions (including schools and hospitals) belonging to religious congregations. Imaginative conceptions of the separation between the state and the Church thus provided the Catholic Church with a powerful position in the Belgian social system.

On the whole, by enabling the creation of relatively autonomous sociological worlds along ideological lines, the Belgian Constitution supported the development of a pillarised society during the first half of the nineteenth century. That society provided intermediary bodies and local authorities with a significant power over public life (Kuty, 2006, pp. 202-203). Then, at the end of the nineteenth century, the socialist pillar grew from workers' movements. They gave rise to social negotiations which resulted in reorganising Belgian society on the basis of the Catholic, liberal and socialist pillars; each of which encompassed its own networks of institutions, exclusively serving the members of their community (Vanderstraeten, 2002).

The sociological reflection provided by Kuty on the growth of the pillarised society is noteworthy for two reasons. First, social institutions previously held by religious congregations, particularly their important network of psychiatric hospitals, played a significant role in successive developments of the Belgian system for addressing personal problems. Second, the pragmatic culture endorsed by members of the Catholic pillar is particularly relevant to the understanding of current political stakes relating to psychiatry in particular and public health in general.

1.2. **A Federal State[10]**

Belgium has been undergoing a process of federalisation that started in 1970, with an initial reform of the state, recognising three regions and three linguistic and cultural communities, continuing to the sixth reform of the state, starting in 2011[11]. The Flemish, Walloon and Brussels Capital regions are based on geographic and economic areas. The Flemish, French and German Communities are delineated as cultural and linguistic communities. Along with the six reforms of the state, the regions were granted additional competencies and became more autonomous in dealing with related policy

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[10] The presentation of the federal state is based on information available on www.Belgium.be and explanations of the Belgian political system provided by Troupin, Steen and Stroobants (2013).
[11] The 2011 reform of the state sanctioned the transfer of most public health competencies from the federal state to the regions. Unfortunately, insofar as that reform was still undergoing at the time of writing this thesis, we have not be able to take its consequences into account.

matters. The federal, regional and community governments constitute the first level of decision making power in Belgium. They have equal power to deal with policy matters falling within their scope of activities.

The federal state is responsible for public interest matters, including foreign affairs, defence, justice, finance, social security, public health and internal affairs. The regional government is responsible for matters related to the occupation of its territory, including economy, employment, agriculture, public transport, public work and environment. The community governments are responsible for persons-related matters such as culture, education, use of language, health promotion and prevention policies, and individual, family and social assistance. However, they gradually delegated competencies to regional governments, among others competencies relating to planning and evaluation of Community Mental Health Services.

The second level of decision-making power corresponds to ten provinces. These are secondary administrations exercising their powers in a way consistent with general policy orientations but independently from first-level government. They are responsible for matters of public interest excluded from the federal, regional, community and municipal jurisdictions. The 589 Belgian municipalities occupy the third level of decision-making power. They are local authorities, close to the people, and responsible for matters relating to the collective needs of their inhabitants.

2.   THE BELGIAN PUBLIC HEALTH SYSTEM[12]

The most important steps in the development of the Belgian Public Health System were taken after the World War Two. In 1963, the Health Insurance Act and the Hospital Act laid the main foundations of this system. The Health Insurance Act defined a system of compulsory health insurance combined with a private system of healthcare delivery based on three key principles: freedom of choice for patients; medical doctors' therapeutic freedom; and fee-for-service payments. It also established the National Institute for Health and Disability Insurance (NIHDI) and the list of reimbursable medical services and categories of beneficiaries. This list gradually enlarged to a broad range of medical services covering the whole population.

The combination of universal and compulsory health insurance (including a broad benefit package) with a liberal care providers' system makes the Belgian public health system a "strange hybrid" (Schokkaert & Van de Voorde, 2011, p. 7) between a state system (Beveridge model) and rather liberal system with insurers or sickness funds playing an important role (Bismarckian model). That hybrid partly resulted from the socio-historical developments related above, which gave an important role to intermediary actors such as the sickness funds in the public health system.

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[12] Generally, that presentation relies on articles about the organisation and the reforms of the public health system (Gerkens & Merkur, 2010; Nonneman & van Doorslaer, 1994; Schokkaert & Van de Voorde, 2005, 2011; Troupin & Verhoest, 2013), and on reports available on http://www.health.belgium.be. More specific references are indicated in the main text.

2.1. **Decision Making in Public Health**

Public health competencies are split between the federal and federate entities. The main responsibilities falling under the federal jurisdiction relate to compulsory health insurance, determination of minimum standards applying to hospital services, hospitals financing, regulation and price control of pharmaceuticals, and legislation on health professionals' qualifications. As shown by the figure below, the Federal Public Service for Health, Food Chain Safety and Environment is the federal department in charge of applying federal public health policies.

Alongside the federal government, regional and community governments have responsibilities for public health, including the implementation of accreditation standards for hospitals, the determination of additional standards, health prevention and promotion, maternity, child and elderly care services, home care, and coordination of palliative care and primary care services.

From 2001 onwards, with a view to improve the consistency of the federal, regional and community public health policies, all ministers with responsibilities in public health regularly met at the so-called Public Health Interministerial Conference (IMC in the remainder). In practice, however, decision making in public health is not limited to the public sphere:

"Though health insurance is compulsory, [its] management … is predominantly left to nongovernmental non-profit organizations [the sickness funds].The role of government is limited to regulation and partial funding, leaving providers with a large degree of sovereignty in both clinical and managerial matters." (Nonneman & van Doorslaer, 1994)

Public health decision making primarily involves the National Institute for Health and Disability Insurance (NIHDI). The NIHDI is a federal agency managed by a general council composed of government representatives, employers, employees and sickness funds representing the beneficiaries of the public health insurance. Government representatives have no particular influence on decision making relating to the financial and administrative management of public health insurance, which is instead controlled by sickness funds and care providers occupying powerful positions within the NIHDI (Schokkaert & Van de Voorde, 2011).
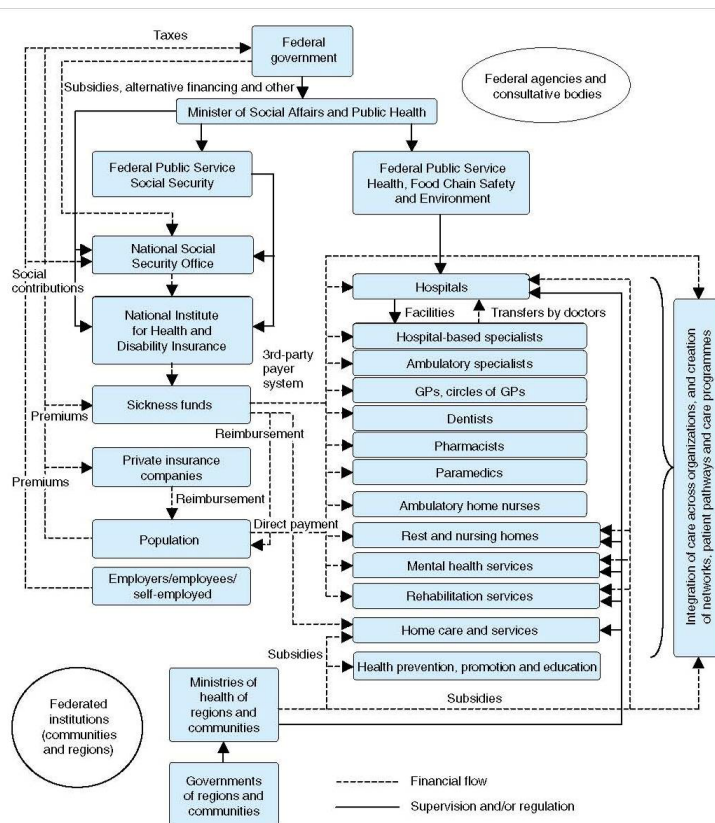
Figure 2 – The Belgian Public Health System[13]

2.2. **Financing and Managing Public Health Insurance**

Health Insurance is one of the six branches of the social security system. Social security contributions proportional to income are its first source of financing. They represent the contribution of employers and employees to public health insurance. This amounts to about two thirds of the total budget. The remaining third is financed by government subsidies and budgets from goods and services value added tax.

2.2.1. *The National Institute for Health and Disability Insurance*

The NIHDI is a federal agency responsible for the general management of compulsory health insurance. The main aspects of its mission are: to organise the reimbursement of medical costs; to ensure replacement of incomes in case of incapacity; to monitor the evolution of healthcare expenditures and the application of the legislation by healthcare providers; to elaborate the budget and to ensure that healthcare providers and sickness funds have adequate financing; to inform healthcare providers and sickness funds; and to organise negotiations between stakeholders.

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[13] Available at http://health.belgium.be

Among the five departments composing the NIHDI, the Healthcare Department is responsible for the financial and administrative aspects of compulsory health insurance. This department is managed by the General Council and the Committee for Healthcare Insurance. The General Council is responsible for decision making on the global budget as well as general policy issues relating to compulsory health insurance. It is composed of the sickness funds and compulsory health insurance financial contributors including employers, employees and the government. Healthcare providers have only an advisory role. In the Committee for Healthcare Insurance, which is responsible for drafting the global budget and making proposals for changing the health benefit nomenclature, the roles are reversed: employers, employees and representatives of the government have only an advisory role, while healthcare providers and sickness funds have the right of initiative. Healthcare providers and sickness funds are thus essential to decision making in relation to the public health system.

2.2.2. *The Sickness Funds*

Sickness funds originated from mutual benefit societies created during the 19th century by workers in order to help victims of works accidents, disease and unemployment. They were recognised by the state in the second half of the 19th century and, at the beginning of the 20th century they merged into national associations formed along ideological lines. In 1963, on the occasion of the creation of the compulsory health insurance system, the state made those associations responsible for the application of the insurance system. Consequently, the utilisation of health insurance became conditioned by the membership to one of the five sickness funds that, in turn, "obtained exclusive access to a captive market" (Nonneman & van Doorslaer, 1994).

The choice between the "Christian", the "Socialist", the "Liberal", the "Free" (professional) or the "Neutral" (ideological neutrality) sickness fund (or "mutuality") has usually been made according to ideological preferences. As Nonneman put it, "this ideological alignment is still very important. Each of the major HIAs [sickness funds] has its supporters in its respective political party and labour movement" (idem, p.148). Consequently, although recent reforms encouraged sickness funds to change their differentiation strategy (see below), "competition between the HIAs often has political and ideological overtone" (idem).

Sickness funds are private non-profit associations with a public mission. At the level of decision making, their mission consists of defending the interests of health insurance beneficiaries within the Healthcare Insurance Committee. At the operational level, they are responsible for applying compulsory health insurance and offering complementary services. The application of compulsory health insurance consists of financing the health expenditures of their members, either by reimbursing them for the cost of healthcare or through direct payments to healthcare providers. Payments for healthcare are based on a fee-for-service model combining direct payment (where patients pay the full cost of a service before of being reimbursed for part of that cost), and a third party payer system (where sickness funds directly pay care providers for services covered by the sickness fund and non-

reimbursed (parts of) services are paid by the patient). The amount of the reimbursement varies according to the medical services provided.

In the domain of complementary insurance services, sickness funds traditionally played an innovative role, detecting new needs of their members and subsequently lobbying for their integration into the compulsory insurance (Troupin & Verhoest, 2009a, 2009b). However, reforms intended to increase their financial responsibility shifted the role of sickness funds in relation to complementary services. This shift provides a very interesting instance of the ideological conflicts unfolding in the public health domains and the respective strategies of the three pillars.

In 1995, public health authorities decided to move from a situation where sickness funds were reimbursed for virtually all their expenditures, to a prospective financing making them responsible for 25% of the discrepancies between the prospective budget and their actual expenditures. Theoretically, this reform involved an incentive for increased costs control. It sharply contrasted with the previous situation, where sickness funds had "incentives not to control expenditures if this could make them more popular and help them to attract new members" (Schokkaert & Van de Voorde, 2005, p. 12). However, with the exception of medications and tests prescribed by medical doctors, the reform was not followed by decisions to implement means supporting effective cost control, such as selective contracting with healthcare providers. Instead, the relationships between sickness funds and healthcare providers continued to be managed by the NIHDI Healthcare Insurance Committee. Consequently, the reform encouraged sickness funds to reinforce their alliance with care providers, with a view to negotiating an increased prospective budget for compulsory health insurance (Schokkaert & Van de Voorde, 2011). In the meantime they started offering complementary services likely to attract "good risks", representing lower health expenditures than those covered by the prospective financing. This strategy, which consisted of compensating for excessive expenditures in the domain of compulsory insurance through supplementary resources from complementary services (Troupin & Verhoest, 2013) induced risk selection in the system (Schokkaert et al., 2011). However, it was applied differently depending on the sickness funds' ideological persuasion and the characteristics of their members (Troupin & Verhoest, 2009). On one hand, sickness funds insuring big risks included in the compulsory insurance (principally the Catholic and socialist sickness funds which insure most hospitals) were particularly encouraged to compensate for the associated costs by using complementary services. On the other, according to their position along a continuum, with market-based models on the one end and state regulation on the other, the sickness funds had different perceptions of the opportunity afforded by generalising that strategy. In this respect, liberal sickness funds supported the strategy's generalisation; the socialist ones were totally opposed to it (bringing into question their traditional role in bargaining for the integration of complementary services into compulsory insurance); and the Christian ones required adaptations protecting their traditional role without increasing state regulation.

On the whole, as intermediary actors, the funds asked for increased rights and means to evaluate the health expenditures of their members. They argued that such an approach would allow them to take advantage of their expertise and influence on health institutions, while improving their ability to cope with the resultant financial constraints. Outside policy measures enabling them to improve their control over the healthcare expenditures of their members, the funds attempt to improve their regulatory power by producing, on their own initiative, knowledge on the effectiveness of care providers in different domains. Very recently[14], the Catholic, liberal and socialist sickness funds provided their first joint research comparing the effectiveness of the main Belgian hospitals in treating a particular pathology. Newspapers remarked that, for the first time, sickness funds compared healthcare providers with the explicit intent of leading public thinking about their relative effectiveness in providing particular treatments, thereby enabling patients to choose the more effective hospital in that particular domain.

2.3. **The Hospital System**

Hospitals were created very early in Belgium. Two hospitals already existed in the 12th century in the Flemish Region. The state became responsible for their management only following the first law on hospitals in 1963. That law defined financing and planning standards applying to public and private hospitals. Private hospitals originated from institutions held by religious congregations. They are now run by non-profit institutions related to the Catholic pillar. In 2008, they represented 75 percent of a total supply of 207 hospitals, including 139 general hospitals and 68 psychiatric hospitals. Public hospitals are generally managed by local public authorities including municipalities, provinces, communities or intermunicipal associations grouping together public welfare centres, public authorities and sometimes private stakeholders. The same legislation and financing system applies to public and private hospitals, and there is no qualitative difference between them. The differences rather relate to the higher control exerted on public institutions, whose "deficits are covered, under certain conditions, by local authorities or inter-municipal associations" (Gerkens & Merkur, 2010).

The general financing system applied to both kinds of institutions distinguishes between nursing activities and medical, medico-technical and para-medical activities. The financing of medical activities is based on a fee-for-service model. Specialists working in hospitals are thus paid at the same fee level as specialists working in private practice. In practice, however, hospital specialists are not directly paid by either their patients or sickness funds. Instead, they negotiate an agreement with the head of their hospital to determine a percentage of their fees that goes to the hospital to compensate for staffs, rooms and equipment, and are paid the remainder. The level of fee-sharing is defined by considering the relative scarcity of a given specialism, the experience and reputation of the specialist and the hospital's reputation and equipment.

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[14] Burgraff, E. (2014/10/1) "The first Classification of Belgian Hospitals", in *Le Soir,* p.2-3.

The financing system applied to nursing activities was reorganised during the period between 1980 and 2002. Measures directed towards controlling costs and supply restrictions included a moratorium on hospital beds provision in 1980, and financial incentives encouraging hospitals to merge into hospital groups in 1998. These measures facilitated a significant decrease in the number of hospital beds and the halving of the number of hospitals (Schokkaert & Van de Voorde, 2005). In the early nineties, complementary measures supported a shift from a retrospective and cost-based financing system towards a prospective system. The retrospective system was based on the key notions of "per diem rate" and "day quota". The per diem rate varied according to the hospital's equipment, but did not decrease as a function of the duration of hospitalisation. Instead, by making "the marginal cost of an additional patient day lower than the per diem rate", this measure "created incentives to increase the length of stay" (idem, p.31). The per diem rate and day quota were thus replaced by the notions of "justified activity and beds", which displaced the focus from the structural characteristics of hospitals to the patients' APR-DRG profiles (All Patient Refined Diagnosis Related Groups). In 2002, the retrospective system was totally replaced by "a hospital budget based on the APR-DRG profiles of the hospital patients and on a normalised length of stay" (Schokkaert & Van de Voorde, 2005, p. 31).

Alongside these measures, changes were introduced in medical and clinical data registration systems. In 1990, the Minimum Clinical Summary (MCS) was implemented in general hospitals to support the rationalisation of costs. The MCS summarised data relating to patients and medical treatments and services according to the *International Classification of Disease-9-Clinical Modifications.* It started using the APR-DRG following changes to the financing system of hospitals in 2002. A few years later, in 2008, the MCS was complemented by the Minimum Hospital Summary (nursing care data) and the Minimum Financial Summary. This system obliged hospitals to communicate clinical, nursing and financial data to public authorities every semester, but did not prevent them from manipulating data in order to improve their prospective financing. The MCS system was thus progressively replaced by the *e-Health platform*, providing public health authorities with real-time information. The e-health platform (whose implementation started in 2013) involved centralised and state regulation, sharply contrasting the regulation exerted by intermediary bodies such as sickness funds.

2.4. The Belgian System for Addressing Personal Problems: a Brief Outline

The organisation and development of the Belgian mental health system is analysed in the following chapter. For now, we intend only to provide an overview of the system's organisation, situating it in relation to changes in the global context related in the following section, and to prepare the reading of the next chapter. The following overview refers to public presentations of the system's organisation; it is mainly based on national and international reviews of the system (Gerkens & Merkur, 2010; Verniest et al., 2008).

The Belgian mental healthcare system is composed of *a residential sector, an ambulatory sector, and a psychiatric rehabilitation sector. Pilot project*s complement those three sectors by providing alternative facilities and integrated services such as *psychiatric home care* and *therapeutic consultation*. Policy reforms which succeeded one another from the 1960s to the end of the 1990s increased the specialisation and segmentation of the system. Recent and ongoing policy initiatives therefore aimed to improve the system integration and the development of community services.

2.4.1. *The Residential Sector*

The residential sector falls under the responsibility of the federal Ministry of Public Health. It is financed by the federal public health budget, which is allocated to residential institutions by the National Institute for Health and Disability Insurance. It is composed of: psychiatric hospitals; psychiatric wards of general hospitals; Initiatives of Sheltered Housing (ISH); and Psychiatric Nursing Homes (PNH). Psychiatric hospitals are both private (n=57) and public hospitals (n=13). The ISH (n=42) and the PNH (n=85) are alternative residential facilities intended for chronic patients and centred on functional rehabilitation and social reintegration. Their creation was supported by a reform launched by Minister Busquin in 1989.

The following tables emphasise the relative importance of psychiatric hospitals, ISH and PNH in the Flemish, Walloon and Brussels Capital Regions.

	Number of psychiatric hospitals in 2009	Number of beds in 2010	Evolution from 2000 to 2010
Flemish Region	39	8460	
Walloon Region	22	3894	Decrease of 81 beds in psychiatric hospitals beds
Brussels Region	9	1075	
Total	70	13429	
Private/Public	57 private/13 public		

Table 4 – Number of Psychiatric Hospitals and Beds, 2009-2010

	Number of PNH in 2008	Number of beds in 2010	Evolution from 2003 to 2010
Flemish Region	24	2230	
Walloon Region	13	793	Decrease of 85 beds in the number of PNH beds
Brussels Region	5	257	
Total	42	3280	

Table 5 – Number of Beds in Psychiatric Nursing Homes in 2008

	Number of ISH in 2009	Number of places in 2010	Evolution from 2003 to 2010
Flemish Region	42	2662	
Walloon Region	27	774	Increase of 396 places in the ISH.
Brussels Region	16	480	
Total	85	3916	

Table 6 – Number of Places in Sheltered Housing Initiatives in 2009-2010

The preceding tables show that the majority of psychiatric institutions are located in the Flemish Region. That situation reflects this region's importance (in terms of population) in relation to the Brussels Capital and Walloon Regions. Indeed, the Flemish population was about 6 million in 2010, while the Brussels Capital and Walloon populations were, respectively, 1 and 3.5 million people. However, such differences between the regions also reflect the importance of the Catholic pillar, whose network of psychiatric institutions is bigger in the Flemish than in the Walloon Region. As mentioned in the analysis of the ongoing reform "Psy 107" (chapter 5), this difference has an impact on the relative capacity of Walloon and Flemish hospitals to take part in the reconversion process. Finally, it is worth noting that the decrease in the number of psychiatric beds highlighted by the tables was partly compensated for by an increase in the number of ISH places and general hospital psychiatric beds, which rose from 2851 in 2000 to 3143 in 2010.

2.4.2. *The Ambulatory Sector*

The ambulatory sector is composed of psycho-social ambulatory services, usually referred to as *community mental health services*. It was created in 1975 on the occasion of the first reform of psychiatry launched by the Public Health Minister De Sager. From the first reform of the state onward, the ambulatory sector fell under the jurisdiction of the Regional Ministry of Public Health. Community governments were also responsible for some aspects of their functioning, particularly mental health promotion and prevention-related issues. Community services are financed through regional subsidies, which are proportionally lower than the federal budget allocated for the residential healthcare sector.

Community services developed along different paths and were organised in different ways in the three regions. Their number is significantly higher in the Walloon and Brussels Capital regions than in the Flemish Region. In 2010, the number of community mental health services rose to 65 in the Walloon Region, 22 in the Brussel Capital Region and 20 in the Flemish Region. In spite of regional differences, those services generally consist of multidisciplinary teams of five to seven workers, including psychiatrists, psychologists, social workers, educational and speech therapists.

2.4.3. *The Psychosocial Rehabilitation Sector*

The psychiatric or psychosocial rehabilitation sector is composed of services financed through special conventions with both the National Institute for Health and Disability Insurances and the law on hospital facilities. In general, these services developed as small structures, based in the community and managed by multidisciplinary teams. They offer intensive, short-term, and individual-centred follow-ups focusing on developing individuals' functional abilities and social skills.

These services started developing in the early 1960s, following efforts made by reformist psychiatrists to promote social psychiatry. In 2004, the NIHDI listed 28 psychosocial rehabilitation services, including 22 day services offering 375 places per day, five residential services offering 91

places, and one night service offering 15 places. Since they arose from local professional projects, psychosocial rehabilitation services developed unevenly across the country. In the framework of the ongoing reform, the NIHDI decided to standardise the psychosocial rehabilitation section; a move which is, indeed, essential to the realisation of the policy programme. Consequently, the Institute invited psychiatric and mental healthcare providers to propose new projects, which started to be implemented during the first half of 2014.

Finally, from the early 2000s onward, several pilot projects developed in the system. Those pilots focused on implementing new care functions jointly provided by residential, community and rehabilitation care structures. They were intended to prepare a shift from a hospital- to community-based system by testing the efficacy of new care functions over a given period of time. Most projects nonetheless continued to operate following the policy initiatives in the framework of which they had been tested out, thus making the system yet more diversified and complex.

3.   THE GLOBAL CONTEXT FOR ADDRESSING PERSONAL PROBLEMS

Defining the global context relevant to the Belgian system for addressing personal problems entails specifying exactly what we are talking about: are we considering psychiatry or mental health? What are the relationships between the two? Are we considering the corresponding systems of action as professional systems, scientific domains or policy sectors? And how do these aspects combine with one another to give rise to large social systems?

3.1. Interrelated Developments in Mental Health and Psychiatry

The domain of collective action studied in this work includes fields of activities that developed under the banners of psychiatry, mental health and psychiatric rehabilitation. They developed in relation to one another, along with changes in social needs, social movements, scientific innovations and international and national policies. This domain started growing under the name of psychiatry in the late nineteenth century. At that time, by advocating a biological approach likely "to give psychiatry an undisputed medical status" (Pichot, 2009, p. 19), psychiatrists made their discipline a modern and scientific endeavour (Rowe & Thompson, 2011, p. 599). This image of psychiatry as a "child of the enlightenment" (idem) sharply contrasted with overpopulated and understaffed asylums providing only custodial care (Pichot, 2009). Efforts were thus made to improve the institutional framework of psychiatry and the training of psychiatrists. In the course of the nineteenth century, the "formal and administrative recognition of psychiatry as a medical speciality" and the use of words such as "hospitals, nurses and patients instead of "asylums, attendant and lunatic" (idem, p.22), reflected the success of the scientific discourse in shaping psychiatry as a medical discipline.

Social psychiatry developed in parallel with biological psychiatry. In contrast to biological psychiatry, which presented itself as a "response to nature's allocation of mental illness …, social psychiatry looked to nurture, which shows itself in culture, class, material circumstances, stigma and

other factors external to the body" (Rowe & Thompson, 2011, p. 598). Moreover, since it implied an explicit protest against the living conditions of people with mental disorders in psychiatric hospitals (Bertolote, 2008) - a protest carried out by the antipsychiatry movement (De Munck et al., 2003) - social psychiatry carried an invitation to provide psychiatric services as close as possible to the people's living environment. Consequently, just as social psychiatry developed *in relation to* biological psychiatry (by highlighting its shortcomings in addressing the context in which personal problems developed), community mental health services developed *in relation to* psychiatric hospitals, by highlighting the isolation and chronicity produced by residential institutions.

The expression "community psychiatry*"* (Rowe, Lawless, Thompson, & Davidson, 2011) thus seems appropriate to refer to the conflictual relationships[15] that took shape following interrelated developments of biological and social psychiatry. Meanwhile, since this expression was used to refer to myriad branches of complementary knowledge, clinical instruments and practical experience, it became an unstable category (R Freeman & Rowe, 2011). The vagueness of the expression regarding the kinds of knowledge of personal problems to which it refers has not been confused, however, with political neutrality. As Freeman and Rowe highlighted, community psychiatry is public psychiatry for poor people. As demonstrated in chapters 4 to 6 of this work, the conceptual and axiological ambiguities of this expression and related concepts such as *psychiatric rehabilitation* (see below), are likely to provoke misunderstanding in collective actions taking place in response to policy initiatives based on the associated care models.

3.1.1. *Psychiatry in the Second Half of the 20th Century: the Need for a New Medical Model*

In the mid-20th century, the rapid growth of the mental health movement and psychotherapies[16] (Gasser & Stigler, 2001) combined to enlarge the domain of psychiatry far beyond the boundaries delineated by the medical approach. As illustrated by professional articles (for example, *The need for a new medical model, a challenge for biomedicine* (Engel, 1977) or *Are psychiatrists an endangered species?* (Katschnig, 2010)), psychiatrists felt threatened by the development of competing occupational groups claiming different kinds of knowledge in addressing personal problems. The development of multiple professional segments within psychiatry (Pickersgill, 2012; Schatzman & Strauss, 1966) resulted, indeed, in making psychiatric knowledge and beliefs system a hybrid whole

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[15] The article "*The Roots of Mental Health*" (Bertolote, 2008) also stressed such interdependence. It particularly emphasised the "para-psychiatric nature" of the mental health movement, before of stating that proponents of psychiatry and of mental health were "more than ever conscious that their objectives are in fact identical and that each group needs the other for the fulfilment of their common task" (p.14).

[16] Psychoanalysis and psychotherapies emerged from studies in neurosis, in parallel to biological psychiatry which largely dominated the field in the first half of the twentieth century. They focused on complex psychopathological mechanisms which would produce neurotic behavior. They endorsed time consuming and relational treatments which were more easily applicable in private than in public practice. Consequently, psychotherapies were rarely the core work of professionals working in public institutions (Pichot, 2009), such as those studied in this work. The presentation of interrelated developments in mental health and psychiatry thus set aside changes specific to the field of psychotherapy.

(Pickersgill, 2012; Samson, 1995). As argued by Samson, such hybrid knowledge could have contributed to the maintenance of medical dominance (Samson, 1995, p. 251) by justifying protections given to professional workers able to *infer* individual and practical solutions from abstract knowledge (Freidson, 1988). However, by the 1970s, "unsystematic linkage to treatment modalities and lack of specificity to medicine" (Samson, 1995, p. 251) were perceived as "the fracturing of medical dominance" (idem).

The response of the profession was a new attempt to medicalise psychiatry. This attempt found concrete expression in the third version of the *Diagnostic and Statistical Manual of Mental Disorders (DMS)*. In contrast to the two first versions, which relied on psychoanalytical theories, the authors of the DMS-III wanted it to be a-theoretical (Gasser & Stigler, 2001). As reported by Andreasen, there was a consensus among the members of the task force responsible for developing the DSM-III that it "should be evidence based, use diagnostic criteria in spite of description, and strive for maximal reliability" (Andreasen, 2011, p. 569).

The resulting manual succeeded in improving communication between clinicians and providing "reliable diagnoses that would be useful in research" (idem) and teaching psychiatry. Considered as a response to the WHO *International Statistical Classification of Diseases and Related Health Problems* (ICD-9) (Gasser & Stigler, 2001), the DSM-III also succeeded in bringing American psychiatry into alignment with the rest of the world. However, the clinical approach induced by the DSM-III, which set aside individual person and history to focus on characteristic symptoms, resulted in dehumanising and decontextualising the practice of psychiatry (Andreasen, 2011). Moreover, by connecting empirically observable symptoms to defined disorders, the manual significantly decreased the importance of inference in professional practice. Consequently, although it gave psychiatrists the opportunity to produce reliable diagnostics, the DSM-III also gave a wide range of occupational workers the possibility of making psychiatric diagnostics. In 1994, by stating their project of making the DSM IV an instrument used by psychiatrists, social workers, psychologists, and educational therapists as well as public health authorities, the authors of the fourth version definitely disconnected it from the professional project initiated by psychiatrists (Gasser & Stigler, 2001).

3.1.2. *The Mental Health Movement and Psychiatric Rehabilitation: Policies and Practices*

In the first half of the twentieth century, the mental health movement arose from attempts by mental health professionals to offer psychosocial treatments outside the hospital walls. It subsequently involved a focus on prevention work (Bertolote, 2008), and a commitment to supply multidisciplinary interventions adequate to individual needs and close to the living environment (Graham Thornicroft & Tansella, 2013).

In the second half of the twentieth century, political movement and scientific innovation came to support the mental health movement's expansion. Politically, the integration of mental health into

the WHO agenda significantly stimulated the development of community-based systems across the world. As explained in the following section, at the turn of the 21st century, the political support brought by the European Commission to the WHO strategy further reinforced the mental health movement at the European level. Practically, the rapid development of psychoactive drugs such as neuroleptics, antidepressants, anxiolytics and mood stabilisers significantly contributed to the professional project of mental health workers (De Munck et al., 2003). Indeed, by decreasing the symptoms of mental disorders, this development considerably supported their attempt to organise community follow-ups (Pichot, 2009).

Alongside the mental health movement, "psychiatric rehabilitation emerged as the leading social arms of community psychiatry" (Anthony & Liberman, 2011, p. 309). In his founding article on *Psychiatric Rehabilitation: Key Issues and Future Policy*, Anthony (1992) explained the concept of psychiatric rehabilitation by distinguishing between the term *psychiatric*, defining the disability on which rehabilitation focuses rather than the kind of services or professionals intervening in rehabilitation, and that of *rehabilitation*, which referred to the intent of the intervention "to improve functioning in a specific living environment" (Anthony, 1992, p. 165). Psychiatric rehabilitation thus displaced the focus from mental illness itself to its consequences. Practically, that displacement implied the use of different techniques such as case management to help people with mental illness to recover their "social and instrumental role" (Anthony & Liberman, 2011, p. 321). This framing also involves a processual and comprehensive approach defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles, [to live] a satisfying, hopeful, and contributing life even with limitations caused by illness" (Anthony, 1993). The psychiatric rehabilitation approach thus induced an important shift in the objective of psychiatric treatment, which moved from "maximizing health" to "minimizing illness" (Anthony, 1992, p. 165).

3.2. OECD Mental Health Policies: Moving at Different Paces but in the Same Direction

OECD mental health and psychiatric policies developed differently according to national cultures and history. The main differences between countries relate to financing systems, the importance of residential psychiatry compared to community psychiatry, the relative diversification of community facilities and centralisation/decentralisation of psychiatric and mental health policies. In spite of these differences, most countries have recently acknowledged a sharp increase in the burden of mental health and psychiatric problems on contemporary society (Knapp, McDaid, Mossialos, & Thornicroft, 2007). Moreover, following conferences, researches and publications stimulated by the WHO at the turn of the 21st century, many countries have taken measures to improve mental health and psychiatric systems (idem). These measures followed similar policy orientations (Amaddeo, Becker, Floritti, Burti, & Tansella, 2007), including shifting mental healthcare systems from

residential to community models, developing evidence-based mental health policies and empowering service users' and carers' groups.

3.2.1. *Different Ways of Moving from Residential to Community Psychiatry*

"Complex systems, rooted in age-old beliefs, and buttressed by powerful interest groups are notoriously difficult to change. And yet, the system for 'caring for' people with serious mental illness appeared to have virtually demolished. … The transformation, which continues in the US to this day, as in other part of the world, was the result of a 'perfect storm' of independent forces working at a broad range of societal levels." (Rosenheck, 2008, p. 100)

The shift from residential to community models has followed different paths, ranging from direct and complete replacement of psychiatric hospitals by community services (as was the case in Italy) to gradual development of community services in complement to residential facilities. The shift has also been supported by various means, including major changes in institutional frameworks (for instance the 1959 Mental Health Act in Great Britain, the 1960 memorandum on sectorisation in France, and the 1963 Community Mental Health Centers Act in the United States), and minor policy reforms supporting gradual changes in mental health systems. Finally, the shift from residential to community models was characterised by different balances between increasing the intensity of residential treatment and developing more community facilities.

Those variations were subject to scientific caution via the widely cited *balanced care model*. This model relied on the argument that "there is no strong evidence that a comprehensive system of mental healthcare can be provided by hospital-based care, but nor is there strong evidence that it can be provided by community based services. Rather, a balance is necessary which includes both hospital and community components" (Graham Thornicroft & Tansella, 2013, p. 248). It also assumes that the right balance depends on the structural and economic resources available in different countries. In this matter, the development of community services in connection to primary care systems would represent a less costly solution than intensifying residential psychiatry (Amaddeo et al., 2007).

Uneven developments of community psychiatry have been equally sanctioned by proponents of the model, who recognised not only that "each community society and nation needs to put the necessary elements for care together in a package that make sense for them" (Singh & Castle, 2008), but also that the implementation of community systems raised interconnected challenges, including professional, political, and institutional issues. The following quote from the widely cited article on *Steps, challenges and lessons in developing community mental healthcare* (G. Thornicroft, Tansella, & Law, 2008) proposes practical means to deal with staffs' resistances to change. It draws attention to the processual, local and relational aspects of implementing the community model, and the extent to which WHO documents provide local services with resources to help them make sense of the change process:

"Commonly there will be a range of staff views on proposals to change the care system. Many opportunities may be necessary to involve the range of staff, including a widespread process of consultation, with planning groups, including diverse opinions. Linking local specific proposals to generally agreed plans, such as the World Health Organisation declarations, can put your services in a wider context, and help to create a sense of the inevitability of change." (G Thornicroft, Tansella, & Law, 2008, p. 89).

3.2.2. *Seeking Evidence, Using Experience*

According to Knapp et al. (2007), producing evidence regarding mental health and psychiatric services constitutes a key challenge for European policymakers seeking to improve the effectiveness of the related systems. At the national level, systematic empirical research (Jenkins, McDaid, Traolach, Cutler, & Hayward, 2007) must provide policy makers with evidence on service organisation. Such evidence must be translated in comprehensible and accessible language by policy makers and a variety of means should be used to ensure the primacy of evidence over knowledge produced by lobbies seeking to influence decision making in mental health (idem, pp. 101-102). Collection of exhaustive information, deriving from different sources and involving different stakeholders, is presented as an efficient means to increase the legitimacy of evidence. The pilot projects presented in chapter 3 will illustrate an attempt to collectively produce evidence on Belgian mental health and psychiatric services.

At the international level, the WHO sought evidence regarding national systems to stimulate the implementation of community systems across the world. As explained in the following section, the incapacity of most countries to provide standardised and harmonised data prevented the WHO from meaningfully comparing different kinds of service organisations (Sturdy, Freeman, & Smith-Merry, 2013). Consequently, not only did the WHO use different means to stimulate change in mental health system, but it also inscribed the production of evidence among the objectives that its member countries committed themselves to by signing the 2005 *Declaration and Action Plan.* The production of standardised data on mental health systems thus became a policy objective as much as a means to stimulate more global reorganisation.

Alongside evidence, service users' experience was increasingly used to support change in mental health system. In turn, service user groups acquired a role in mental health policy making. The pilots studied in chapter 3 will also illustrate attempts to formalise users' participation at the organisational and institutional levels.

Service users' and carers' groups started developing at an accelerated pace in the1990s. First, deinstitutionalisation processes launched by several countries resulted in a transfer of the burden of care to families and relatives of people with chronic mental health problems (Amaddeo et al., 2007). Families consequently created associations lobbying to obtain recognition for their role in caring for people with mental health problems and to be invited to participate in mental health policy-making.

These associations joined together in the European Federation of Associations of Families of Mentally Ill People in 1992. Second, practical experience in reforming mental health systems evidenced that services users were often better placed than professionals to assess the effectiveness of mental health services (G. Thornicroft et al., 2008). Third, research on the participation of services users in the evaluation of mental health services highlighted that such participation helped the individuals involved to develop "new skills and knowledge, a sense of empowerment and being valued and a better understanding and relationship with other researchers" (Rose & Lucas, 2007, pp. 336-337). These observations supported the creation, in 1991, of the European Network of Users and Ex-Users in Mental Health. This organisation obtained its current status as the Federation of Services Users' Associations in 1998. The Federation was supported by the European Commission to develop anti-stigma campaigns and to encourage the strengthening of human rights legislation in relation to mental health (Parker, 2007).

At the national level, the creation of services users' associations generally followed moves from residential psychiatry to community systems (Rose & Lucas, 2007). In the 1960s, the antipsychiatry movement stimulated a first wave of service user groups, which carried a strong protest against traditional psychiatry. However, as they obtained public recognition and funding, most of them "lost their radical edge" (Rose & Lucas, 2007, p. 340) and started to concentrate on organising self-help and mutual support groups, promote mental health, and fight against discrimination (idem). In 2005, the WHO *Declaration and Action Plan* (2005) also contributed to increase the enrolment of services user groups in mental health policies decision making and services organisation and planning (idem). As a result, the role of service user groups gradually shifted from contesting the organisation of mental health and psychiatric services to taking part in devising their reorganisation in community settings. As we shall see in chapter 3 and beyond, the rise and development of Belgian services users' and carers' groups reflected those international trends.

3.3. The World Health Organisation: Moving in the Same Direction

Faced with the uneven development of community mental systems across the world, the WHO attempted to impose international standards on national change processes. The following presentation of the WHO strategy is based on a case study provided by Freeman, Sturdy and Smith-Merry[17] (2012; 2013; 2014). As we will emphasise in chapters 4, 5 and 6, the creation and implementation of the ongoing Belgian reform has much in common with the process described in this case study. This section summarises its main features.

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[17] These analyses of the activities of the WHO, especially the European Regional Office, were provided by Freeman, Sturdy and Smith-Merry following the *Know&Pol* European research project (R. Freeman, Smith-Merry, & Sturdy, 2012; R. Freeman & Sturdy, 2014; Sturdy et al., 2013).

3.3.1. *From Universal to Situated Knowledge of Mental Health Services*

The WHO was created just after WW2. A Mental Health Unit and an Expert Committee were set up in 1948 and 1949, respectively. From that time onward, leading positions at the WHO and WHO's European Regional Office were occupied by psychiatrists more concerned with mental health than traditional psychiatry. Their interests in relation to mental health alternatively consisted in promoting social psychiatry, focusing on preventive medicine and developing community-based systems (Sturdy et al., 2013). These objectives led the WHO to seek standardised data on mental health services across the world, which could be used to compare their effectiveness and to define guidelines to help member countries to consider change in their mental healthcare systems (Sturdy et al., 2013, pp. 5-7). Since the WHO had "no powers to compel member states to adopt any particular course of action" (idem, p.1), producing and mobilising knowledge was, in practice, the only way for the organisation to reach its objectives. The lack of adequate data and differences in national conceptions of mental health prevented the WHO from realising the expected international comparisons. Consequently, in the early 1970s, the Regional Office increasingly endorsed an alternative approach involving "more detailed, in-depth investigations of smaller areas" (idem, p.9). As noticed by Sturdy et al. (2013), not only did this "kind of holistic, case-based knowledge of local services" (idem) entail different methods of investigation, including immersion in local services, but it could not circulate as easily as standardised data. The Regional Office then adopted a new strategy, which consisted of creating opportunities for people embodying knowledge of local services to meet and to share their knowledge (idem, p.11). The WHO case-based strategy was reinforced in the course of the 1980s and 1990s (idem, p.12), culminating in the early 2000s with the creation of a network of national counterparts. National counterparts were in charge of ensuring the link between their countries and the WHO Regional Office. To this end, they met "twice a year to discuss the development of mental health services across Europe and … to share personal knowledge and experience of mental health services in different national settings" (idem, p.14).

3.3.2. *Calling for Change in European Mental Health Systems*

Shortly before the turn of the century, "a number of factors came together to stimulate renewed efforts to build a Europe-wide strategy to review and reform mental health services" (Sturdy et al., 2013, p. 13). Among these factors, the project of the new General Director of the WHO to support the generalisation of community-based mental health services is worth noting. The project's realisation started with the decision of the Regional Director of Health Services to organise a ministerial conference on mental health.

The first step in organising the conference was to settle a steering committee responsible for "the making of the mental health declaration and action for Europe" (R. Freeman & Sturdy, 2014, p. 62). This committee enabled the Regional Director and other members to jointly use their knowledge

of mental health services to draft the *Declaration and Action Plan.* Their knowledge included professional experiences as well as knowledge of public health systems across Europe, and "procedural knowledge of how to run an effective interministerial conference (idem, p.63) … [and] how to take forward the WHO agenda" (p.64).

Successive drafted versions of the Declaration finally gave rise to a single document which was reviewed by international NGOs and users' and carers' groups before being discussed by representatives of member countries during a meeting held in Brussels in 2004: "The final text of the *Declaration and Action Plan* was thus the outcome of multiple interactions between a group of highly networked actors occupying key (but not central) positions in national health systems, professional bodies and national and international organisations" (R. Freeman & Sturdy, 2014, pp. 64-65).

The Ministerial Conference on Mental Health in Europe took place in Helsinki in January 2005. It was attended by public health ministers of half of the member countries, representatives of the European Commission and the Council of Europe, service users' and carers' groups, psychiatrists and representatives of departments responsible for mental health services. They collectively endorsed the *Declaration and Action Plan*, which was signed by representatives of the member countries at the end of the conference.

Following the conference, and to make sure that the Declaration was implemented at the national level, the WHO's Regional Adviser for Mental Health launched a research study on mental health services across European countries. The explicit objective was to provide the member countries with a reference "against which progress in implementing the *Declaration and Action Plan* could be measured" (R. Freeman & Sturdy, 2014, p. 66). Doing this required local mental health professionals to complete a questionnaire on mental health services' organisation. WHO's officers attended to the relevance of data collected by cultivating "a personal relationship with those responsible for generating the data" (idem). In this way, they also succeeded in improving the ability of local professionals to collect and use data to stimulate change at both the local and national level (idem, pp.66-68). Thus, as noted by the authors of the case study, the process of carrying out the WHO research was as essential to the *Declaration and Action Plan* as the resulting report on *Policies and Practices for Mental Health in Europe.*

3.3.3. *Lost in Translation*

The relative success of the WHO in supporting the generalisation of community-based models across Europe depended on the production of particular kinds of knowledge, which in turn exerted a particular kind of regulation on European mental health policies.

Concerning the kind of knowledge produced by the WHO, Sturdy et al. (2013) remarked that "case-based knowledge of particular interventions" (p.19) proved particularly successful in helping the WHO to reach its objectives. By relying on that observation, they argued for changing the way we conceive of knowledge in international policies, i.e. on the basis of technocratic models. They

suggested replacing technocratic models with the idea of "epistemic communities", which underscores "the collective nature of the work of scientific knowledge production, and … the social organisation of the communities of practitioners who undertake that work" (idem). Moreover, in reference to that conception, they proposed defining the work of the WHO as stimulating an epistemic community that "has evolved around the production and circulation … of context-sensitive knowledge, [which was] in large part generated … through face-to face discussion, negotiation and sharing of personal experiences" (idem, p.21).

Regarding the potential for the WHO to regulate national change processes, the authors noted that its success in stimulating the development of epistemic communities did not imply that it managed to direct implementation of the Declaration, which was rather left to the "collective judgement" of those communities (idem, p.22). In other words, although the WHO succeeded in setting the conditions for sustained enactment of its recommendations across the world, it was not able (except for the training of mental health professionals to collect relevant data) to control how those enactments occurred.

The concept of "rhizomic" regulation (R Freeman, Smith-Merry, & Sturdy, 2012), borrowed from Deleuze and Guattari (1998) to define the regulation exerted by the WHO on the mental health policies of its member countries, equally stresses that WHO recommendations made room for national and local appropriations. This idea denotes a kind of regulation occurring "in translation between meetings and documents, between national and international domains, and as the authority on which it depends is produced and reproduced" (R. Freeman et al., 2012, p. 16). Successive translations bring about new assemblages of a "composite nature" (idem, p.35), including knowledge and practices that have been "accommodated into existing cognitive and normative frame" in the course of a "collective process of sense making" (idem, p.37).

This conception is consistent with the organisation's explicit intent to provide "illustrative or indicative mechanisms through which action can be undertaken in countries" (WHO, 2013, p. 23). It also indicates the possibility for powerful institutions and professions to translate the WHO's recommendations in a way suitable to their interests, although these might conflict with the community model supported by the WHO. In this respect, Freeman et al. (2014) mention the case of the appropriation of the WHO *Declaration and Action Plan* by Hungarian psychiatrists attempting to reinforce the position of traditional psychiatry in the Hungarian system.

On the whole, the analysis of the work of the WHO in terms of knowledge production (Sturdy et al., 2013) and international regulation (R. Freeman et al., 2012) supports the observation that change in mental healthcare systems first and foremost depends on a collective process of learning about new conceptions of mental health and the associated model of relationships. Recent documents of the WHO (2014) have largely echoed that conception:

"One of the most interesting findings from the survey is the reported importance of political skill in fostering mental health reform. In this regard, the survey reveals that 'innovation in deinstitutionalization' is not so much a particular set or sequence of health policy-level interventions, … but rather, the ability to understand the motivation of local stakeholders and changing situational demands and to use that knowledge in strategic ways. Rethinking 'innovation' along these lines implies the need for greater investment in current and future mental health leaders in terms of building their capacity to use political skill to promote deinstitutionalization." (WHO, 2014, p. 6).

3.4. **A European View of Mental Health**

During the period between 1999 and 2005, the European Commission (EC) supported thirteen events and actions relating to mental health (EC, 2005). Four of those events were organised under the EU Presidency, while the nine others were jointly organised by the EC and the WHO. Joint actions of the WHO and the EC gave a particular strength the project of generalising community models (Knapp, McDaid, Mossialos, & Thornicroft, 2007). In turn, the European view of mental health has been deeply influenced by the WHO ideology.

As stated in the 2005 Green Paper of the European Commission, published just after the 2005 WHO ministerial conference, the EC supports a definition of mental health as:

"…a state of well-being in which the individual realises his or her abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community." (EC, 2005, p. 4).

The associated definition of *mental ill-health* includes a broad range of "mental health problems and strains, impaired functioning associated with distress, symptoms, and diagnosable disorders such as schizophrenia and depression" (idem). The strategy used to implement this conception of mental health should be based on a comprehensive approach involving the participation of:

"…many actors, including health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the population. Patient organisations and civil society should play a prominent role in building solutions." (EC, 2005, p. 5)

The overall concept of mental health jointly supported by the WHO and the EC has been widely referred to in Belgian policy documents since the early 2000s. By involving a social and positive approach to mental health, which makes the system a resource for individuals attempting to deal with multiple social roles and a source of social welfare, it implied shifting the prevailing paradigm of the Belgian system.

4.   CONCLUSION

This chapter presented the global context relevant in understanding of the development of the Belgian system for addressing personal problems. Its national and international dimensions were exposed selectively, by highlighting only the elements required to make sense of the policy changes related in the remainder of this work. The two following "knowledge regimes" summarise these elements, in a way that stresses their meaning in relation to change in the Belgian system. As outlined in the methodological chapter, there are ideal-types providing an overall picture of the context.

Institutional arrangements specific to Belgian pillarised society are essential to the first regime, which relies on intermediary institutions that seemed to gradually incorporate knowledge-based regulation into negotiations directing collective action in field of public health. By contrast, the second regime is fundamentally based on knowledge. It used scientific, professional and procedural knowledge (political skills) in devising overall concepts and strategies prevailing on international regulation in the fields of mental health and psychiatry.

The first regime is very specific to Belgian society. The above section on the origins of Belgian society mentioned the growth of a pragmatic culture that enabled conflicting sociological worlds – the Catholic and the liberal – to reach an agreement on the Belgian Constitution. Those two worlds, and later the socialist one, came to form ideological pillars involving most social institutions. Among those institutions, we focused on sickness funds and hospitals. They provided striking illustrations of the strength of the pillars to regulate the concrete functioning of the public health system through the intervention of intermediary organisations, which are continuously negotiating agreements protecting the interests of the members of their respective pillars. Considering the importance of negotiations in regulating particular fields of social action, Mangez and Delvaux argue that there was no room for knowledge-based regulation in the Belgian pillarised society:

> "Decision-making in a pillarised society is fundamentally based on compromises. This has implication for knowledge use in the process: the decision making process cannot be guided by expertise and evidence; as it must firstly be oriented by the will to reach a compromise. … Compromised-based policy-making prevails over knowledge based policy making. This is one of the reasons why there has never really been any clear and strong political discourse … promoting evidence-based policy … in Belgium. Such discourse does not go with the historical institutional settings of the country." (Mangez & Delvaux, 2008, p. 116).

Schokkaert and Van de Voorde rely on similar arguments to explain impediments to change in the organisation of the public health system. In their view, the fact that "health policy is determined through a complex network of administrative procedures in which the providers and the sickness funds play a crucial role" (Schokkaert & Van de Voorde, 2005, p. 36) explains the impossibility of launching any "drastic reform in the Belgian healthcare system" (p.36). The "collection of adequate

information" (idem) and the transfer of such information to consumers are, according to the authors, obvious means to take a first step toward the reorganisation of the system. However, they wondered if anybody is in fact able to oppose care providers who have succeeded in blocking past attempts at reform (idem, pp.36-37). They concluded that attempts to develop knowledge-based regulation in the system should be preceded by changes in the "administrative procedures [that] put severe limits on the regulatory power of the government" (idem, p.37) Those change should be complemented by measures facilitating the devising of comprehensive policies, overcoming the "incoherent division of power between the federal government and the regions" (idem).

Recent changes in the strategies used by both sickness funds and hospital policy highlighted that, in spite of those obstacles, slight moves have been made towards knowledge-based regulation. More precisely, it seems that knowledge-based regulations have been gradually incorporated into historical arrangements shaping Belgian society. In this respect, recent attempts by sickness funds to produce knowledge on the respective efficiency of care institutions in providing particular services seems to indicate that they were considering the need to rationalise the use of the public health budget, and the possibility of reaching that objective by producing knowledge on their functioning. However, in parallel to this emerging consensus on the need for improving knowledge-based regulation, a latent conflict regarding who should be responsible for producing knowledge is rising. This conflict appears to be structured along ideological lines, with the liberal pillar supporting the direct mobilisation of knowledge by services providers competing on a free market; the socialist pillar supporting the regulation of knowledge by the state only; and the Catholic pillar defending the role of intermediary structures in managing knowledge production.

By drawing on these observations, we suggest raising the question of regulation in the Belgian system for addressing personal problems by keeping in mind that: 1) the Belgian public health system was fundamentally based on negotiations bearing upon interests at the exclusion of knowledge; 2) knowledge-based regulations were gradually incorporated into negotiations; and 3) the centre of disagreements thus moved towards the question of who, among services users, the state and intermediary actors, should produce and use which kind of knowledge of healthcare institutions.

The second regime is based on knowledge. It alternatively mobilised scientific, professional and procedural knowledge (political skills) to support international regulations in the fields of psychiatry and mental health. At the beginning of the history of psychiatry, changes in the corresponding system were directed by medical knowledge produced by the profession of psychiatrists. Subsequently, social knowledge of addressing personal problems came to support further development of the system. Following this, medical and social knowledge continued to develop interdependently, by taking advantage of scientific innovations and ideologies arising in adjacent ecologies.

Successive enlargements of the system to embrace new kinds of knowledge and knowledge producers eventually caused systematic attempts to produce objective knowledge on mental health systems. They found concrete expression in the promotion of evidence and experience-based

knowledge, which should be used as the basis for the reorganisation of European mental health systems. However, it became rapidly apparent that standardised data on national mental health systems were lacking. Consequently, the WHO stimulated the production of holistic and case-based knowledge, before organising events and producing documents intended to establish connections between those who embodied knowledge of various mental health systems.

Finally, mobilising such knowledge for the purpose of developing community psychiatry across the world required helping the proponents of community psychiatry to support local and national change processes by providing them with training to produce and effectively use knowledge of mental health and psychiatric services. It also entailed providing national leaders of change processes with "illustrative or indicative mechanisms through which action can be undertaken" (WHO, 2014). By allowing for national appropriations, these techniques succeeded in stimulating change processes in most European countries. Nevertheless, those processes were likely to follow different trajectories at national and local levels, depending on national contexts and culture, and the varying strength of professional and institutional actors to oppose to the development of community psychiatry. In other words, although international regulations were primarily based on knowledge, their translation into concrete practices required negotiations making room for the expression of professional and institutional interests.

To conclude, with a view to helping us understand the events that occurred in the Belgian system for addressing personal problems in reaction to international regulations, we suggest relying on the assumptions that: 1) international regulations initially involved medical knowledge held by psychiatrists; 2) social knowledge came to complement medical knowledge to stimulate interrelated moves in the fields of psychiatry and mental health; and 3) international regulations depending on social knowledge increasingly involved actors whose political skills became just as important as their professional expertise.

Chapter III – PAST CHANGES IN THE BELGIAN SYSTEM FOR ADDRESSING PERSONAL PROBLEMS

INTRODUCTION

Sociological and historical accounts relate various stories regarding the development of the Belgian system for addressing personal problems, or parts thereof. The book *Mental Health and Citizenship* (De Munck et al., 2003), provides a good instance of sociological accounts of the system's development. It explains changes in mental health policies and institutions by relating them to particular kinds of state interventions and conceptions of citizenships, which found concrete expression in specific institutions. Accordingly, the authors relate the growth of asylums to the liberal state, the institutionalisation of psychiatric hospital to the welfare state, and the development of mental health care network and care circuits to the network state.

The following story relates the development of the system as a social process through interdependent ecologies, developed following claims by different groups to held better knowledge of personal problems. By exploring changes in this social process and the associated system at the global and local level, it intends to understand how different forms of institutions gradually took shape. By highlighting social mechanisms underpinning changes in mental health and psychiatric institutions, it enables us to identify the particular challenges that the current Reform 107 raised and, more generally, to problematise the issue of change in the Belgian system for addressing personal problems. This story is only one possible way to describe how the Belgian system for addressing personal problems developed over time*;* it is neither the history of the system from 1948 to 2010, which would suppose other methods and purposes, nor the only possible sociological account of its development.

The story is composed of five sections corresponding to sub-processes included in the overall development of the Belgian system for addressing personal problems. Every sub-process starts with events, generally the arising of a new policy initiative, reflecting changes in the "frame" (Radaelli, 1995, p. 168) defining what is doable and thinkable in the field at a given time.

The first section summarises the main step of the growth of the residential ecology. The first event occurred in 1850. It corresponded to the "politisation" of psychiatry, when madness became "object of policy and politics, issues of public concern, and subject to state regulation" (R Freeman, 2012, p. 14). The second event is the transfer of psychiatry from the Ministry of Justice to the Ministry of Health. This prompted a series of actions, all directed towards the institutionalisation of psychiatric hospital as the main site for the treatment of personal problems, and of psychiatrists as the dominant profession in dealing with those problems.

The second section relates the institutionalisation of the community ecology, following the 1974 reform of psychiatry launched by the Public Health Minister, De Saeger. This reform created

Community Mental Health Services (CMHS), conceived as sites appropriate to psychosocial treatment of personal problems. In spite of policy measures designed to ensure the functional interdependence of the residential and community ecologies, they started growing separately, bringing about an enlargement of the system going far beyond the boundaries delineated by the medical approach. Following the institutionalisation of the community ecology, changes in the immediate environment of the system settled new conditions for further moves in the system. On one side, the first reform of the state split the responsibilities related to personal problems between the federal, regional and community governments. On the other side, the budgetary crisis at the end of the 1970s led the federal government to take policy measures which put an end to the growth of the residential ecology.

The third section relates the institutionalisation of the rehabilitation ecology. This happened in the course of the 1989 Busquin reform of psychiatry, which created alternative housing facilities, respectively the sheltered housing initiatives (ISH) and psychiatric nursing homes (PNH), based on the principle of psycho-social rehabilitation. Those new facilities reflected a change in policy objectives. In a manner consistent with changes in the global context, policy objectives moved towards deinstitutionalising the system.

The fourth section relates the setting of new conditions for further moves in the system. It presents a series of professional and policy documents which outlined a new understanding of personal problems and a new model for the reorganisation of the system. It also introduces new actors and instruments which circulated a new conception of personal problems in the system. Those actors and instruments straightforwardly questioned the dominance of residential institutions and the profession of psychiatry in the system.

The fifth section sets out the policy initiative of the "therapeutic project" and the "horizontal dialogue". Those pilots put the new conditions established between 1995 and 2005 to the test of empirical reality. The short stories of the local therapeutic projects and horizontal dialogue evidence conflicting claims to embodying better knowledge of personal problems and attempts by multiple kinds of actors to position themselves as an "obligatory passage point" (Callon, 1986) in the reorganisation of the system. Successive enactments of such conflicting views eventually facilitated the questioning of local professional and institutional routines on the one hand, and the building of objective coalitions likely to support the coming Reform 107 on the other.

Finally, this chapter concludes by proposing a conceptualisation of the Belgian system for addressing personal problems as an encompassing system composed of interdependent ecologies whose relationships are cross-regulated by protective and offensive games played by a traditional coalition and a reformist network. By outlining this conception, it draws a series of hypotheses as to how organisational changes happened in the system. Those hypotheses are then mobilised in interpreting ongoing changes in the system, such as observed in the framework of Reform 107.

1.   THE GROWTH AND INSTITUTIONALISATION OF THE RESIDENTIAL ECOLOGY

"By putting the institutions for insane under the administrative and judicial jurisdictions, by imposing objective rules on the insane' admissions to and release from those institutions, and by carefully organising the medical service, the law of the 18th of June 1850 opened a new era." (Wouters & Poll, 1938, p. 7)

1.1. 1850: Making Personal Problems a Public Issue

In the course of the first half of the nineteenth century, psychiatrists started drawing the Belgian government's attention to absence of policy measures framing collective action in relation to personal problems, and the dilapidation of psychiatric institutions. A special committee was thus set up to think about ways of improving the living conditions of the insane, and psychiatric care in general. The work of that special committee was significantly influenced by Dr. Guislain, a reformist psychiatrist heading an asylum in the Flemish city of Gand.

Dr. Guislain knew about the developments in European psychiatry, and he was particularly interested in the works of Pinel and Esquirol. While witnessing the decay of Belgian asylums, he committed himself to "translate" (R Freeman, 2009) growing knowledge in psychiatry into the Belgian context (De Boismont, 1867). As early as in 1826, his *Treaty on Mental Insanity and the Insane's Homes* (Guislain, 1826) stressed difficulties in aligning Belgian psychiatric institutions with changes in European psychiatry. Guislan attributed those difficulties to "'entrepreneurs heading private institutions [who] disagreed, due to a lack of faithful records and other inappropriate reasons, to provide the information that could be used to achieve a general statistic" (idem).

"Our institutions have not adopted the many improvements achieved abroad. No use is made of physical and psychological treatments successfully practiced elsewhere. Since the beginning of this century, the London, Cork, Paris … institutes offered instances of successful reforms. It would be easy to imitate all what our … habits and needs would enable us to borrow from those instances. However, our institutions for insane are still sites where different kinds of mental illness are mixed-up, where numerous ill-fated are moaning, sometimes locked-up in dungeon …" (Guislain, 1826)

The Treaty written by Guislain inspired the special committee in charge of drafting the first *Law on the Belgian System for Insane People*. Three aspects of this law are relevant in relation to the entrance of personal problems in both the political sphere and the medical jurisdiction. First, it sanctioned the state's regulation of the opening and functioning of asylums. Accordingly, it made it compulsory for the heads of asylums to provide the public authorities with annual reports on the global situation of their institutions. Second, the law attempted to increase the medicalisation of asylums by

compelling them to distinguish between "imbecile" and "senile" people, who had to be sent back to their families, and the "insane" deserving medical treatments. Third, medical doctors who had passed clinical, therapeutic and general psychiatry exams had then to be appointed by the minister in charge. Medical doctors were in turn responsible for the training of psychiatric nurses and for the inscribment of clinical observations in registers monitored every year by public inspectors. Fourth, the law defined safety and sanitary measures as well as standards applying to the number of medical doctors required for asylums whose population was less or higher than 150.

The 1850 law pioneered public regulation imposed on private institutions devoted to the medical treatment of personal problems. The need to find a balance between the autonomy of private institutions in treating personal problems and the intervention of the state in organising psychiatric institutions was a consequence of the existence of a large network of institutions held by religious congregations. Indeed, among the seventy one open and closed psychiatric institutions that existed in the second half of the nineteenth century, sixty five belonged to that network while the others (including the hospital headed by Dr Guislain) were managed by the Belgian State. As noticed by Liégeois, this situation was understandable only in the "political climate of liberal Catholicism which was prevalent in Belgium before and after the independence of 1830" (Liégeois, 1991).

1.2. The Foundations of the System for Addressing Personal Problems

"Thanks to its belonging to the public health jurisdiction, the sector has been significantly professionalized over the last decades; when I started working in a psychiatric hospital, there were at best two nurses by wards and most of time the nuns prevented them to do their work. Now, it is the exact opposite!" (Interview with the head of a psychiatric hospital, 04/2011)

1.2.1. *Institutionalising Medical Psychiatry*

In 1948, closed establishments fell under the jurisdiction of public health. This transfer of responsibility from the Ministry of Justice to the domain of health accelerated the institutionalisation of the medical approach to personal problems, now referred to as mental illnesses. The institutionalisation of medical psychiatry involved: the transformation of asylums into hospitals; the gradual integration of hospital psychiatry into the global health system; and the legal recognition of psychiatry as the dominant profession dealing with mental illness (De Munck et al., 2003).

First, the creation of psychiatric hospitals consisted, in most cases, of transforming asylums into medical institutions, by secularizing the hospital management, developing new facilities and professionalising medical and paramedical staffs[18]. That transformation was supported by a set of policy measures, including a Ministerial Decree of July 1960 defining neuropsychiatric units for acute

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[18] The short story of the development of the Peter Brothers and the PRIPH psychiatric hospitals provided in the second part of this work illustrate the gradual transformation of asylums in hospitals.

disease, and a Royal Decree of November 1965 defining partial-hospitalisation units for psychiatric patients exerting professional activities.

Second, few months after the creation of the National Institute for Health and Disability Insurance (NIHDI), in December 1963, psychiatric treatments were incorporated into the Public Health Insurance System (De Munck et al., 2003). Only closed services remained outside the system still 1972, when the integration of psychiatry into the public health system was completed.

Third, in 1958, the Belgian state recognised the profession of psychiatry, then "seen as belonging to the specialism of neuropsychiatry" (Hermans, De Witte, & Dom, 2012). The reimbursement of psychotherapies by the NIHDI, from 1963 onwards, came to complement the state recognition of psychiatrists, whose dominant position was not significantly challenged by psychologists. Indeed, while the NIHDI intended to intervene in the reimbursement of psychotherapies provided by both psychologists and psychiatrists, the former missed this opportunity, due to a lack of cohesiveness as a professional group (De Munck et al., 2003, p. 38).

The transfer of responsibilities from the Ministry of Justice to Public Health heralded a period during which the medical approach became central to the system. Medical knowledge was inscribed in NIHDI administrative categories and in psychiatric hospitals, whose equipment and social organisation were appropriate to the application of medical knowledge. Those two material supports were very effective in ensuring the domination of medical psychiatry over the system for several decades.

These moves toward increased medicalisation were consistent with changes in the global context, characterised by psychiatrists' efforts to dissociate psychiatry from its social and custodial functions. Meanwhile, in Belgium, improvements in psychiatric institutions appeared alongside the incorporation of psychiatry into the Public Health jurisdiction, which made increased resources available to private and public institutions. The role played by the Ministry of Public Health in professionalising psychiatry brought about an objective alliance between public health authorities and representatives of the residential ecology, the latter strongly defending this alliance each time they felt their area of work threatened by the "social wave" (Pichot, 2009).

That social wave started developing at the edge of the Belgian system for personal problem in the early fifties. It included two contrasted conceptions of personal problems, respectively psychosocial approaches and psychiatric rehabilitation, which gradually gave rise to new care structures, namely the community clinics and psychiatric rehabilitation centres.

1.2.2. *The Emergence of the Community Ecology*

Community clinics were created by the Belgian National Mental Health League, which started developing in 1923 "on the line of the National Committee for Mental Health set up in the United States in 1909" (Orenbuch 1981: 116). The community clinics were "primarily and basically concerned with the improvement of the care of people with mental disorders" (Bertolote, 2008, p.

113). Later, following the enlargement of the US committee's programme, their scope of activities enlarged to "milder forms of mental disability and a greater concern with preventive work" (Idem, p. 114).

Community clinics gained public recognition through the Royal Decree of 12th June 1953. The decree specifically limited the clinics' mandate to prevention work, defined as consisting in "diagnosing the problem and sending the person to a psychiatric hospital … and checking up on patients who had been discharged to prevent a relapse" (Orenbuch, 1981, p. 117). By making community clinics "a kind of bridge…between no treatment at all and the maximum amount of treatment" (Idem: 119), that decree did not really challenge the role of psychiatric hospitals, and even confirmed their absolute monopoly over treatment.

However, the community clinics rapidly contested the mandate inscribed in the 1953 Royal Decree. They contended that the weak subsidisation established by the decree underestimated their work, which often exceeded prevention activities. Thus, in 1966, the National League established a working group tasked with conceiving of a new status for the clinics. Five years later, the annual report of the Ministry of Public Health stated that community clinics should hold a central position in the system for addressing personal problems (Versporten, 2006). The next step was the 1975 Royal Decree, which constituted the masterpiece of the first reform of psychiatry started in 1974.

1.2.3. *The Emergence of the Psychiatric Rehabilitation Ecology*

"The system of special agreements appeared at the end of the sixteenth to allow Insurance organisations supporting rehabilitation treatment provided outside the traditional hospital frame. At the very moment when this system was growing, the notion of rehabilitation gained in importance. It was stimulated by a will of reintegrating the victims of industrial accidents, people with physical disabilities and the mentally ills into professional and social life." (Boffa, 2001, p. 157)

Psychosocial rehabilitation services started developing following the creation of the Julie Renson[19] Foundation in 1957 (Idem, pp. 34-57). The Foundation supported a professional movement promoting social psychiatry in Belgium. This movement was led by Paul Silvadon, a Belgian physician holding the chair of psychiatry at the Université Libre de Bruxelles, and key actors representing the Belgian Mental Health League and the Ministry of Public Health; especially Dr Sam Halter, who played a central role in devising the first reform of psychiatry.

The movement started growing from conferences where international experts such as Dr. Amiel, the leader of social psychiatry in France, shared their experiences in psychiatric rehabilitation practice with Belgian mental health professionals and public authorities. They gave rise to some forty meetings

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[19] The Julie Renson Foundation was created at the initiative of Julie Renson. Being concerned with the subsistence of her daughter suffering from mental illness, Julie Renson devoted her inheritance to the creation of a foundation intended to help mentally ill people (see Boffa, 2001, pp. 34-35).

which resulted, in 1959, in a report devising a "project for the organisation of psychiatric community support" (Boffa, 2001, p. 42). The report's impact was considerably amplified by the *World Day* and *World Year for Mental Health*. Initiated by the WHO and the World Federation for Mental Health, this event stimulated reflection on how best to implement community psychiatry in Belgium. The study committee in charge of this reflection drafted a pilot project intended to test this model in a Brussels district.

Started in 1961, this pilot gave birth to the non-profit association *L'Equipe*. Initially composed of a post-treatment centre, *L'Equipe* rapidly enlarged its activities to include socio-professional insertion (1963) and rehabilitation (1964). Given this expansion, the board of directors of the Julie Renson Foundation asked for public license and subsidies. They were first assimilated to partial-hospitalisation units created in 1965, before receiving subsidies allocated by the NIHDI through "special agreements".

Special agreements became a support specific to Psycho-social Rehabilitation Centres (PRC). They were granted by the NIHDI on the basis of the therapeutic projects suggested by mental health professionals. They could be adapted following changes in mental health problems and social environments. At the end of the 1960s many others PRC developed in the framework of such special agreements. Initially focused on psychosocial/psychiatric rehabilitation for adults, they enlarged their scope of activities to include young people with severe mental health problems in 1969, and to drug addicts in 1981 (De Munck et al., 2003).

1.3. Conclusion

At the end of the 1960s, the system for addressing personal problems was dominated by the medical approach to personal problems. The medical approach was inscribed in the administrative and institutional framework of the system and continuously enacted by psychiatrists. However, alternative approaches to personal problems were developing at the margins of this system, thus questioning the ability of psychiatrists and psychiatric hospitals to maintain complete control over the treatment of personal problems (Abbott 1988:69-79).

The development of alternative approaches was supported by non-profit associations connected to international movements. Those associations involved lay members as well as mental health professionals occupying key positions in public administration. These actors tried to interest policy makers in alternative knowledge of personal problems, with a view to gaining both public recognition and subsidies. Interessement processes gave rise to a minimalist royal decree and the NIHDI special agreements, respectively supporting the development of community clinics and PRC.

Such policy responses did not straightforwardly question the dominance of medical psychiatry. However, the rapid expansion of community clinics and PRC proved the relevance and effectiveness of alternative treatments. First, their development showed that new methods were required to help new target groups composed of "mentally sick persons whose condition was not, or was no longer, bad

enough for in-patient hospital treatment" (Orenbuch, 1981, p. 117). Second, by emphasising the need for early preventive medicine, mental health clinics encouraged "integrating the "madman" into the field of social medicine, what implied a shift of emphasis in the work of the psychiatrist" (idem). Third, by encouraging multidisciplinary work, community clinics and PRC evidenced the relevance of social work to psychiatry (Idem).

2.   THE INSTITUTIONALISATION OF THE COMMUNITY ECOLOGY

"Around 1960, mental health policy took an abrupt turn in most of the Western democracies… three governments Acts set new directions: the Mental Health Act of 1959 in Great Britain; the 1960 memorandum on sectorization in France; and in 1963, President Kennedy's Community Mental Health Centers Act in the United States. Different in many other aspects…These three acts stressed…three fundamental concepts: (1) limitations on hospitalization and;(2) encouragement and organization of community alternatives to hospitalization; and (3) diversification of psychiatric services…Within this context of reducing psychiatric hospitalization, the reaction of Belgium was somewhat delayed: a new policy for mental health care was not officially defined until 1974-1975." (Verhaegen, 1987, p. 42)

The first reform of psychiatry was launched by Minister De Saeger in 1974. By shifting policy objectives from medicalisation to diversification, it enlarged the system far beyond the boundaries delineated by medical psychiatry. The proponents of the reform, especially Minister De Saeger and Mr Sam Halter (physician and general secretary of the Ministry of Public Health) justified this enlargement by referring to quantitative and qualitative changes in personal problems: "I think that today, mental health is like an iceberg. You see a little part of it and the greatest part of this problem is hidden under the water" (Halter, 1981, p. 7). The leading ideas advocated by those two "progressive thinkers" (Sartorius, 1981) included: active treatment of psychiatric patients; preventative activities in coping with mental health problems; coordination, integration and continuity of care; treatment and rehabilitation of the patient in his or her living environment; reduction of the number of psychiatric beds; and destigmatisation of mental illness and of mentally ill people (Verhaegen, 1987). Those ideas were very close to those promoted by the WHO. Their inscribment in Belgian mental health policies resulted from the involvement of De Saeger and Halter in the work of the WHO: "It was Prof. Halter and other progressive thinkers in the field of public health, like Mr De Saeger, who have helped W.H.O. to define mental health in a broad sense, dealing not only with the care for the mentally ill but also with psychosocial aspects of general health care …" (Sartorius, 1981, p. 9).

2.1. The Specialisation of Residential Psychiatry

The reform was based on three Royal decrees supporting interrelated objectives. The Royal Decree of February 1974 was the first piece of a "policy of re-conceptualizing mental illness as a

medical problem", by suppressing "the old, closed psychiatric facilities for adults and replac[ing] them with two new types of facilities, centred exclusively on active treatment" (Verhaegen, 1987, p. 43). It created neuropsychiatric services providing active treatment for the acute phase of mental illness (services *A*), and treatment services (services *T*) devoted to middle to long-term hospitalisation and focused on social insertion. Services A and T replaced the standards defined by the 1960 and 1965 ministerial and Royal decrees.

As noticed by De Munck et al. (2003, p.36), by shifting the criteria for distinguishing among psychiatric services from their public accessibility to the time parameters of mental illness, that decree reflected the success of the medical discourse. It also confirmed that increasing the medicalisation of psychiatry meant increasing the financial, human and material resources available to psychiatry. Indeed, by entailing short-time hospitalisation and acute treatments, the new services "A" made "more personal and technical infrastructures" (Verhaegen, 1987, p. 43) necessary to the treatment of mental illness.

Following the 1974 decree, the 1976 decree limited the expansion of the residential ecology by defining standards "for structuring hospital psychiatric facilities in terms of the maximum number of beds or places per 1.000 inhabitants" (Verhaegen, 1987, p. 43). This limitation made sense in relation to the improvement of the statues of the CMHS, which were conceived as a means of reducing psychiatric hospitalisations.

2.2. **Institutionalising the Community Ecology**

The Royal Decree of March 1975 defined the new status of community clinics, now called Community Mental Health Services (CMHS). They were conceived as alternative facilities for people with "other disorders…which do not necessarily lead the people to psychiatric intervention"; that is to say people "who have trouble with their behavior…like alcoholics, drug abusers, all kind of delinquency or criminality, [and] the very important mass of the public which is dissatisfied, not happy to live…" (Halter, 1981, p. 7). The decree supported the development of CMHS provided that "they give guarantees of organization, working and coordination with other services concerned with mental health problems" (Royal Decree, 1975).

The decree defined the mandate of the CMHS, the composition of multidisciplinary staffs and their relationships with psychiatric hospitals. First, the mandate of the CMHS consisted in providing social, psychological or medical diagnosis and treatments for sectors comprising around 50 000 people. The prevention work and the training of mental health professionals also fell within their scope of activities (Royal Decree, 1975, art.3). Second, the CMHS teams were defined as multidisciplinary teams belonging to the field of mental health and psychopathology. They primarily included mental health professionals fulfilling psychiatric, psychological and social functions, but these could be complemented by nurses, psychotherapists and speech therapists. They were supervised by medical doctors specialised in neuropsychiatry (Royal Decree, 1975, art.6). Third, the decree required the

CMHS to negotiate "functional links" with psychiatric services and other services concerned with the population of their sector. Functional links were intended to improve continuity of care (Royal Decree 1975, art.8). They entailed written agreements allowing CMHS staff members to participate in staff meetings held in psychiatric hospitals and vice versa, as well as the creation of coordinating committees in charge of making proposals to public authorities responsible for mental health (Royal Decree, 1975, art.19).

The 1975 decree provided the CMHS with institutional existence. It recognised the specific relationship to personal problems advocated by proponents of psychosocial approaches to personal problems. As social entities objectifying the community ecology, the CMHS had different properties to psychiatric hospitals. While the later became increasingly exclusive (in the sense of being exclusively devoted to medical psychiatry) the former were more inclusive. Indeed, the decree required CMHS to perform several tasks based on medical and psycho-social knowledge held by various mental health professionals. Furthermore, though the 1975 decree provided the community ecology with increased subsidies, they continued "to cut a rather sorry figure in Belgium, where health policy [was] centred primarily on the hospital." (Verhaegen, 1987, p. 49)

As noted by the French-Speaking League for Mental Health in 1988, the proponents of the new psychiatric policy not only sanctioned the existence of contrasting ecologies but created institutional mechanisms intended to keep them together (C. Bontemps, 1988, p. 3). Those mechanisms made the CMHS "privileged partners of residential facilities, coming before and after psychiatric hospitalisations and releasing them for emergencies and post-cures" (Bontemps, 2006, pp. 18–19). The concept of "settlement by division of work" helps to understand such situations, where "changes in the objectives qualities of the tasks" (Abbott 1988: 73) lead to public recognition of "functionally interdependent but structurally equal parts" (Idem). Moreover, by drawing attention to the fact that settlements by division of work retrospectively sanctioned professional practices developed in response to changes in personal problems, it helps us to understand the attention paid by policy makers to the devising of coordinating mechanisms, created to prevent professional segments from continuing their development independently from one another (C. Bontemps, 1988; Orenbuch, 1981).

2.3. Outlining a System of Concrete Action to Address Personal Problems

"Generally speaking, there is no doubt that the hopes of the promoters of the new policy … in relation to the teams' functional links … have not been realised. In other words there is no integrated psychiatric treatment in Belgium at the moment … Very often, written agreements between the CMHS and hospital psychiatric departments have been formal response … [with] so little practical value that many CMHS workers do not even know the name of the institution to which they are linked by this agreement …" (Orenbuch, 1981, p. 123)

Instead of improving the functional integration of the system, the reform supported an "expansion of institutions", which was followed by "an expansion of clienteles and an increase in consumption" (Verhaegen, 1987, p. 49). By avoiding enacting the functional link properly, proponents of each ecology instead succeeded in expanding their respective jurisdiction.

2.3.1. *Expanding the Community Ecology*

Although more than a half of the CMHS existed before 1975, about 25 new services were created following the reform. In 1985, their number reached 54 in Wallonia and 26 in the Brussels region. They provided care for about 4500 users, including 2632 adults, 1615 children and 232 couples and families (C. Bontemps, 1988, pp. 5-10). The growth of the community ecology evidenced that the CMHS used the 1975 decree to continue their local expansion, without regard for improving collaborations with the residential ecology.

Moreover, as highlighted by Orenbuch, the CMHS increasingly referred to a "new approach to prevention" (1981, p.118), entailing early treatment, psychotherapy and rehabilitation. This shift in community treatments reflected changes in the global context. Not only did psychoanalytical theories and epidemiological studies increasingly stress the relevance of social factors to the understanding of mental health problems (Orenbuch, 1981), but the rapid development of psychoactive drugs also facilitated the organisation of follow-ups outside the hospital (De Munck et al., 2003; Orenbuch, 1981; Pichot, 2009). In Belgium, this trend kept increasing over the following decades to reach a situation, in 1988, where curative aspects represented about 65% of the CMHS' activities, while the preventive aspects represented only 19% and diagnostic activities 15% of their work (Bontemps, 1988, p. 12).

Alongside this global trend, the French-speaking League for Mental Health reported that the CMHS work varied widely from one service to another, depending on the target groups and the area of work in which each of them specialised (Idem). A research study conducted by the WHO corroborated their observation. According to that study, there were no equivocal correspondences "between a population profile (socio-demographic and clinical characteristics) and a given type of institution. There were differences among population, but they related to the area of specialisation of the different institutions, i.e. their therapeutic settings and the therapeutic options offered by professional staffs…" (Verhaegen, 1987, p. 49).

Given the enlargement of the scope of activities of the CMHS and their local specialisation, their institutionalisation did not help in reducing the overall number of psychiatric beds. The slight decrease in the number of psychiatric beds observed following the reform rather resulted from the opening of psychiatric wards in general hospitals (Orenbuch, 1981; Verhaegen, 1987).

2.3.2. *Protecting the Residential Ecology*

Psychiatric hospitals also implemented the reform in a way suitable to their own interests. In 1981, among 24506 psychiatric beds offered by Belgian institutions, 77% were private beds (with 60%

of them being located in Flanders and belonging to the Caritas Catholica), and only 16.5% were public beds, (located in Geel, Tournai, Redekem and Mons). Private institutions thus dominated the psychiatric landscape. They were managed by private non-profit associations which replaced religious congregations at the head of psychiatric hospitals. Representing powerful interest groups strongly related to the Catholic pillar, those associations did their best to avoid the new reform decreasing the importance of the residential ecology.

Given that the financing of psychiatric hospitals was based on occupancy rate and increased with the level of specialisation, their interest consisted in implementing standard A, entailing an increase in the specialisation of some wards, while avoiding the transfer of too many patients toward the community ecology. Consequently, they translated the main aspects of the 1974 and 1976 decrees into practice by distinguishing between services "A" and services "T" and limiting their expansion to the standards set by the 1976 decree, while paying little attention to the development of functional links with the community ecology.

2.4. A Two-faced Policy Device

According to Orenbuch, the outcomes of the reform proved that "public authorities [were] alone in their desire to organise integrated treatment" (Idem). The policy project at the origin of the reform relied on innovative ideas borrowed from the WHO. However, confronted with the opposition of local actors to such major reform, policy makers attempted to improve the integration of the system through separate policy measures making room for local appropriation.

> "The civil service, obliged to preserve the private institutions and to take into account both the requirements of existing community centres and the need for implementing an integrated system comparable to those established in other countries, had opted for an assemblage of heterogeneous elements … Instead of seeking to prompt a global change through a law reforming the whole psychiatric sector, the government had decided to launch separate reform of the residential and community sectors." (Boffa, 2001, p. 104)

The public authorities also devised coordinating mechanisms designed to avoid the community and residential ecologies continuing to develop independently from each other, in spite of the absence of a single organising body ensuring the functional integration of the system:

> "By making collaboration possible through the psycho-medico-social nucleus in each of the two sectors, the individual written agreements and the possibility of half-time work, we get round the problem of establishing a single team or a single organising body which is what has been done in other countries." (Orenbuch, 1981, p. 121)

By devising such policy devices, directed towards a complete reorganisation of the system but making room for local appropriations by institutional actors, the proponents of the 1974 reform

pioneered the use of dualist instruments in the Belgian policies for addressing personal problems. Embodying both innovative ideas and a social configuration divided between competing movements, such instruments supported the enlargement and the diversification of the system for addressing personal problems, but did not succeed in improving its overall integration.

2.5. **Changes in the Political and Professional Environment of the System**

In parallel with the reform, changes in the immediate environment of the system created new conditions influencing the orientation of the following reforms. The 1970s fiscal crisis endured by the OECD-countries induced a reduction in Belgian public health expenditure. It also caused policy measures characterised by a "projectual minimalism", which entailed (among other things) the application of a "moratorium" on psychiatric beds planning. The moratorium consisted of a list of "residual beds", which had to be closed when released from their occupants. Following this policy measure, every further change in the system for addressing personal problems would necessarily involve a reduction in psychiatric beds.

Next, the first reform of the state split responsibilities relating to mental health and psychiatry between the federal, regional and community public health ministers. Since the three ministers had equal power in dealing with their own competencies, the splitting of responsibilities created "an important barrier for the development and implementation of a comprehensive and long-term vision on mental health policy." (Hermans, De Witte, & Dom, 2012, p. 287)

Professional associations followed the movement of regionalisation by dividing up into different parts or by creating new associations. These played an important role in the following reforms, either as knowledge brokers or by defending the interests of the residential, community and rehabilitation ecology. First, in 1978, the Federation of Hospital Institutions was divided between three professional organisations: the FIH Wallonia (FIH-W); the VVI (*Verbond der Verzogingsinstellingen*); and the CIB (Brussels coordination of institutions). The FIH-W became a powerful association representing most private institutions established in the Walloon Region. Second, the French-speaking Association of Health Institutions was created in 1980. This association, which took the name of Santhea in 2008, defended the interests of public and private non-denominational healthcare institutions and services. Third, in 1977, the Belgian National Mental Health League was split up in three parts, including the French-speaking Mental Health League which kept supporting the development of community services established in Wallonia.

2.6. **Conclusion**

The first reform of psychiatry shifted policy objectives form medicalisation to diversification of the system. It caused meaningful developments in the ecological and social configurations of the system. Regarding the ecological system, the reform caused an increased specialisation of the residential ecology, before recognising the community ecology and devising coordinating mechanisms designed to ensure the functional integration of both ecologies into the system. By institutionalising two contrasting ecologies, the reform sanctioned the relevance of two kinds of relationships to personal problems, respectively based on medical psychiatry and psychosocial perspectives. However, those ecological boundaries did not fit perfectly with professional and organisational boundaries. The community ecology was composed of CMHS whose actual activities did not completely correspond to the CMHS' mandate. Indeed, depending on local needs and professional projects, the concrete tasks performed by the CMHS were either limited to particular aspects of that mandate, or expanded beyond the corresponding formal jurisdiction. Conversely, although the residential ecology was dominated by psychiatrists (while the community ecology was shared by psychologists and social workers), neither the community nor the residential ecology was exclusively held by to those professional groups. Instead, mental health professionals were allowed to choose to integrate multidisciplinary teams based in the two ecologies according to their individual preferences. Thus, the community and residential ecologies encompassed large systems which included overlapping relationships, linking different kinds of actors to personal problems in different ways, depending on the kinds of knowledge and ideologies they embodied.

Regarding the social system, the implementation of the reform highlighted the system of concrete action relevant to the understanding of collective action in the Belgian system for addressing personal problems. This system was based on an opposition between proponents of a complete reform of the system, and competing ecologies enacting the reform in such a way as to preserve professional and institutional interests. By jointly enacting strategies of protection and extension of their respective jurisdictions, the residential and community ecologies shifted the outcomes of the reform from diversification and integration (as envisioned by policy makers) to diversification and differentiation. Since it incorporated the social context in which it had to be implemented, the policy device supporting the reform did not prevent these strategic appropriations from happening.

Seeking for a means to overcome impediments to change in the system, at the outset of the 1980s Orenbuch suggested the creation of "something like 'travelling salesmen' allocated to each sector, who would move from one to the other to obtain information about the network and to organise any contacts regarded as useful." (1981: 125). With this proposal, Orenbuch defined a new professional role corresponding to the function of "network coordinator", which is central to the ongoing Reform 107. However, Orenbuch also specified that his proposal "to deal with institutional resistance to integrated psychiatry will have little effect if an attack was not made on the social and

economic conditions which produce the segregated system of treatment that everyone attempted to maintain" (Idem, p.126). In the early1980s, changes in both the global and immediate environment of the system set opposing conditions. Consequently, the devising of a complete reform first required finding a means to overcome administrative and political boundaries. Those means were developed during the period between 1995 and 2005, following the last policy initiative to implement a centralised reform of psychiatry, which unfolded between 1989 and 1999.

3.   STABILISING THE REHABILITATION ECOLOGY

The reform launched by Minister Busquin in 1989 significantly "reverberated" (R. Freeman, 2012) previous moves in the system and its environment. First, given the reform of the state, the residential and community ecologies started moving at different paces, along with federal and regional policy initiatives. Second, the moratorium on psychiatric beds caused changes in policy objectives, toward the deinstitutionalisation of the system. The Busquin reform supported that move by creating new facilities based on the principles of psychiatric rehabilitation. Third, the ecological moves towards differentiation and specialisation initiated on the occasion of the new psychiatric policy (1974-1976) kept unfolding in the framework of federal and regional initiatives, respectively the Busquin reform of psychiatry and the 1996 Walloon Decree refining the Community Mental Health Services. On this occasion, ecological diversification and specialisation appeared strongly related to the maintenance of the socio-technical configuration observed following the first reform of psychiatry.

3.1. Preparing for the Deinstitutionalisation of the System

At the end of the 1980s, the Minister of Health and Public Affairs commissioned two sociologists specialised in social policies to assess psychiatric and mental health care planning. Following his request, the Prof. Groot and Breda produced a study report emphasising that: the distinction between "care" and "cure" was not yet achieved; the reinsertion of chronic and stabilised patients into their own social environment had be improved; psychiatric services T were understaffed; and the interventions of the CMHS and psychiatric hospitals were not coordinated. In order to remedy to that situation, the professors suggested (among other measures) the creation of new facilities, specifically as ambulatory devices taking care of psychiatric patients in their living environment.

3.1.1. *The Rehabilitation Ecology: a Defining Process*

Some years prior to the 1989 reform, the minister proposed assimilating psycho-social rehabilitation centres that had developed in the framework of NIHDI conventions into psychiatric services "T", defined by the law on hospital facilities (Boffa, 2001, p. 157). In response, psycho-social rehabilitation centres undertook a defining process through which they positioned themselves in relation to the residential and community ecologies.

In 1988, they first created a working group responsible for identifying the defining features of PRC (Idem, p. 158) in comparison to psychiatric hospitals. The resulting study report defined the PRC as institutions with a therapeutic intent, providing comprehensive rehabilitation plans based on different techniques including the use of practical aspects of daily life. Their objective was social and professional insertion, and their approach recognised the processual nature of rehabilitation and the need for preserving institutional diversity in order to offer therapeutic responses appropriate to particular social environments. With this definition, the working group positioned the PRC as belonging to psychiatric rehabilitation, defined as an approach designed "to help persons with psychiatric disabilities to become successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention" (Anthony, 1992).

Then, in December 1988, the PRC reinforced their independence from the National League for Mental Health by appointing their own representatives. The Federation for Psycho-Socio-Therapeutic Structures was thus created on the basis of the working group which had just redefined the PRC identity (Boffa, 2001, p. 162). The first mission allocated to the federation consisted of attending the round table for mental health held by the federal minister, "in order to help outlining a policy recognizing the specificity of the "out-of-hospital psycho-therapeutic structures" (Idem).

3.1.2. *The Round Table for Mental Health: the Creation of Mental Health Platforms*

Following the report of professors Groot and Breda, the federal minister decided to hold "round tables for mental health", designed to collect the proposals of mental health professionals for improving the organisation of the system. The round tables were attended by mental health professionals from community, residential and rehabilitation services and institutions. Their first outcome was the creation, in 1990, of the Mental Health Care Dialogue platform.

The Mental Health Care Dialogue Platforms (MHCDP) consisted of private non-profit associations whose members were the psychiatric and mental health services established in a given area. Every platform corresponded to a catchment area roughly comparable to the administrative boundaries delineating the Belgian provinces. For instance, the platforms of the Red city covered an area of 3862 square meters, corresponding to a population 1,082,110 people.

As defined by the decree, the mandate of the platforms had two main aspects; the first consisted of organising working groups composed of their member institutions and designed to improve mental health care quality and continuity for definite targets groups in their catchment areas; and the second was to report the needs of their members to federal and regional public authorities, and to take part in the follow-up of policy initiatives launched by the related governments. The platforms were thus intermediary actors, positioned between local actors and public health authorities, and at the intersection of the residential, community and rehabilitation ecologies.

3.2. Two Alternative Facilities: Sheltered Housing Initiatives and Psychiatric Nursing Homes

The Busquin reform started in 1989. It included an initial phase focusing on the creation of alternative housing facilities, respectively the sheltered housing initiatives (ISH) and the psychiatric nursing homes (PNH), and a second phase designed to improve coordinating mechanisms and the intensity of residential care. The first phase was supported by 19 royal decrees published between 1989 and 1990.

3.2.1. *The Psychiatric Nursing Homes*

The psychiatric nursing homes (PNH) were created in July 1990. They were tasked with providing alternative housing facilities for 6000 psychiatric hospitals beds, among which 3000 should have gradually disappeared. Depending on the reconversion of psychiatric hospital beds, they were clearly related to the residential ecology. Nevertheless, the decree made it clear that the PNH should be established outside the hospitals' sites, and as close as possible to the community. As defined in the decree, their mandate was to "offer supportive permanent care for chronic psychiatric patients whose symptoms are stabilized and consequently do not require curative intervention or medical surveillance" (Hermans et al., 2012, p. 289). They were devised as small structures of 10 to 60 beds, managed by multidisciplinary teams and supervised by a psychiatrist.

3.2.2. *The sheltered housing initiatives*

The sheltered housing initiatives (ISH) were created in July 1990. According to the decree, the creation of an ISH depended on a partnership involving either a psychiatric hospital and a general hospital, or a psychiatric hospital and a Community Mental Health Service. The proponents of the reform expected the ISH to provide alternative housing for 2000 psychiatric patients. Consisting of specific accommodations where "activities are organised and support is provided to help residents to acquire relevant social skills" (Gerkens & Merkur, 2010, p. 194), the ISH were devised as transitory spaces, referring to psychiatric rehabilitation principles and directed towards social autonomy.

3.2.3. *From Deinstitutionalisation to Budget Savings*

"More than 20000 mentally ill in mental hospitals: how are they going to be cured, housed, and treated tomorrow? The Minister Busquin started a big reform of psychiatry. It does not intend to put the past behind us or to close asylums as in Italy, but it required major changes in psychiatry. The mentally-ills needing intensive care will stay in mental hospitals, where the follow-ups will be intensified. Meanwhile, long-term chronic patients will be transferred to specialised accommodations. What is at stake? Significant budget saving." (Vaes, 1990)

By converting psychiatric hospital beds into alternative facilities with smaller staffs and requiring a higher financial contribution from the patient than psychiatric hospitals did, the Busquin reform enabled budget savings (Gerkens & Merkur, 2010; Hermans et al., 2012). In turn, by encouraging the transfer of chronic and stabilised patients towards community facilities, it reassert the new role of psychiatric hospitals as "specialised institutions, offering short and specialised treatments that should lead to social reinsertion" (De Munck et al., 2003). Therefore, this moved aligned with change in the global context, which stressed the need to improve hospital care but to distance personal problems from psychiatric hospitals and (re)place them within the community (Bertolote, 2008, p. 115).

However, by simultaneously facilitating "the leaving of a considerable amount of chronic patients from psychiatric hospitals … [and] putting an important financial strain on patients and families" (Hermans et al., 2012, p. 289), the introduction of the new services "has been met with some ambivalence" (Idem). This ambivalence increased when it became apparent that most chronic patients housed in alternative facilities, though they no longer required hospital treatment, were unable to reintegrate into their living environment (De Munck et al., 2003).

3.3. Assessing the Busquin Reform: Returning to the System of Concrete Action

As reported in the press at the time, in spite of new policy objectives and an impressive set of measures (19 Royal decrees), the Busquin reform succeeded in downscaling large psychiatric institutions, but failed to question the dominance of psychiatric hospitals and the medical approach to personal problems. According to the proponents of a complete reform of the system, this failure was explained by the continuing assimilation of psychiatry into hospitals and the influence of representatives of the residential ecology on mental health policy making (Lamensch 1990).

The representation of psychiatric hospitals (seventy percent of which were private non-profit organisations belonging to the Catholic pillar) in federal administrations and advisory bodies helped them to orient the reform in a way consistent with their interests:

> "In Belgium, the Catholic pillar held a long-standing resistance to public reform in psychiatry, through lobbying, at the level of the federal Minister of Public Health. The Flemish Christian Democratic Party (CVP) has a long-term occupation strategy at the Federal Public Health Service. Thus, the VVI, which is the Flemish Catholic hospital pillar, significantly impacts on policy initiatives, supported by several and powerful civil servants belonging to the CVP…" (Interview with an ex-social and health policy adviser, 01/2012)

Moreover, the fact that the law on hospital and health care facilities was a framework law made room for appropriation of the initial policy project by representatives of the residential ecology:

"The Hospital law is a framework law. Therefore, every policy initiative implies a Royal decree (to modify this law). This has been true for the ISH and the PNH. So, we depend on a framework law, and then, what happens? The minister drafts the Royal decree with his/her administrative department. They generally achieved very consistent projects. Then, the project is submitted to formal and less formal advisory committees, the hospital lobby goes into action, and the project is more or less dismantled. This brings about compromise solutions." (Interview with an ex-social and health policy adviser, 01/2012)

Negotiations that preceded the Busquin reform resulted in defining the ISH as alternative housing facilities rather than ambulatory services, as suggested by the Professors Groot and Bred in reference to professional practices developed by exiting PRC. The financial interests of the residential ecology were challenged by the mere idea of ambulatory cares. Its representatives particularly feared a shift from a federal financing based on psychiatric hospitals beds to a global budget allocated at the regional level, which was claimed for by the proponents of a complete reform of the system. Faced with this opposition, policy makers decided to assimilate the creation of the ISH and the PNH into a project of psychiatric beds reconversion. Indeed, by asking psychiatric hospitals to transform a proportion of their beds into alternative facilities, it was possible to decrease the number of psychiatric beds without reducing the overall resources of psychiatric hospitals.

However, that policy decision implied incorporating the new structures resulting from the conversion of psychiatric beds (as well as the existing PRC with very specific therapeutic projects) into the same institutional category. As a result, that category was defined very broadly; this in turn enabled new and pre-existing structures to develop increasingly specialised therapeutic projects (De Munck et al. 2003: 82-90). Consequently, just as in the case of the creation of the CMHS, an implicit and organisational diversification added to the explicit and institutional diversification established by the 1989 reform.

3.4. The 1996 Walloon Decree: Refining the Community Ecology

The 1996 Regional Decree "organizing accreditation and subsidization of community mental health services" (RD 1996.04.10; 1996.05.23) applied to the community "mental health services established in the French-speaking region" and corresponding to the following definition: "an ambulatory structure which, through a multidisciplinary approach and in partnership with other services or people concerned with mental health, perform the functions of demand reception, diagnosis and psychiatric, psychological and psychosocial treatment of people with mental health problem" (Regional Decree 1996, art.3).

The 1996 decree modified three aspects of CMHS mandate and organisation. First, it included demands reception and mental health promotion in the CMHS' area of tasks. Second, it replaced the functional link between the community and the residential ecology by making it obligatory for the

CMHS to engage in partnerships stimulated by private structures and institutions as well as public authorities, including the federal and regional governments. Third, the decree compelled the CMHS to provide regional authorities with epidemiological data, in order to improve their understanding of mental health issues, to evaluate the number and geographical location of the CMHS, and to support decision-making in the Walloon mental health policy framework (Art. 4 to 9). Thus, the 1996 Decree both enlarged the mandate of the CMHS and made them "Walloon devices" (Interview with the Director of the Regional Public Health Department, 2014/02), acting as relay between people with mental health problems and the regional authorities.

3.5. **Conclusion**

The Busquin reform was the last policy initiative which attempted to reorganise the system in a centralised way, i.e. by institutionalising new care structures. The following initiatives instead consisted of pilot projects designed to test new care functions and located at the local level. Thus, the Busquin reform completed the institutional landscape of the Belgian system for addressing personal problems.

The system initially included psychiatric hospitals, sheltered housing initiatives and psychiatric nursing homes. These three kinds of institutions fell under the jurisdiction of the residential ecology. Following the creation of the PRC and ISH, the residential ecology was no longer exclusively related to medical psychiatry. Instead, it was shared by proponents of medical psychiatry and psychiatric rehabilitation.

Second, the CMHS were included in the community ecology. The 1996 Regional Decree sanctioned the independence of CMHS from psychiatric hospitals, by replacing their "functional link" with an obligation to participate in pilot projects launched by public authorities, and a relationship with regional authorities, to which the CMHS were made accountable. Moreover, the community ecology also came to include ISH and PNH created by CMHS following the reform. Indeed, provided that they initiated a partnership with psychiatric or general hospital, CMHS were allowed to create alternative housing facilities.

Third, and consequently, not only did the rehabilitation ecology overlap the community and residential ecologies, it also consisted of different kinds of alternatives housing facilities developed in the framework of NIHDI conventions or the Busquin reform, thanks to psychiatric beds reconversion conducted by psychiatric hospitals and specific alliances initiated by CMHS. In spite of its embeddedness in institutional categories borrowed from the residential and community ecologies, the rehabilitation ecology appointed its own representatives and claimed a particular relationship to personal problems, defined in reference to the principle of psychiatric rehabilitation.

At the intersection of the community, rehabilitation and residential ecologies, the new Mental Health Care Dialog Platforms (MHCDP) were responsible for improving the consistency of mental health and psychiatric facilities at the local level. The MHCDP were related to the federal and regional

public health authorities, and their members were residential, community and psychiatric rehabilitation structures. They were intermediary actors enhancing dialogue with public authorities and between its members, while respecting their institutional and professional autonomy. In this respect, they appeared to be consistent with the need for services integration advocated by proponents of a complete reform of the system on the one hand, and with the professional and institutional autonomy required by established professional bodies and institutions on the other.

Finally, policy measures supporting the Busquin reform pioneered the use of psychiatric beds reconversion as a driver to create further global reform of the system. This mechanism had two important side-effects. Places opened in alternative housing facilities were counted as psychiatric beds, which was not the case in other countries. International comparisons produced by the WHO and the European Commission had never taken that difference into account. Consequently, those comparisons (and the related discourses on the extremely high number of psychiatric beds in Belgium) were never taken very seriously by care providers. In contrast, while such reforms gave psychiatric hospitals the feeling of striving to reconvert themselves (at the expense of medical psychiatry), they gave other actors, especially the CMHS, the impression of a continuing enlargement of the psychiatric hospital dominance, from the residential world towards the community.

4. SETTING NEW CONDITIONS FOR FURTHER SHIFTS IN THE SYSTEM

This section relates a period of transition, which witnessed the setting of new conditions enabling further shifts in the system. Starting with NACH advisory documents, it introduces new actors, policy and professional instruments and documents that prepared changes in the paradigm dominating the system for addressing personal problems. Those actors, instruments and documents circulated a new organisational model and understanding of personal problems in the system. The policy initiative related in the next section, the *Therapeutic Project and the Horizontal Consultation*, then put those new conceptions to the test of the empirical reality.

4.1. The NACH Advisory Documents

The National Council for Hospital Facilities (NACH) was created in 1982. From 1989 onwards, it has been divided in two sections: licensing and planning; and financing. It contained three working groups: university hospitals; rest and care homes; and psychiatry. Two French-speaking and Flemish Federations for Hospital Institutions, the FIH and VVI, had key position at the NACH. Consequently, it embodies the interests and values of the residential ecology, particularly the Catholic pillar.

Nevertheless, the psychiatry working group also routinely borrowed from international experiences to prepare its advisory notes. The council was thus in a position to claim a legitimacy "from within", (deriving from its embeddedness in the residential ecology), as well as a legitimacy from outside (resulting from its knowledge of shifts in neighbouring systems for addressing personal

problems). On the whole, it might be viewed as a "knowledge broker"(Meyer, 2010), translating new knowledge and international standards in a way appropriate to the Belgian system.

Following the request of Minister Busquin to assess the 1989-1999 reform, the NACH psychiatry working group produced two advisory document outlining the leading concepts and objectives of the following policy initiatives.

The first NACH document, the *Advice on the Assessment of the Reorganization of Psychiatry* (1996) stated that only the objective of increasing the distinction between the cure and the care functions of psychiatric hospitals were achieved through the reform, by creating the ISH and the PNH. Therefore, the NACH argued for a strengthening of the policy objectives defined in 1990, especially the intensification of residential treatments and improvement of services integration and continuity of care. The means to be used to reach those objectives included collecting epidemiological data by enlarging the Minimum Psychiatric Summary to include psychiatric hospitals and psychiatric wards in general hospitals and implementing comprehensive mental health policies, supported by appropriated training of mental health practitioners. Such comprehensive policies might be designed to develop integrated services networks in defined catchment areas.

The second NACH document was an advisory note *Concerning the Future Organization and Development of Mental Health Care* (1997). It contended that the reflection on the reorganization of the system should consider the bio-psycho-social dimensions of mental health and the specific needs of services users and relatives. It also stated that the complexity inherent in mental health problems called for multidisciplinary work, involving mental health professionals as well as key actors from boundary sectors such as social work, justice and employment.

Given this conception, the NACH suggested rethinking the organisation of mental health care delivery on the basis of particular target groups and their specific needs, instead of conceptualising mental health care delivery on the basis of psychiatric services and institutions. Concretely, the NACH advised the implementation of "care circuits" specific to the target groups: adults, elderly people, and those experiencing drug addictions. Those care circuits were defined as developing from "care networks" providing integrated care in precise catchment areas. Care networks consisted of independent mental health and psychiatric care providers developing functional collaborations.

Regarding the means to implement mental health care networks and circuits, the NACH first advised public authorities to reassure local actors that reorganising mental health care delivery would not imply a reduction of their current budget. Second, it advocated deregulation, with a view to enabling services and institutions to reallocate financial means to new forms of services delivery. Third, the NACH stated that the local care networks should involve at least one psychiatric hospital, one general hospital, one CMHS, and other specific key partners depending on their targeted audience. Fourth, adapting the MPS to mental health networks might help to find a common language overcoming institutional and professional differences. Finally, the NACH highlighted the need for starting such reorganisation through a comprehensive policy, prepared by pilot projects limited to

specific target groups, realised in an experimental framework, and assessed by processual and scientific means. In this way "both public authorities and local actors will acquire relevant expertise before the generalization of those concepts as the organisational model of the future mental health care system" (NACH 1997: 8).

4.2. The 2001 Policy Brief: Advocating a Complete Reorganisation of the System

In 2001, the Federal Ministers of Public Health and Social Affairs seized the opportunity of the *Mental Health Year* to present their policy brief *The Psyche, the Least of my Worries* (Vandenbroucke & Aelvoet, 2001). This document set out a new conception of mental health, before explaining how mental health care delivery should accordingly be reorganised. The ministers did not refer to the NACH documents but to the 2001 World Health Organization report *Mental Health: New Understanding, New Hope* (WHO, 2001). In reference to the WHO documents, they stated that mental health should be considered as a dimension of global health, corresponding "to the psychological abilities of individuals to face and to overcome little and major life problems, but mental illness and disorders too" (Vandenbroucke & Aelvoet, 2001, p. 1). In accordance to that conception, they supported a complete reorganisation of the system, based on the specific needs of defined target groups. In a manner consistent with the NACH advisory notes, they continued by drawing attention to the fact that moving the centre of the system from institution to services user entailed defining specific target groups and developing horizontal, flexible and integrated responses appropriate to their needs. In contrast to the NACH, they argued that such reorganisation meant shifting from a federal financing based on psychiatric hospitals beds to a global budget allocated on a regional basis.

4.3. New Actors and Instruments: Vehicles for Evidence and Experiences

New actors and instruments included producers of evidence on mental health services and holders of knowledge embodied through experience of particular forms of services delivery. Producers of evidence included the Knowledge Centre for Health Expertise and the Minimum Psychiatric Summary. Holders of experiences were services user groups and mental health professionals. These actors were increasingly requested to test out new form of mental health services delivery in the framework of pilot project, on the basis of which they had to issue policy proposals. The federal department of the Ministry for Public Health was responsible for devising policies supporting the production and utilisation of both kinds of knowledge, while the inter-ministerial conference had to help to launch a comprehensive mental health policy.

4.3.1. *The Knowledge Centre for Health Expertise: A Producer of Evidence*

The Knowledge Centre for Health Expertise (KCE) is a federal agency created in 2002. It held a specific status protecting its scientific independence. Its objectives consisted of improving healthcare quality and facilitating a more efficient allocation of healthcare resources by assessing new technologies and stimulating changes in healthcare financing. The creation of the KCE occurred in a context characterised by healthcare budget control and health information management. As summarised by Gerkens and Merkur (2010), the KCE' "overall objective is to support health policy decisions which offer value for money and so contribute to an efficient allocation of scare health care resources."

The KCE realised its first research study in the field of psychiatry and mental health only in 2008. When finishing that research on long-stay patients in psychiatric hospital T-units, it stated its intention to produce further reports on mental health:

> "The Belgian political debate could be improved if it was supported, as it is the case in other countries, by a scientific expertise. However, still now, in Belgium, the debate on the content and organisation of mental health and psychiatric cares had almost exclusively been led by the opinions of experts from advice committee and interests groups involved in this field … This report announces a series KCE researches in mental health. We hope that those researches will help feeding the reflection about psychiatry objectives and reforms, which sometimes yield tricky discussions." (Verniest et al., 2008, preface)

4.3.2. *Services User Groups: Holders of Experience*

Belgian services user groups emerged in a decentralised ways. The two associations which started participating in mental health policies in 2007 are Similes and Psytoyens.

When it was created in 1967, Similes intended to improve psychiatric patients' quality of life. It supported the 1974 reform and took an active part in the Busquin reform by creating sheltered housing initiatives in three Walloon cities. It was only in 2001 that French-speaking associations belonging to Similes joined together into the French-speaking Similes Federation, before joining with the Flemish Similes Federation in 2007. In the course of its development, the federation became increasingly concerned with the distress of services users' relatives. Accordingly, in the early 1990s, Similes started organising self-help groups for services users' relatives and representing their interests at the institutional and policy levels.

Psytoyens is a French-speaking association which arose from the merging of the existing Brussels and Walloon services user groups in 2003. It created reflection groups and started producing advice and proposals for mental health professionals, institutions and policy makers.

Similes and Psytoyens were involved in mental health policy making from 2007 onwards. Their participation followed international requirements to increase service users' participation in organising mental health care (Gerkens & Merkur, 2010). It also reflected changes in policy objectives, which

made it necessary for policy makers to know about services users' specific needs. The director of the FPS PH Psychosocial Department described the involvement of Similes and Psytoyens in the following policy initiative as a means to develop a collaborative relationship between public health authorities and services user groups (Interview with the director of the psychosocial department, FPS PH, 2013/02). This initiative gave birth to an objective alliance between the FPS PH and service user groups, which was then reinforced by the project leader of Reform 107.

4.3.3. *The Federal Service for Public Health: Towards Evidence- and Experience-Based Policies*

The Federal Service for Public Health, Food Chain Safety and Environment (FPS PH[20]) is the administrative department of the federal minister in charge of public health and social affairs. The FPS PH is responsible for crisis management, health professions, medical expertise, care institutions, data communication, consultative structures and specialised care. The devising of mental health and psychiatric policies fall under the jurisdiction of the psychosocial care service, which is part of the specialised care department. Created in 2001, the objectives of this service are to develop evidence-based mental health policies and to prepare for future reforms through pilot projects. It devised pilot projects launched in 2002 and 2005 and exploratory projects (Reform 107) started in 2010. From the turn of the 21st century, the appointment of actors involved in international mental health organisations to key positions in the FPS PH increased its determination to stimulate significant changes in the system.

4.3.4. *The Inter-Ministerial Conference: Making Comprehensive Policies*

The Inter-Ministerial Conference (IMC) was created in 1995. It is a public health policy committee composed of the federal, regional and community ministers in charge of mental health and psychiatric policies. Following the splitting of the mental health competencies resulting for the first reform of the state, the creation of the IMC became the only means to undertake comprehensive reform of the system. Meanwhile, the IMC was central to decision making processes leading to the 2005 pilot projects, and later to Reform 107. In this regard, it is worth noting that the ability of the IMC to agree on comprehensive policy increased thanks to a relative political stability and ideological continuity among the federal, regional and community ministers responsible for mental health. Indeed, during the period from 2005 to 2014, the federal, Walloon and French-Community ministers responsible for mental health all belonged to the same socialist party.

4.3.5. *Seeking Evidence: a New Clinical Instrument*

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[20] For the remainder of this work we have used the acronym FPS PH to refer to the psychosocial cares services responsible for mental health policy decision and implementation.

The Minimum Psychiatric Summary (MPS) was designed to collect evidence on hospital care services, which might serve as a basis to improve psychiatric hospitals' planning and financing. It had to enable the implementation of global data collection in spite of the splitting of responsibilities (Hermans et al., 2012; Verhaegen, 1987).

The project manager in charge of conceiving the MPS was a medical psychologist representing Belgium at the WHO. He insisted that the instrument was conceived according to biopsychosocial model: "in mental health care, you need to meet the person, to come to know his or her many-sided problems … the M.P.S. inventory includes different 'blocks of information' relating to the therapeutic trajectories of the patient, the psychosocial environment, the DSM-IV diagnosis … In this way, it is clearly based on a biopsychosocial approach …" (Pelc et al., 1999, pp. 131–132)

In spite of this explicit attempt to adapt the instrument to the specificity of psychiatry, psychiatrists and other kinds of mental health professionals resisted the classification systems proposed by the instrument. The National Council of the Physicians Order came to psychiatrists' defence by contending that "the recording of patient data critically impaired the doctor-patient relationship … [and] that the making of this data collection system did not take into account the specificity of psychic illness" (Physicians Order, National Council Advisory Note, 1996.05.11).

The intervention of the Physicians Order prompted the federal minister to ask the project manager to modify the MPS. The resulting improvements enabled the implementation of the MPS in psychiatric hospitals and psychiatric wards of general hospitals (1996), and in the sheltered housing initiatives and Psychiatric nursing Homes (1998). However, they did not led to an agreement between mental health professionals regarding the nature of the relationships - based on accountability and transparency - advocated by the MPS. Thus, as will shall see in the following section, further attempts to implement the same kinds of data registration systems raised similar conflicts between local actors and public health authorities.

4.3.6. *Stimulating New Experiences: Changes in Policy Instruments*

This period pioneered the use of pilot projects in preparing mental health policies. Those pilots implied a shift from centralised policies entailing the devising and institutionalising of new care structures, to decentralised policies proceeding through flexible devices enabling local actors to test new working conditions. Genard and Donnay (2004) looked at this shift towards "a less centralised definition of the very nature of public services as well as the forms in which such services should be supplied", as reflecting an attempt to adapt "the state intervention to a changing society" (Genard & Donnay, 2004, p. 13).

Alongside shifts in state interventions, the increased use of flexible and decentralised policy means made sense in relation to policy learning from *past* developments in the system. Considered from this perspective, the use of pilot projects can be understood as a means to handle the influence exerted by the residential ecology over the devising of public policies. Indeed, theoretically, pilot

projects displaced the responsibility for refining policy objectives from the institutional to the local level. Moreover, they provided the Federal Minister for Public Health with opportunities for involving mental health services, which did not fall within its scope of competence, in local change processes, by requiring psychiatric hospitals to develop pilot projects on the basis of partnerships with community centres. Thanks to the 1996 Regional Decree redefining their mandate, the CMHS were, in fact, obliged to engage in partnerships stimulated by private structures and institutions as well as public authorities, including the federal and regional governments.

The *Psychiatric Home Care Projects*, launched by the Federal Minister for Public Health in 2001, pioneered the use of pilot projects to reorganise the system. Those projects gave psychiatric and general hospitals the opportunity to ally with sheltered housing initiatives and home care services to supply the local population with psychiatric home care. Twenty eight hospitals participated in the initiative, thus providing some 1120 patients with psychiatric home care over a three-year period. At the end of this period, following the observation that the pilots brought "a missing piece to the big puzzle of mental health care", the Psychiatric Home Care Projects have been kept in operation (oral presentation at the conference on Psychiatric Home Care Projects, 2004). In the meantime, although at a smaller scale, these projects supported the implementation of psychiatric home care, as advised by the Prof. Groot and Breda before the Busquin reform.

4.4. Conclusion

At the turn of the 21st century, public health authorities were seeking to develop new alliances with services user groups as well as scientific experts likely to produce new kinds of knowledge regarding mental health and psychiatric services. As knowledge brokers, services user groups and the KCE importantly differed from the NACH, whose expertise was deeply embedded in the system. The KCE made this difference explicit by distinguishing between its scientific expertise and "opinion of experts form advisory groups" (Verniest et al., 2008, op. cit.). By emphasising this difference, the KCE highlighted the dis-embedded, and thus objective, character of its particular knowledge of the system.

Clinical and policy instruments such as the MPS and pilot projects also supported the development of new kinds of relationships between local actors and public health authorities. Following the implementation of the Minimum Clinical Summary in general hospitals, the Minimum Psychiatric Summary made sense in relation to a policy driver to improve the accountability of mental health care providers. Concerning mental health policy making, the use of pilot projects reflect a policy driver to involve local actors in the local translation of policy objectives, according to the particularities of local care systems and the specific needs of the local population.

Finally, advisory and policy documents suggested a new conception of personal problems. Those documents involved an agreement on a bio-psychosocial conception of personal problems, entailing the development of integrated care networks responding to the needs of specific target

groups. However, they equally involved a disagreement on the means by which such reorganisation might be achieved, policy makers arguing to shift the financing system towards regional financing based on the needs of the local population, and the NACH advocating a deregulation allowing psychiatric hospitals to use their budgets to perform new activities.

The following policy initiative of the *Therapeutic Project and the Horizontal Consultation* put this abstract social, technical and documentary system to the test of empirical reality.

5.   TESTING NEW SETTINGS, PREPARING CHANGE

This section focuses on a federal policy initiative called the *Therapeutic Projects and the Horizontal Consultation.* It unfolded from April 2007 to April 2010. It consisted of testing multidisciplinary therapeutic consultations and working conditions in mental health care networks, through the implementation of local pilots. Learning achieved by enacting therapeutic consultation had to be collected through the horizontal consultation. This horizontal device consisted of a scientific evaluation, a "participation project" designed to collect instances of good practice relating to users' participation, and "cross-project discussions", through which mental health professionals involved in local pilots were required to share innovations resulting from local pilots testing the therapeutic consultation. The following analysis[21] of the pilots includes a presentation of two key documents framing the policy programme, explanations of how the federal administrations responsible for regulating the pilots operationalised that programme, and short presentations of empirical cases showing how it was enacted at the local and horizontal levels. Finally, this section mentions a regional decree slightly modifying the role of the Community Mental Health Care Services. It particularly highlights regional measures devised to prepare community services for a more complete reorganisation of the system (Reform 107).

5.1. **Two Key Documents**

In June 2002, the Interministerial Conference issued a Joint Declaration (24.06.2002, MB: 23.05.2033) stating that the concept of care networks and circuits would be central to future mental health policy. "Given the sharing of responsibilities between the federal, regional and community government … and considering that mental health is a continuously changing concept", the IMC recognised "the need for a new concept for mental health". Moreover, it stated that the "Resolution *Mental Health: Responding to the Call for Action* approved on the 18th May 2002 on the proposal of

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[21] As mentioned in the methodological chapter, in-depth analyses of those pilots were provided in the framework of the European research project *Knowledge and Policy in Health and Education Sectors.* Two main publications reporting the associated research results are *When policy makers consult professional groups in public policy formation: Transversal consultation in the Belgian Mental Health Sector* (Thunus & Schoenaers, 2012) and *Knowledge work: organizing mental health care networks in Belgium* (Thunus, Schoenaers, & Cerfontaine, 2014). The presentation of the Therapeutic Project and Horizontal Consultation provided in this section summarised research results presented in those articles as well as a Master thesis (Thunus, 2008) research reports (Vrancken, Schoenaers, & Cerfonatine, 2010; Vrancken, Schoenaers, Cerfontaine, & Thunus, 2010; Vrancken, Schoenaers, & Thunus, 2010).

Belgium … required to stimulate the development of a new mental health care model … based on patients and their specific needs".

The IMC then set up a task force whose participants were representatives of the federal, regional and community authorities responsible for psychiatry and mental health. The task force was required to design a reform of the system, the first phase of which must consist in pilot projects implemented in the sub-field of child psychiatry. The task force had to work on the basis of the following assumptions: mental health provision is determined by the patients' needs; the three target groups "children and adolescent", "adults", and "elderly" have specific needs and require suitable care circuits; care circuits involve network agreements among care providers; the patients' freedom of choice and continuity of care are key principles, mental health care must be supplied as close as possible from the patients' living environment; the federal, regional and community authorities have to adapt their policies in order to encourage collaborative practices among care providers; and finally, the reform must depend on a flexible and comprehensive framework enabling the integration of existing resources. Those assumptions represented new policy orientations, which prevailed to the pilots and the future Reform 107.

The decision of the IMC to implement the pilots in the field of child psychiatry was quickly contested by local actors, who argued that this was not consistent with the objective of preparing a comprehensive policy, and that child psychiatry was too specific a domain to experiment in with new working conditions. This opposition caused negotiations between the members of the IMC who agreed, in May 2004, to enlarge the initiative to include patients with chronic and complex problems, including young people and adolescents, adults and elderly people. The IMC also decided to allow the federal minister to launch the initiative on the basis the joint declaration, although it normally required a draft agreement. That agreement was reached only in 2009, before the beginning of Reform 107.

The IMC decision was followed by the *Policy Briefing on Mental Health*, introduced by the Minister for Public Health and Social Affairs, Demotte, in May 2005. Starting by quoting the *World Health Report 2001* ("*Without mental health and a sense of wellbeing, there is no real health*"), the document emphasised the growing importance of mental health problems in the world and their significant costs for society. By drawing on the NACH advisory notes and the joint declaration, it outlined the therapeutic projects and the horizontal consultation. It presented them as two complementary tools, which had to be implemented through collaborative partnerships between policy makers, mental health professionals, services user groups and scientific experts. Given their intent to enhance collaborative partnerships and the creativity of local actors, policy makers set out only a minimal framework, outlining the form and the content of local pilots. In turn, mental health professionals were required to provide policy makers with proposals for a future reform, based on their experience in practicing therapeutic consultation.

5.2. **Devising Therapeutic Projects and Therapeutic Consultation**

The FPS PH and the NIHDI conducted the operationalisation of the policy programme. It induced many negotiations between most stakeholders of the system, including the KCE, MHCDP, and professional federations, which gave rise to a multi-level and multi-actor policy device.

Following those negotiations, the responsibility for selecting and financing local pilots was entrusted to the NIHDI, while the FPS PH remained responsible for horizontal consultation.

The NIHDI imposed precise requirements on the conception of the pilots. Those requirements were intended to ensure that therapeutic consultation brought members of the three ecologies together. They prefigured some aspects of the exploratory projects supporting the development of the future Reform 107. The main requirements were the following: first, local actors interested in developing a pilot had to appoint a "promoter", which was a psychiatric hospital or the psychiatric department of a general hospital; second, this promoter had to find network partners, including CMHS, federal pilot projects such as the psychiatric home care project, primary care services; GPs and home care services associations, and psychiatric or psychosocial rehabilitation services; third, the catchment area and age group targeted by the pilot had to be precisely defined; fourth, the promoter and network partners had to specify how they intended to implement therapeutic consultation, by taking into account the global objectives of improving quality and continuity of care; and fifth, a local coordinator must be hired by the promoter hospital to manage the concrete organisation of therapeutic consultations. Psychiatric hospitals intending to promote a pilot had to specify those aspects in the format of application documents provided by the NIHDI.

The NIHDI also defined administrative rules designed to check the compliance of the pilots with the administrative framework. The three following rules hindered the development of the pilot, thus leading their coordinators to enact strategies to help them navigate institutional and professional oppositions, while keeping their NHIDI financing. Consequently, instead of improving the comparability of the pilots, they made them idiosyncratic projects whose federal administration had a misleading representation. The first rule compelled every pilot to admit at least thirty patients a year; the second rule put that therapeutic consultations must be held every three months for each patient included in the project; and the third rule obliged mental health professionals representing the network partners to participate in every therapeutic consultation.

The FPS PH defined the operational framework prevailing to the horizontal consultation. As defined by the NACH in 1997, it was a means "to identify ways to organise mental health care networks and circuits in their content and form, based on experimentations conducted in therapeutic projects, in order to bring a structural proposition for organising such care networks and circuits'' (NACH, 1997, p.4). The FPS PH distinguished between the scientific evaluation, the participation projects and cross-project discussions. Each part must lead to the production of policy proposals, formalising knowledge produced on the basis of the pilots.

The scientific evaluation was entrusted to the Belgian Health Care Knowledge Centre (KCE). It intended "to identify effective and efficient ways to organise and deliver high-quality care adapted to the care needs of (particular) patients (groups) and to understand the processes facilitating or impeding the functioning of the services" (Ces, Dejaeger, Feys, & Leys, 2009, p. 12). It included a literature review, alongside quantitative and qualitative analysis. The qualitative analysis focused on organisational learning. In contrast, the quantitative analysis assessed the impact of the therapeutic consultations on patients' well-being, based on measurement scale defined by the KCE and submitted to patients included in local projects by mental health professionals.

Second, Psytoyens and Similes were responsible for the participation project. Two other associations (respectively a research centre attached to Catholic university of Louvain and a private non-profit association managed by local powers of the Red city) were required to provide Psytoyens and Similes with scientific support. The participation project included a scientific part, intended to collect instances of good practice relating to the participation of users and their relatives in organising mental health care in Belgium and abroad; and the accompaniment part, which was designed to train users and relatives to play an active role in therapeutic consultation and cross-project discussions. Trained users, called "experiential experts", attended therapeutic consultation and cross-project discussions to appreciate the extent to which the needs of the patients were taken into account in organising consultations and devising care plans.

Third, the Mental Health Care Dialogue Platforms were responsible for cross-project discussion. Cross-project discussion was divided into seven clusters, defined on the basis of the target groups relevant to the pilots and their linguistic community. Pilots were spread among the clusters on the basis of the application forms submitted to the NIHDI. For instance, pilots unfolding in the Walloon Region and devoted to adults with mood disorders were included in the French-speaking cluster "adults: general psychiatry". Every cluster held three cross-project discussions per year. These consisted in meetings during which local coordinators and experiential experts shared learning achieved by attending local therapeutic consultations. Each cluster was managed by a discussion convener hired by the MHCDP. The tasks of discussion conveners included the organising of three meetings per year and reporting the learning achieved through local pilots to the public health authorities.

5.3. Enacting Therapeutic Consultation and Horizontal Consultation

In March 2007, the NIHDI selected seventy eight pilot projects on the basis of the requirements imposed by their definition. The seventy eight pilots, spread over the Flemish, Walloon, and Brussels Regions, included twenty pilots devoted to the "children and adolescent" age group, forty-five to "adults" and thirteen to the "elderly". The testing of therapeutic consultation was planned to take place over a three-year period, from April 2007 to April 2010.

5.3.1. *The Art of Local Translation*

The minimal framework defined by public health authorities made room for appropriation by local actors, who devised their pilots according to local and very situated needs and concerns. The following cases illustrate contrasting local translations of the federal framework. They show that the conception of the therapeutic projects varied depending on: the actors who devised the pilots; their approach to personal problems; their position in the system; organisational strategy and identity (Rondeaux & Pichault, 2012); local "professional projects" (Larson, 1977); and the characteristics of their work environment. The main variations in the pilots' conceptions related to the extent to which they focused on medical or social aspects, and the way in which they planned to enact therapeutic consultation (either by organising two-hour inter-professional meetings taking place at regular intervals, or by creating a therapeutic club welcoming patients eight hours a day). Such local translations made the 78 pilots a heterogeneous whole and brought about increased diversification and local specialisation of the system.

Moreover, the two following cases show that the NIHDI rules, designed to check the pilots' compliance with the federal framework, led local coordinators to act as a strategic relay (Friedberg, 1997) between the pilots' environment, including constraining administrative requirements, and the working of the pilot, in order to find innovative and flexible ways to enact therapeutic consultation in inter-professional and inter-institutional settings. The resulting local arrangements increased the discrepancies between the definition of therapeutic consultation inscribed in the application form and the way it was, in reality, practiced.

a)   Enacting Therapeutic Consultation in the Residential Ecology

The first pilot was promoted by the Peter Brothers Psychiatric Hospital, situated in a rural area in the surrounding of a town of 85 000 inhabitants situated in the south-east of Belgium. To explain his decision to take part in the initiative, the head of the hospital evoked an organisational strategy consisting in taking advantage of every opportunity of testing new ways of working. This "jumping on the band-wagon strategy" was based on his belief that psychiatric hospitals were condemned to change:

> "We were obviously interested in the therapeutic projects because psychiatric hospitals are increasingly required to open to the outside world. We already had the psychiatric home care; the therapeutic projects provided another opportunity to remain involved in this shift and to test working conditions in the ambulatory field." (Interview with the head of the Peter Brothers Psychiatric Hospital, 08/2009)

The head of the hospital appointed a psychologist, who was already working in the hospital, to the function of local coordinator. His involvement in developing previous psychiatric home care

projects and in the NACH psychiatry working group helped him to cope with the federal framework. The head, head doctors and coordinator defined their project by drawing "equivalencies" (Callon, 1986) between the administrative requirements and local needs unmet by the existing care system. Being aware that "general practitioners were mistrustful of psychiatric hospitals, because there was … a problem in the transfer … of the patients at the end of their stay at the hospital" (Interview with the local coordinator, 12/2008), they designed their pilot to improve the continuity of care between the hospital and the patients' living environment. Moreover, considering that the majority of the patients staying at the hospital were people with psychosis or mood disorders, and that their psychiatric home care project was targeted towards psychotic patients, they decided to focus their efforts on adults with mood disorders.

This objective (i.e. of improving continuity of care between the hospital and the living environment for adults with mood disorders) would be achieved by organising consultation between the hospital's medical and clinical staffs, and general practitioners, primary care providers and CMHS's professionals. Therapeutic consultations would be organised every three months, as expected by the NIHDI, as a means of defining care plans appropriate to the needs of the patient and to then adapt those plans regularly, following changes in his/her needs.

However, the initial enactment of therapeutic consultations evidenced that this conception was hard to translate into concrete practice. First, since therapeutic consultation added to mental health professionals' current activities, they had insufficient time to participate in many meetings. Second, except for general practitioners working in private practices, mental health professionals appointed by public services and institutions received no compensation for their participation. Third, the NIHDI rule making it compulsory to hold three consultations a year for each of the thirty patients included in the project also impaired the coordinator ability to organise therapeutic consultation as he planned to do it. Indeed, for professionals involved in the follow-up of several patients, this meant a considerable number of consultations, some of which seemed to respond to administrative requirements instead of changes in the patients' needs. Consequently, with a view to avoid financial sanction from the NIHDI, the local coordinator billed consultations supposed to be attended by all the required partners (who agreed to sign the register sheet even if they did not attend the meetings) while only few of them were actually there.

The local coordinator had good reasons (Friedberg, 1997) for using that strategy. Indeed, through his involvement in the NACH psychiatry working group, he knew that the initiative initially originated from the FPS PH, which conceived of the pilots as very flexible and innovative devices. However, when it became aware that it would not be able to finance the initiative on its own, the FPS PH allied with the NIHDI, which became responsible for the financing of the local pilots. The NIHDI thus inscribed its medical and administrative logic in the federal framework which, in turn, departed from the logic of innovation at the basis of the initiative. In contrast, by developing strategies that

helped him to keep the pilot into operation, the coordinator felt faithful to the initial intent of the initiative.

b)   Enacting Therapeutic Consultation in the Rehabilitation Ecology

Another pilot was devised by a psychosocial rehabilitation service (PRC) situated in a town of about 56 000 inhabitant in the south-west of Belgium. This service developed in relation to a general hospital, in the framework of a NIHDI convention. This hospital, which promoted the project, did not exert any influence on its devising. The defining process was rather managed by the psychologist running the PRC and his colleagues.

The psychologist considered that stays at the psychiatric hospital significantly weakened social cohesion, especially in the case of people with psychosis. When those people left the hospital, nothing was done to restore this cohesion and, most of time, their loneliness provoked new crises and hospital stays. Moreover, according to him, social workers and home care professionals caring for those people in their living environment often lacked adequate training regarding the best way to behave when confronted with a psychotic patient. Finally, the psychologist and his colleagues were convinced that "even people with mental health problems always have some desires, even if those desires appear out of reach to them. Encouraging them to take a first step towards their objective helps them to become aware of their own resources" (Interview with the local coordinator of the therapeutic club, 11/2009). Therefore, they decided to take the opportunity of the therapeutic projects to create a therapeutic club.

In accordance with the principles of institutional therapy, they defined the club as a place where psychotic individuals, different kinds of mental health professionals, home care and social workers came to do something together. The club opened from Monday to Fridays and the activities occurring there ranged from cooking to organising a Christmas market. Thus, in contrast to the previous case, where the defining process consisted in relating local needs to the federal framework, the defining process leading to the creation of the club consisted in contorting the federal framework according to a local professional project:

"We did not feel like organising therapeutic consultations as expected by the NIHDI. In their view, it consisted in putting users in front of a range of mental health professionals supposed to know what was best for them. Here, we thought of therapeutic consultation differently, we intended to help users find what they want to do by discussing it with them when they came to the club … The NIHDI also requested us to define our pilot according the ICD or DSM classifications, but for proponents of the institutional therapy, diagnosis is a very complex process …" (Interview with the local coordinator of the therapeutic club, 11/2009)

Following the call for projects, local actors thought that the initiative intended to support innovative practices and social psychiatry. Accordingly, they were surprised that the federal framework included administrative and clinical classifications specific to medical psychiatry, but

excluding alternative projects from the scope of the initiative. After having discussed the opportunity to participate in the initiative in spite of that medical framework, they did their best to translate their project according to the concepts imposed by the NIHDI. They succeeded in convincing the NIHDI to allow them to create the therapeutic club and, following its creation, they enacted therapeutic consultation according to their first intent; that is to say by opening the club, welcoming psychotic individuals, and developing some projects together. Moreover, considering that the club's opening hours met all the criteria imposed on the organisation of therapeutic consultation, the local coordinator preserved the project from financial sanctions by billing particular activities of the club as therapeutic consultations.

c)   Slight Shifts in Professional Life

Local appropriations and strategies intended to cope with the federal framework were widespread among the pilots. Interestingly, they were particularly helpful to very innovative projects, which felt excluded from the federal framework. The consistency of the federal framework with the logic of medical psychiatry reflected the significant involvement of the NIHDI and the representatives of the "medical profession" (Freidson, 1988) and psychiatric institutions in negotiations during which the operationalisation of the 2005 policy brief was decided. The detailed knowledge of the policy device embodied by the coordinator of the first project also supported that point. It particularly emphasised that the members of the residential ecology acted as a relay, moving from the local level to the arena of policy making, and enacting knowledge they embodied in those two arenas in purposeful ways. In contrast, the second coordinator did not embody knowledge of the creation of the policy device. As a result, it was harder for him to come to know how to enact the federal framework. In this respect, it is worth noting that shifting the policy instrument (i.e. from centralised and institutional policies to decentralised pilot projects) did not prevent the dominant logic of action from being inscribed in the policy device. Meanwhile, it set a context (John Law, 1986) in which particular actors (those embodying the residential ecology's logic of action) held knowledge adequate to immediately make sense of it. By contrast, the actors who did not understand the medical and residential logic underlying the device had first to collectively enact it, in parallel to local professional projects, in order to find ways of inscribing their own view of therapeutic consultation in the federal framework.

Although local strategies made the pilots less challenging to mental health professionals contending they the lacked time to participate in every therapeutic consultation, they were the very condition under which the pilots could be kept into operation. Indeed, pilots which refused to endorse this pragmatic logic of action, due to their commitment to remain fully accountable to the administration or with the explicit purpose of demonstrating the inadequacy of the framework to professional innovations, had no other choice than to leave the policy programme. Thus, although local arrangements unceasingly increased the pilots' idiosyncrasy as well as discrepancies between the image of the pilots projected at a federal level and their actual workings, they supported the

continuous enactment of therapeutic consultation, which successfully questioned professional and institutional routines (A. Strauss, 1994).

The following instances of innovations noted by professionals involved in the two local pilots showed that, in spite of the apparent inadequacy of the policy outcomes, the process involved in enacting therapeutic consultation at the local level supported the change process unfolding in the system. In the first instance, psychiatrists found it very interesting to discuss the care plan with the patient during the consultation. As explained by a young psychiatrist, this yielded the opportunity to confront the patient with choices made at previous consultations and to assess those choices collectively. Most psychiatrists were also very interested in meeting GPs and other mental health practitioners working outside the hospitals. Knowledge enacted in this way allowed them to improve their understanding of the problems met by the patient: "for us psychiatrists, a very positive aspect is that we achieve a better understanding of the patient's life in this way than 'from our castle', because even if we wish to change the situation, we are rather isolated in the care system" (Interview with a psychiatrist regularly involved in therapeutic consultation, 06/2009).

For their part, general practitioners better understood the therapeutic decisions made by the colleagues psychiatrists and developed relationships with mental health professionals from the community ecology. Given that psychotherapies were not reimbursed in Belgium, those connections with the CMHS were interesting resources in coping with the psychosocial problems with which they were increasingly confronted.

At the margins of the community ecology; social workers appointed by CMHS found it interesting to develop concrete collaborations with the "residential world", although they feared that the leading role played by psychiatric hospitals in the pilots' development resulted in over-formalising mental health care networks. Home care workers were more interested in participating in therapeutic consultations which developed their knowledge of how to behave when confronted with psychiatric crisis.

Finally, therapeutic consultation also enabled new practices and relationships to develop within residential institutions. In this respect, psychiatric nurses noticed that, by provided them with occasion to share their understanding of patients' behaviour with psychiatrists, it gave them a more active role in the conception of patients' follow-up. Moreover, in cases where therapeutic consultations intended to prepare for release from the hospital, the care plans resulting from therapeutic consultation helped them to intensify and to orient their daily follow-up according to objectives inscribed in it. The care plan was thus used as extension of therapeutic consultation.

Those instances showed that therapeutic projects gave rise to professional and organisational learning consistent with policy objectives. However, the horizontal consultation had not succeeded in translating those learning into policy proposals, as expected by policy makers.

5.3.2. *Enacting the Horizontal Consultation*

The horizontal consultation was significantly impaired by competing claims to hold better knowledge of personal problems (Abbott, 1988). Those conflicts between mental health professionals, scientific experts and experiential experts were underpinned by their respective attempt to position themselves as "obligatory passage points" (Callon, 1986) in deciding how to reorganise the Belgian system for addressing personal problems.

a)   The Cluster of Adults General Psychiatry: the Failure of Experience

The cluster of adults general psychiatry was managed by a discussion convener appointed by a Brussels mental health care dialogue platform. It was composed of ten coordinators of local pilots focusing either on mood disorders or on psychosis, two experiential experts and the coordinator of the association Psytoyens. It held fifteen meetings during the period from April 2007 to April 2010.

At the beginning of the process, local coordinators focused on contesting the participation of services user groups and the KCE in the horizontal consultation. Regarding the participation project, they argued that experiential experts must have a different status than that of mental health professionals:

"It is clear that services users are key players in the ongoing reorganisation of mental health care. Therefore, they will be invited to take part in cross-project discussion and to share their thoughts, questions and arguments. However, they have a different status to professionals, which does not allow them to be involved in every aspect of professional discussion." (Cross-project Discussion Minutes, 2007: 6)

Concerning the scientific evaluation, local coordinators were "wondering about the scientific value of the KCE patient's data registration" (Consensus Note, 2009). They argued that measurement scales impose by the KCE contained questions on the patients' private and sexual life which were impairing the trust relationships between mental health professionals and patients taking part in therapeutic consultations: "pilots which already started working with the scales observed their impact on clinic activities … Thus, next to their theoretical opposition to the KCE research methods, local actors feel that the scales could modify the very conditions of their clinical work" (Idem). They also feared that the KCE had overstepped its mandate, by using data collected on the basis of the measurement scale to compare the efficiency of different models of consultation implemented at the local level. Moreover, by emphasising the "deontological, ethical and clinical issues" (Idem) raised by the KCE registration system, they expressed their fear that public health authorities might use patients' data to adapt the Minimum Psychiatric Summary to the evaluation of mental health care networks.

The discussion convener eventually put an end to those discussions by summarising the arguments put forward by local coordinators in a consensus note that was sent to the NIHDI and FPS PH:

"This note set out some essential reflections taken from the horizontal process. The projects are ongoing trials…. It is important to remember that experimentation necessarily preceded the formalization of any care network…. The implementing of the initiative revealed that this humble position was hard to maintain…. the system devised by the NIHDI and the FPS PH provided local actors with little opportunity to adjust their practices to the new work methods…" (Consensus Note, 2009)

Afterwards, by relying on the assumption that "every pilot born in a particular context, with specific partners, different routines and work cultures*"* (Cross-project discussion minutes, 2010), the discussion convener suggested that local coordinators tell the story of their pilots according to a framework specifying key issues to be addressed, including how they enacted the function of coordination, how therapeutic consultations were developing, and how mental health professionals and services users were experiencing it. Although it enhanced the sharing of experience by local coordinators, this story telling method made the generalisation of learning achieved through cross-project discussion more challenging:

"Even if the selection of relevant data implied additional workload, and even if it set local coordinators free to share their disagreement and their fears, I would have preferred encouraging the development of true debates and open discussions." (Interview with a discussion convener, 2010)

The discussion convener nevertheless succeeded, at the end of the three-year process, in formalising knowledge of key aspects of the therapeutic project. The final report of cross-project discussion put, for instance, that the function of coordination was the "core of therapeutic consultation", before of defining its three main dimensions as consisting in "process control…; clinical coordination; and administrative coordination', and identifying 'skills which bring an added value to the coordination work, including knowledge of the mental health sector; … social skills, flexibility and stress resistances (Cluster Adults General Psychiatry, final report, 2010).

In the view of the FPS PH responsible for financing cross-project discussion, such achievements occurred too late. In April 2010, confronted with the decision of the NIHDI to support local pilots for an additional year, the FPS PH refused to extend the horizontal consultation. Following that decision, participants in the cluster started questioning their methodology: "we have not gone beyond the local project level; we wondered what the rules were, how we would move forward …. But there was insufficient perspective: no real project that would result in real proposals for structural reorganisation" (Interview with a discussion convener, June 2010).

Therefore, when applying to the FPS PH to be granted with a short extension, discussion conveners from the seven clusters suggested writing more focused proposals based on semi-structured interviews with local coordinators. By separating the process of inscribing professional learning in policy proposals from the interactions during which they were collectively enacted, discussion conveners prevented their rewriting from being delayed by power struggles.

b)   The Scientific Evaluation: a Failure of Evidence

The KCE scientific evaluation encompassed a qualitative and a quantitative part. The qualitative part, defined as "a health services research" focusing on "organisational issues" (Ces et al.2009), pointed at key organisational learning rather similar to that highlighted by the proposals resulting from cross-project discussions. Accordingly, it did not raise any opposition. In contrast, the quantitative study raised strong opposition from local actors. The KCE defined the "patient monitoring" as a "before/after study" (Idem, p.34), using the DSM-4 and ICD-10 international classification of diseases, and designed to analyse the patient characteristics at an aggregated level (case-mix) without any objective to measure and/or analyse the details of the individual patient at all to assess individual outcomes (Idem, p.18). It relied on a measurement borrowed from international literature according their "psychometric properties (validity, reliability)" (Idem).

Local actors strongly opposed the use of these scales, by refusing to use them in assessing changes in the patients' situation. In response, the FPS PH planned an information meeting where the KCE had the opportunity to explain its registration system to local coordinators and discussion conveners. Following this event, however, the latter felt that "the KCE made a very technical presentation that had not been understood by most people attending the meeting" (Interview with a local coordinator, 2008/10). Consequently, the meeting reinforced the opposition of local actors, who raised ethical and clinical issues very similar to those raised by the MPS few years before.

Confronted with this second wave of opposition, the KCE planned a pre-test phase, during which one pilot by cluster (for instance the cluster adult general psychiatry described above) tested the scale before making suggestions to improve its application to empirical reality. Those suggestions were taken into account by the KCE, which slightly modified its registration system:

> "On the basis of the remarks and suggestions of the testers in the test phase, some adaptations to the content of the test battery as well as to the procedure of the patient monitoring were made … answering categories were included for intimate questions, allowing the patient not to answer the question or allowing the caregiver not to ask this question." (Ces et al.2009, p.18)

In spite of these modifications, the conflict enlarged to include powerful actors, among others the French-speaking Association for Health Institution (AFIS), the Federation of Psycho-Socio-Therapeutic Structures, the Professional Association of French-speaking Child and Young Psychiatrists, and the General Practitioners Associations Forum (FAG). The FAG immediately and

purposefully reminded the group that only physicians were allowed to hold data protected by medical confidentiality, and that the trusted third-party system enabling access to anonymised patient data was not yet available. In so doing, the FAG succeeded in relating the issue of the KCE registration system to that of the e-Health platform; another project of the FPS PH which had been blocked by the Belgian Associations of General Practitioners (Vrancken, Schoenaers, & Cerfonatine, 2010). Given the delays involved in the developing of the trusted third-party system, the FPS PH simply decided to forgo the quantitative part of the scientific evaluation. This was a decision that the KCE deeply deplored:

> "This choice is beyond the will and initial intentions of the KCE research team. The content of the patient monitoring was developed but never implemented, by a decision of the FPS motivated by technical problems and time delays in the implementation, reducing the scientific relevance of data collected. But the decision was also inspired by the resistance in the sector on the mere fact of implementing a registration system which was not announced in the call for projects." (Leys et al.2010, p.8)

c)   A Successful Participation Project

Service user groups enacted their participation project independently from the conflict in which the KCE and local actors were involved: "Services users groups experienced participation in a well-defined policy frame intended to enable services users and relatives to make policy proposals on the reorganization of mental health care" (Participation Project 2010, p. 20). They started by training service users, with a view to provide them with resources helping them to play an active role in the initiative. Those resources included knowledge of the legal, professional and institutional aspects of the system, as well as skills in communicating their viewpoint to mental health professionals. The trained users, or "experiential experts", then participated in therapeutic consultations and cross-project discussion. When their participation in cross-project discussion was questioned by local coordinators, they simply asked the FPS PH to clarify their mandate.

Following the FPS PH intervention, experiential experts regularly attended therapeutic consultation and cross-project discussion, thus collecting the data and observations required to write proposals. They also continuously discussed their observations with their peers and the coordinators of Psytoyens and Similes. Those discussions allowed them to identify key issues, which were then discussed in sub-groups. However, at the outset of summer 2009, experiential experts became increasingly worried about their proposals: "a broad range of issues had been highlighted and reflected on, but the groups wondered whether they would be able to agree on precise issues to be inscribed into policy proposals" (Participation Project 2010, p.15). The process of writing a proposal was very challenging as well: "the group was very circumspect about choosing every word used in the proposals; their weight and their meaning were continuously considered and the layout of the proposals was also painstakingly elaborated" (Participation project 2010, p.16). Those difficulties

were resolved by requiring experiential experts to draft the issues to be discussed at every meeting, together with using the Tremblay method, designed to improve the ability of a group to agree on common principles.

The process eventually gave rise to the services users and relatives' proposals for the reorganisation of mental health care. Their main points were the following: relaxing the law on protecting the mentally ill; improving the application of the law of social defence; promoting destigmatisation to professionals, services users' relatives and the public at large; creating structures managed by users themselves; developing mobile teams providing mental health care in the living environment; developing mental health care networks appropriate to patients' specific needs in connection with psychiatric hospitals; recognising the status of experiential experts and the specificity of the mental handicaps; recognising service user associations among advisory bodies for mental health policy makers; and implementing a balanced allocation of resources between the psychiatric hospitals, CMHS and Psychiatric Rehabilitation Structures.

Those proposals were publicly presented in October 2010, during a conference held by services user groups responsible for the participation project. This event was well attended by services users as well as professionals and representatives of public health authorities. It represented a very important step in the institutionalisation of services users' participation in mental health policy making. Indeed, at the end of the conference, the project leader responsible for devising the future Reform 107 announced that the group of experiential experts developed throughout the pilots would receive a key role in the coming reform. Thus, in contrast to the MHCDP and the KCE, respectively responsible for the scientific evaluation and cross-project discussions, Psytoyens and Similes succeeded in positioning themselves as obligatory passage points in the devising of mental health policies.

d)   From Competing Knowledge Claims to Power Struggles

Most disagreements between stakeholders of the horizontal consultation concerned the KCE registration system. That registration system grew up from an alliance between the FPS PH and the KCE. On the one side, the project leader responsible for the horizontal consultation at the FPS PH was a psychologist, previously the WHO national counterpart. As emphasised by Vrancken et al (2010), although he was aware that it would be challenging, he supported the development of evidence-based mental health policy: "Developing mental health evidence-based policy is uneasy because a large part of the mental health community is opposed to that. Yet it is important to develop this kind of policy…It is about stating what is working and what is not" (Interview with a project manager at the FPS PH, Psychosocial Department, 2009). His appraisal of the situation was consistent with that of the KCE, which had clearly expressed its intent to take over advisory bodies influencing the devising of Belgian mental health policies. For their part, local coordinators were totally confused about the KCE registration system. In spite of being aware of an enduring policy driver to develop evidence-based policies, they did not know about the KCE registration system before starting to implement their

pilots. Thus, when they were requested to use the measurement scales in assessing those pilots, they required the FPS PH and the KCE for additional explanations.

The KCE presented its registration system to local actors, but made few efforts, except for the pre-test phase, to diverge from its scientist way of thinking (Vrancken, Schoenaers, & Cerfontaine, 2010). Thus, local coordinators sought support in other arenas. This gave the opportunity to hospital managers and professionals to prompt their spokespersons' intervention. In the event, as we have seen, professional associations mobilised sufficiently powerful means to put an end to the KCE undertaking. In this respect, the failure of the KCE can be viewed as resulting from its misinterpretation of its relationship to local actors, which was characterised by their interdependency (Friedberg, 1997) in producing evidence on the working of the local pilots.

In the meantime, local coordinators focused on disqualifying competing logics of action involved in the horizontal consultation. With this purpose, they borrowed arguments from professional rhetorics emphasising, among other things, the specificity of the doctor-patient relationship and the need to protect medical confidentiality. While enacting professional rhetoric specific to their local care system, they forgot to reflect on the formalization of their local experience. As a result, they (especially the MHCDP representing local actors) missed an opportunity to impose themselves as an obligatory passage point in the reorganisation of the system. In contrast with the KCE, it was their embeddedness in local care system, or their lack of independence, which impaired their ability to produce effective proposals.

By remaining independent from conflicts unfolding at the horizontal level, service user groups succeeded in inscribing knowledge embodied by experiential experts into policy proposals. In so doing, they approached the right balance between embeddedness in local experience and independence from power struggle. Although the writing of proposals proved to be challenging, they achieved separating this collective exercise from disruptive influence by ecological conflicts. In turn, they succeeded in reinforcing their growing alliance with the FPS PH, which was about to support their participation in the coming reform.

5.4. **Shifts in the Community Ecology**

The Walloon Decree of 3rd April 2009 introduced important changes in the organisation of Community Mental Health Services. First, the decree compelled the CMHS to define a "project of mental health service" (art. 3) which was conceived as a flexible tool enabling self-evaluation and joint analysis of the CMHS. Second, the section "networking and institutional dialog" stated that, "depending on the users' needs" mental health networks should involve care structures falling under the scope of the hospital law, primary care services, GP's associations, and the psychiatric/psychosocial rehabilitation centres subsidised by the NIHDI. Moreover, partnership agreements should be concluded first and foremost with psychiatric hospitals or psychiatric

departments of general hospitals, sheltered housing initiatives, psychiatric nursing homes, and Mental Health Care Dialogue Platforms.

Third, the decree created a Mental Health Reference Centre responsible for cross-sectorial and cross-regional dialog. Acting as an observer, the Centre was required to produce qualitative evidence on mental health practices. It was also expected to support the CMHS by providing them with data and instruments responding to their needs and to ensure the follow-up of institutional changes in connection with local actors and the regional government.

Fourth, the 2009 Decree mentioned that multidisciplinary teams had to include professionals holding the title of psychologists, as defined by the law of 8th December 1993. It also sanctioned the possibility for newly recognised professions, among other occupational therapists, to perform complementary functions in the community ecology.

Thus, on the whole, the 2009 decree changed the institutional framework of the CMHS in order to make it suitable to shifts in the professional and residential ecologies.

> "Our inputs [in federal initiatives] are our devices, our Walloon devices. The last one dates from 2009; I'm thinking to the Walloon Decree on Community Mental Health Services, which had not only preceded but *prepared* the reform by putting forward the ideas of networking, partnerships, and so on. This device perfectly fitted with the framework of the Reform 107, even before the [functional] care model prevailing to the reform had been devised." (Interview with a regional policy maker and a civil servant, 2013/03)

5.5. Preparing for Change?

The two short stories of local pilots showed that, through the intervention of the NACH in devising the pilots and the NIHDI in operationalising the policy programme, representatives of the residential ecology succeeded in inscribing a medical and professional logic of action into the federal framework. In so doing, they helped their local representatives to play a key role in making sense of the policy programme. However, continuing enactments of therapeutic consultation into local care systems challenged professional and organisational routines, including professional practices and relationships. They also enabled the gradual building of a common interest shared by different kinds of actors, including psychiatrists, GPs, social workers and other care workers. Accordingly, by rendering the traditional division of work and social relationships increasingly uncertain, the therapeutic projects prepared the ground for Reform 107.

At the horizontal level, the participation of scientific experts and service user groups challenged the dominance of the representatives of the residential ecology over mental health policy making and implementing. The obstacles met by MHCDP in imposing themselves as an obligatory passage point in the systemic reform corroborated the determination of policy makers to find new allies in deciding on the orientation of the change process. However, by underestimating its dependence on local actors,

the KCE missed an opportunity to take over advisory bodies as the NACH in informing the reorganisation the system. For their part, services user groups succeeded in acquiring a position in the system. By reaching the right balance between embeddedness in, and independence from, dominant professions and institutions, service user groups positioned themselves as objective allies of the FPS PH in reforming the system.

At the end of the pilots, in May 2010, the presentation of the policy guide launching Reform 107 made the environment of the system even more uncertain. Not only did local actors experience a break between past initiatives and the new policy programme, but the federal, regional and community governments joined together to announce the start of a big reform of the system, the day after the collapse of the Belgian government. Was it a good or bad sign?

6. CONCLUSION

By summarising key analytical points made through the previous sections, this conclusion suggests conceptualising the Belgian system for personal problem as an encompassing social system composed of interrelated ecologies, whose integration is achieved through cross-regulation (Thoenig & Crozier, 1975) exerted by two coalitions of actors with different sociological properties. It first summarises the main steps in starting to shift the dominant paradigm for addressing personal problems, before highlighting the gradual building of interrelated ecologies and the corresponding system of concrete action. The dominant games, strategies, and coalition of actors involved in enacting this system are then conceptualised. Finally, on the basis of this conceptualisation, it suggested problematising the issue of change in the Belgian system for addressing personal problems.

6.1. Stretching Knowledge Boundaries: Toward a Comprehensive Paradigm for Personal Problems

Personal problems fell under the jurisdiction of medical psychiatry following the transfer of competencies from the judicial to the public health jurisdiction. Then, following claims made by proponents of competing approaches to personal problems, psychiatrists were forced to share their jurisdiction with other professional groups, and then with different groups of actors, for instance scientific experts and services user groups, supported by public health authorities. Consequently, although each ecology continued to hold specialised conceptions of personal problems, the overall paradigm for personal problems was unceasingly enlarged.

Successive enlargements were reflected in changes in the expressions used to denote personal problems, from mental illness to mental disorders to mental health. Those expressions indicated, in turn, changes in linked ecologies. At the beginning of the story, the concept of mental illness meant a jurisdiction held exclusively by medical specialists, with the exception of a set of tasks delegated to psychologists and social workers, operating before or after psychiatrists. Such "settlement by division

of work" (Abbott, 1988) started to form during the second period of the system's development, to be institutionalised on the occasion of the first reform of psychiatry. However, professional practices and relationships sanctioned by that settlement already operated outside the division of work it established. Consequently, the concept of mental illness was gradually replaced by the expression "mental disorders", which allowed for the jurisdiction to be shared between different professionals, all claiming specialised solutions to the biological, psychological and social dimensions of personal problems. The 1996 regional decree on CMHS sanctioned that change by abolishing the division of work sanctioned by the 1975 Royal Decree. Following this, the concept of mental health indicated a shifting objective, from treating personal problems to improving mental health, defined as the individual's ability to cope with daily life problems as well as mental disorders. This last conceptualisation, announced by the NACH 1995 documents and corroborated by the 2001 policy briefing, called for an enlargement of the system's jurisdiction to include the neighbouring domains of justice, social help and employment.

Successive and significant enlargements of the dominant paradigm did not mean paradigm shift. Changes in the dominant paradigm were followed by major changes in the "goals of policies" (Hall, 1993, p. 279), which moved from diversification, to deinstitutionalisation to services integration. Meanwhile, changes in policy goals were followed by changes in "the kind of instruments that [have been] used to attain them" (Idem). In this respect, the increasing use of pilot projects illustrated moves from centralised policies processed through the definition of new care structures (and their corresponding administrative categories) to decentralised policies stimulating practical change at the intersection between institutional boundaries. However, shifting policy objectives and instruments were not followed by "third order change in policy", entailing "a shift in the locus of authority" (Idem, p.287). Accordingly, they equally failed in stimulating changes in the nature of social relationships and balance of power between actors forming part of the system (Crozier & Friedberg, 1980).

By drawing on the story told in this chapter, we can postulate that such complete paradigm shift would imply: 1) to relativise the exclusive relationship between the system and the public health jurisdiction; 2) to move from a federal financing going through psychiatric hospitals to a regional financing; and 3) to change the nature of the relationships between systems of actors, by moving from a professional model to a new model of governance based on the principles of transparency and accountability.

6.2. **Shifts in Linked Ecologies**

The Belgian system for addressing personal problems developed following the creation of, and changes in, adjacent ecologies. Those ecological moves resulted in enlarging the system's overall jurisdiction and the corresponding paradigm (Abbott, 1988, 2005). At the origin of each ecology, demands were made by professionals or social movements (or both) for developing new approaches to personal problems. The processes of raising new ecologies, defined as a set of links between a set of

actors and a set of tasks (Abbott, 2005, p. 251), followed a similar pattern throughout the system's development.

First, at the origin of the residential, community and rehabilitation ecologies, were demands to develop new approaches to personal problems. These claims were situated and relational (Friedberg, 1997); meaning that they made sense in relation to adjacent ecologies and their position in the system. For instance, the emergence of the community and rehabilitation ecologies became meaningful in relation to the dominance of the medical approach which, according to proponents of psychiatric rehabilitation and psychosocial approaches, was not successful in addressing the different dimensions of personal problems.

Second, ecological [jurisdictional] claims (A. Abbott, 1988, p. 59) were initiated by mental health professionals embodying knowledge of OECD countries' mental health and psychiatric systems; for instance, Dr Slivadon was encouraged to promote the development of social psychiatry in Belgium thanks to his knowledge of psychiatric rehabilitation services developed in France. Mental health professionals were helped by social movements and non-profit associations, such as the Julie Renson foundation, to perform an interessement process directed toward public health authorities. Such interessement processes generally succeeded in stimulating policy decisions regarding the creation of new care structures, thereby stabilising particular relationships to personal problems. It follows that claims to hold better knowledge of personal problems preceded the creation of facilities designed to translate that knowledge into concrete practices.

Third, ecological claims led to public recognition of new settlements (A. Abbott, 1988, p. 69), including a particular division of work and specific locations. Public discourse and professional and policy documents supporting the establishment of new settlements did not refer to interessement processes performed by new claimants, but instead referenced the external changes (predominantly changes in qualitative and quantitative aspects of personal problems). For instance, the discourse held by Sam Halter in 1969 did not refer to the interessement process conducted by Dr Slivadon, but to changes in the nature of personal problems. From the early 2000s, WHO documents and knowledge was also referred to in legitimising particular positions. In contrast, the operationalisation of policy projects and the translation of new settlements into concrete practice bought about negotiations, which involved considerations specific to the system, ranging from the financial interest of the Catholic pillar to local professional projects.

Fourth, and consequently, the process of raising ecologies not only started with claims to hold particular knowledge of personal problems; it also ended with such claims. Indeed, institutional and local translations of policy projects brought about new assemblages between knowledge developing in the global environment of the system on the one hand, and strategies directing its internal working on the other. Those assemblages supported the continuing enactment of specific relationships to personal problems, likely to be advocated or opposed in further sequences of collective action. For instance, the "Therapeutic Club" was devised by mental health professionals who connected their knowledge of

institutional therapy with the initial policy project to develop innovative pilots and address local needs expressed by local mental health professionals, without considering the intervention of the NIHDI's bureaucratic and medical way of thinking. Although their local relationship to personal problems was hard to work out in the framework devised by the NIHDI, local actors kept enacting it, eventually making the club a successful experience. Thus, the club came to constitute a new ecology, championed by its proponents in the course of other sequences of collective action occurring in other places and at other times, for instance the horizontal consultation of the ongoing Reform 107.

On the whole, the concept of ecology allowed us to account for the building of the Belgian system for addressing personal problems by considering its particular working. It enabled us to make sense of the development of ecologies existing beyond, below and alongside professional boundaries. It also allowed us to understand the particular positioning of particular actors at particular times, without underestimating the heterogeneity of their connections or their ability to move from one connection to another in their attempt to defend different positions in different situations. Accordingly, in the remainder of this work, we will assume that: 1) ecologies consist of both very local systems such as the therapeutic projects and macro-level such as the residential ecology; 2) they resulted from claims to hold better knowledge of personal problems; 3) those claims made sense in relation to existing ecologies; 4) they preceded the establishment of social entities such as CMHS, ISH and therapeutic project - as Abbott put it "boundaries [defined as "sites of difference" (A. Abbott, 2001, p. 265)] come first, then entities"(idem, p.263); 5) multiple ecologies are unceasingly enacted through situated attempts to succeed in collective endeavour; and 6) to understand the position of given actors in relation to specific issues, it is necessary to identify the multiple sites of difference they connect with one another, rather than mobilising ready-made solutions such as organisational or professional memberships.

6.3. The System of Concrete Action

All ecologies are linked ecologies. As emphasised by Abbott (2005), successes and failures in reaching a hinge between two ecologies depends on what is going on in neighbouring ecologies. For instance, the success of "progressive thinkers" (Sartorius, 1981) in developing new ecologies depended on negotiations with historical incumbents of the system, duly represented at the NIHDI and at the FPS PH. Such negotiations were continuously directed by a system of concrete action (Crozier & Friedberg, 1980) involving interrelated games outside of which the arising of new settlements were not comprehensible.

6.3.1. *The Protective Game: Disintegration and Conversion Strategies*

Following their entrance in the jurisdiction of public health, psychiatric hospitals underwent successive measures directed toward increasing their medicalisation. Increased medicalisation meant increased public financing and, in turn, the beginning of a rapid process of professionalisation. As

illustrated by the following quotation, in comparison with their long history, the transformation of asylums (Goffman, 1961) in modern hospitals occurred very quickly:

> "I have been head doctor in this institution for forty years! … When I started working here, we were absolutely self-sufficient, even the bread was made here! We lived happily. Then the head doctor was also the head of the institution; everything worked so well! It was a world withdrawn from the world. Now, where have psychiatric hospitals been located? At the end of world; after us, there is nothing, except for the railway." (Interview with a psychiatrist, head doctors of a private psychiatric hospital, 07/2008)

In the course of every reform of the system, psychiatric hospitals did their best to hold public health authorities back from transferring any part of their resources toward competing ecologies. *Protective games* helped them to keep control over most parts of private and public resourcing available to deal collectively with personal problems, and thus to maintain their dominant position in the system. Protective games were enacted through specific strategies, especially disintegration and conversion strategies.

The *disintegration strategy* was employed by representatives of the residential ecology to decrease the consistency of policy projects, in a way that ensured the independence of local institutions in implementing new policies. By occupying key positions at the FPS PH, the NIHDI and the NACH, representatives of the residential ecology purposefully enacted this strategy in the course of the operationalisation of every policy programme. In the case of the 1974-1976 reform of psychiatry, it caused the decision to implement innovative ideas borrowed from the WHO through three separate decrees, enabling local actors to enact the corresponding policy measures independently from one another. In the case of the 1989 reform, it shifted the policy objective from the creation of mobile psychiatric care to alternative housing facilities. In both cases, it resulted in enlarging the system and increasing the specialisation of its constituent parts instead of improving the integration of the whole.

Moreover, from the 1989 reform onward, the *disintegration strategy* was complemented by a conversion strategy. This consisted in ensuring that psychiatric hospitals kept controlling the change process, by allowing them to use their resources to create new facilities. Following the Busquin reform, the NACH made that strategy explicit, as inscribed in its 1997 advisory document. Disintegration and conversion strategy were simultaneously enacted during the operationalisation of the policy programme supporting the therapeutic project and the horizontal consultation. They supported the inscription of the medical approach to personal problems in the federal framework, and the decision to ask psychiatric hospitals to promote the pilots and appoint local coordinators.

6.3.2. *An Offensive Game: Opportunistic and Decoupling Strategies*

Offensive games denote the success of the advocates of the community and rehabilitation ecologies in interesting policy makers in alternative approaches to personal problems in two ways. The first way is by highlighting shortcomings of the residential ecology in addressing their biological, psychological and social dimensions, and the second is by relating successes in implementing the corresponding approaches in neighbouring countries. Interessement processes led to a redefining of public conceptions of personal problems in a way that created vacancies (Abbott, 1988) in the system, before claiming the right to occupy the resulting (vacant) positions. Offensive games were enacted through opportunistic and decoupling strategies.

Opportunistic strategies consisted of relating moves in the global context (for instance the growth of the mental health movement) to moves in the immediate environment of the system (for instance the appointment of progressive thinker as Minister for Public Health) to create conditions in which a well-managed interessement process might be led to a successful conclusion. Such strategies were enacted by actors holding knowledge of innovation in mental health, psychiatric knowledge, and relationships with actors occupying key positions in federal administration. They resulted in policy initiatives which, in spite of the influence of disintegration strategies, provided local actors with opportunities to develop innovative professional projects.

Opportunistic strategies enacted at the institutional level were complemented by *decoupling strategies* enacted at the local level. Decoupling strategies were used by local actors to compensate for discrepancies between initial claims for developing new ecologies and the resulting settlements, in which medical knowledge had been inscribed following the enactment of disintegration strategies. Local enactments of decoupling strategies successively resulted in: making CMHS very specialised services; allowing for the development of multiple professional practices in the framework of the ISH; and making the therapeutic projects idiosyncratic local devices.

On the whole, not only did opportunistic and decoupling strategies bring about a great diversity within the system for addressing personal problems, but they also went hand in hand with disintegration strategies to support the independent development of the residential, community and rehabilitation ecologies.

6.3.3. *Interdependent Games and Cross-Regulation*

Thoenig and Crozier (1975) argued that cross-regulation allows organisations involved in the same inter-organisational network to work independently form each other, although their respective developments were interdependent. To explain that combination of independence and interdependence, they highlighted the intervention of intermediary actors or "relays". These relays occupied key positions in inter-organisational networks. Multiple organisations involved in collective action do negotiate their participation in the system with each other, but through intermediaries. Consequently, conflicts between organisations included in the system were mediated by a third party; i.e. they occurred through relays. Regarding professional systems, Abbott (1988) argued that they

were competing systems, within which actors sought to develop privileged relationships with key actors, helping them to enact their jurisdictional strategies. In this respect, Thoenig and Crozier specified that knowledge of the concrete functioning of the system (including dominant games directing its development) improved the ability of actors to find adequate relays and accurate strategies (Thoenig & Crozier, 1975).

Applying this argument to the story of the system's development helps to understand the interdependence of offensive and protective game in directing collective action. In the early 1950s, psychiatric hospitals and psychiatrists developed privileged relationships with public health authorities. Their alliance was inscribed in administrative categories and enacted by relays of the residential ecology occupying key position at the FPS PH, the NIHDI, and later the NACH. During the following decades, when psychiatric hospitals felt threatened by alternative knowledge of personal problems, they did not directly oppose their proponents. Instead, they responded to those threats through the interventions of their privileged relays, which brought powerful support to their cause. The case of the MPS and the KCE registration systems provided striking illustrations of such oblique action (Thoenig & Crozier, 1975) .

From the beginning of the system's development, proponents of alternative movements understood the concrete working of the system within which they were coveting a position. They relied on that knowledge to devised rewarding strategies. Accordingly, they undertook *oblique action* each time they perceived opportunities to prompt change in the system. Those actions consisted in directing interessement processes towards relay-actors, instead of directly contesting the position of psychiatric hospital. In response, relays of the residential ecology systematically and purposively enacted their disintegration and conversion strategy.

Offensive and protective games thus appeared as interdependent in directing the development of the system. Meanwhile, their joint enactment by intermediary actors gave rise to policy devises enabling local actors to keep developing independently from each other. The enactment of dominant games involved network of actors (or coalitions) which were not limited to the residential, community and rehabilitation ecology. The two following ideal-types suggest a summary of the sociological properties of the two coalitions enacting offensive and protective games.

6.3.4. *Contrasted Coalitions Enacting Dominant Games*

The first coalition can be defined as traditional. It grew from the alliance between psychiatric hospitals, the professional group of psychiatrists and federal departments, agencies (NIHDI), and advisory bodies (NACH). It had powerful spokespersons including professional associations and federations of care providers. These actors claimed academic and medical knowledge of personal problems. Their logic of action can be defined as professional. It stressed rights and obligations specific to established professions, including their autonomy in dealing with personal problems. It was

inscribed in institutions securing their position in the system, and regularly enacted through discourses and actions intended to defend the coalition against competing movement.

In this traditional coalition, the NACH acted as knowledge broker by translating international benchmarks into particular concepts, for instance the mental health care networks and circuits, which incorporated the requirement of local actors to be able to adapt those concepts to local institutional and professional projects. The ability of the NACH to devise concepts which made room for local appropriation proved its deep understanding of the concrete working of the system. However, since this knowledge derived from its embeddedness in the system, this could weaken the NACH in front of competing knowledge producers, claiming objective (dis-embedded) knowledge of the system.

Politically and ideologically, the traditional coalition was closely aligned to the Catholic pillar. Given the secularisation of psychiatric institutions, the particular beliefs of the traditional coalition cannot be deduced from that relationship. Organisational behaviour endorsed by members of the traditional coalition are nevertheless close to the pragmatic culture defined by to Kuty to account for the willingness the Catholic pillar to create unthinkable alliances, provided that they help them to protect their institutional interests (Kuty, 2006). The strategic resources of the traditional coalition also derived from the Catholic pillar. They included psychiatric institutions belonging to the pillar and the role played by its representatives in drafting decisions relating to the public health system in the NIHDI Committee for Healthcare Insurance. Those resources significantly helped the coalition to control change processes unfolding in the system

The second coalition can be defined as reformist. It had contrasting properties. Its members relied on a professional network to support the growth of alternative knowledge of personal problems within the system. Their professional networks contrasted with those mobilised by the traditional coalition. Instead of being embedded in the Belgian system, they originated from and expanded outside the system. Deriving from the involvement of its members in multiple local and national movements, the reformist coalition appeared wider but less integrated than the professional one. Accordingly, the concept of a *network* is more appropriate to describe the connections existing between actors championing community care models and social psychiatry.

However, that weak organisational integration seemed to be compensated for by the sharing of common values and knowledge. In this respect, the reformist network evoked the epistemic communities defined by Haas (Haas, 1992). Indeed, from the first reform of psychiatry to the 2002 Interministerial Conference, proponents of major reforms of the system had been expressing relatively stable ideas and concerns. They derived from professional experiences in testing alternative care models and participating in international organisations. They consisted of embodied knowledge of different kinds of approaches to personal problems, as well as embodied and inscribed knowledge of mental health systems across the world.

The kind of knowledge shared by members of the reformist network thus differed from the academic knowledge claimed by the traditional coalition. Embodied knowledge of alternative care

models seemed more practical and situated than theoretical and abstract. Conversely, inscribed knowledge of mental health care systems (for instance the WHO documents) appeared more objective and a-contextual than situated and subjective. In this respect, it contrasted with the NACH documents. Both embodied and inscribed knowledge specific to the reformist network entailed an idea of movement. Embodying knowledge of alternative care models entailed moving outside the Belgian system, and the very purpose of a-contextual knowledge is to move from one place to another, to be used as benchmark to which national systems can be compared.

Politically, the capacity of action of the reformist network depended on the presence of progressive thinkers in federal administration and departments. However, following the drafting of reformist mental health policy projects, the network's capacity for action remained fundamentally dependent on negotiations prevailing to decision making in public health. It follows that the political resources of the pragmatic network appeared much more uncertain and contingent than those of the traditional coalition, which were firmly anchored in historical institutional arrangements.

On the whole, neither the traditional coalition nor the reformist network was limited to particular ecologies. Although seventy percent of the residential ecology was historically connected to the Catholic pillar, various kinds of professionals working in residential institutions were supporting progressive ideas. Conversely, members aligned with the traditional coalition were working in community settings. Since the ecological and social configuration of the system did not perfectly overlap, both are required to understand the positioning of particular actors in collective action.

6.4. The Issue of Change in the Belgian System for Addressing Personal Problems

By providing collective action in the system for addressing personal problems with a "sense of purpose and continuity" (Corbin & Strauss, 2008, p. 97), interdependent games defined the rhythm of the process of change. The overall process of change unfolded through interrelated micro (e.g. therapeutic consultation, the devising of local pilots) and macro (e.g. interministerial conferences, public discourse about new reforms) sequences of collective action directed by interdependent protective and offensive games. They occurred following changes in the global context (e.g. the birth of the mental health movement in the US, WHO's conferences and documents), creating further opportunities for stimulating ecological moves. Protective and offensive games were enacted through different kinds of strategies, including disintegration and conversion strategies on the one hand, and opportunistic and decoupling strategies on the other. Their enactment involved particular coalitions/networks of actors with contrasting but relatively stable sociological properties.

Recurring strategies allowed for the combining of rapid and frequent ecological moves with institutional stability. Institutional stability was supported by protective games ensuring the continuing dominance of psychiatric hospitals over the system. Conversely, repeated attempts to create new

vacancies caused successive ecological moves. Meanwhile, given the combination of interdependent games and independent development allowed by cross-regulation, successive ecological moves caused the continuing enlargement of the system's overall jurisdiction. Such enlargement induced the gradual definition of a very comprehensive paradigm for personal problems, making the system increasingly vulnerable to radical change, or paradigm shift. However, shifting policy objectives and instruments were not followed by shifts in the social configuration, which would imply: relativising the exclusive relationship between public health authorities and psychiatric hospitals; transferring decision making power from federal to regional authorities; and changing the nature of the relationships between actors making up various parts of the system.

By relying on that conceptualisation, we suggest problematising the issue of change in the Belgian system for personal as depending on: 1) the possibility of removing collective action in the system from the scope of influence of cross-regulation exerted by interdependent games; 2) enhancing the deployment of resources specific to the reformist network. The following analyses of the ongoing reform are based on this problematisation.

PART TWO – WITNESSING CHANGES IN THE SYSTEM FOR ADDRESSING PERSONAL PROBLEMS: FOLLOWING DOCUMENTS INTO COLLECTIVE ACTION

"Among the salient properties of this negotiation context, one of the most striking is that many negotiations are novel.… For the first time, virtually all were thrown together with people of other profession to work as a team. … And for the first time people were about to find themselves doing tasks for which they had had no precedent in their training. Another property … was that the stakes of the individual negotiators … were both common and very different. What [they] had in common was to the goal of getting the work done. However, what work ought to be done was sometimes a matter of disagreement. Beyond that, each wished to do the kind of work that would be most satisfying. … Of great importance was also the matter of ideological stakes: Each professional tended to represent some ideological position on the question of psychiatric treatment, and many had firm conviction about implementing their particular ideologies. … One additional dimension of the context … is that much of the negotiation has to do with what are or should be legitimate actions. The legitimacy boundaries are not covered by clear rule or conventional understandings: The boundaries themselves must often been negotiated." (Strauss, 1978, p. 112)

INTRODUCTION

The second part of this thesis is composed of four chapters, including a case study recounting the creation of the policy guide devising Reform 107; two cases studies illustrating the implementation of the reform in local care systems; and a conclusive discussion summarising empirical and analytical findings achieved through telling the story of change in the Belgian system for addressing personal problems.

The first case study relates the making of the policy guide devising a new reform called "Psy 107". This case study is composed of three main parts. The first part explains what the guide tells us about the functional care model and the organisational networks to be implemented through the reform. It also reports the decision of the proponents of the reform to start reorganising the system through exploratory projects which made room for the creativity of local actors. It then presents the actors, roles and procedures involved in the local development of these projects. The second part of the case study relates the writing of the policy guide. It shows how knowledge embodied by those who wrote the guide and different kinds of inscriptions were brought together to form a new conception of change in the system for addressing personal problems. It also explores how and for what purposes those assemblages were inscribed in the guide. The third part of the case study presents the initial enactments of the policy guide, first through a public information event where the document was distributed and explained to local actors, and then through the selection process by which public authorities evaluated whether local versions of the guide were consistent with the global philosophy of the reform.

The two following chapters expose case studies relating the implementation of Reform 107 in local care systems characterised by different ecological and social configurations. These case studies relate the local life of the guide, from the moment when local actors decided to apply to develop an exploratory project to the moment when this project had been put into practice.

The first case study relates the story of an exploratory project called REST. It developed in a Belgian Province called the Red Province. Mental health and psychiatric services and institutions involved in the REST project were members of the regional Mental Health Care Dialog Platform (also called the "Red platform"). The REST project was situated in a rural area with a big territory and a medium to low population density. The biggest city of this area was the Green city. Based on the conceptualisation of the system for addressing personal problems proposed at the end of the first part, we can define the local care system involved in the REST project as follows.

Regarding the ecological configuration, we assume that the REST project developed in a local care system in which psychiatric hospitals played a central role. Accordingly, the main actors of the REST project were two psychiatric hospitals (called the "promoter hospitals") including a private psychiatric hospital (the Peter Brothers' Hospital) and a public hospital (the Wood Hospital). The residential ecology thus dominated the ecological landscape. The community ecology also existed, but

was not very developed. The rehabilitation ecology existed only through sheltered housing initiatives (ISH) and psychiatric nursing homes (PNH) resulting from the reconversion of psychiatric beds. Accordingly, they were closer to the residential ecology than to psychiatric rehabilitation principles.

The social configuration of the local care system corresponding to the REST project was dominated by the traditional coalition. Indeed, the Peter Brothers' Psychiatric Hospital was managed by actors closely aligned to the catholic pillar and the traditional coalition. The other hospital involved in the REST project was a public hospital. Following a recent restructuring, it had been incorporated into a big hospital grouping closely aligned to the socialist pillar. However, in the framework of Reform 107, the managerial strategy endorsed by the head of the Wood Hospital was consistent with the logic of action claimed by the Peter Brothers' Hospital. Their objective alliance ensured the domination, for a while, of members of the traditional coalition over the implementation of the REST project.

The second case study relates the story of an exploratory project called FUL. It developed in the same province than the REST project, the Red Province. Thus, the partners of the FUL project were also member of the Red platform. The FUL project was situated in an urban area with a large territory and a high population density. The main city of this area was the Red city. The main actors of that case study were two psychiatric hospitals who supported the project, including a private psychiatric hospital (the PRIPH) and a public hospital (the PUPH). The "Association" and the "Club" were two actors from the community ecology who also played an important role in the FUL project.

Regarding the ecological configuration, we assume that the three ecologies were equally involved in the FUL project. The residential ecology was represented by public and private psychiatric hospitals, the PRIPH and the PUPH. Both held different kinds of resources including psychiatric wards, ISH, PNH and pilot projects developed over the preceding decades. The residential ecology played a leading role in the FUL project, by devising the project and managing most financial, structural and human resources involved in the project. The community ecology was also well developed in the territory of the project. By appointing front-line professionals to participate in meetings taking place in the framework of the reform process, the community ecology played an active role in its local implementation. The rehabilitation ecology was particularly well developed in the territory of the FUL project. Indeed, a non-profit association (called "the Association" hereafter) had stimulated the development of a considerable network of psychiatric rehabilitation centers. The Federal Coordinator of the reform, who played a leading role in the writing of the policy guide, had been working in the Association for about thirty years. Thus, through the intermediary of front-line professionals appointed by rehabilitation centres to participate in the project, the Association played the role of relay between the federal programme and the local FUL project.

Regarding the social configuration, the FUL project was divided up between the traditional coalition and the reformist network. On the one side, the PRIPH was strongly connected to the traditional coalition. On the other side, the PUPH and the Association were closely aligned to the

reformist network. Both brought their respective resources into the FUL project. As a result, that project can be viewed as a stage where different conceptions of how to reorganise the system, and conflicting models of professional expertise, met with one another.

The three case studies have been organised according to the framework presented through the methodological chapter. As illustrated by the figure proposed in the section devoted the "case study design" (see chapter 1), every case study involves three steps: (1) setting the conditions that preceded and led to the development of a project (either the policy programme or exploratory project); (2) analysing the document in which that project was recorded; and (3) attending to successive and interrelated sequences of interactions through which the documents were enacted. The empirical material, including semi-structured interviews, direct observation of meetings and documentary analyses, is presented through quotes taken from interviews or observation notes. The quotes from our observation field notes had been selected according to their potential in illustrating the social process unfolding in the REST and FUL exploratory projects. In cases where interactions unfolding in the course of the observed meetings are fully transcribed, they are preceded and followed by analyses of the case mentioned. The quotes from our observation field notes are referred to as: CF (Committee of Function), number 1, 2, 3, 4 or 5, M (Meeting) number 1 … 10, month/year). When we needed to refer to precise interactions through our analyses, we numbered the interventions of the attendees.

The last chapter of this second part discusses the main aspects of the sociological account of the Belgian system for addressing personal problems proposed in this work. It includes: a brief reminder of analytical and methodological decisions taken at the beginning of this work; a summary of key analytical findings following from the first and second parts of the thesis; the main features of the approach to changes in collective action set out throughout those two parts; and key learning achieved through using the phenomenology of inscribed, embodied and enacted knowledge to analyse ongoing changes in the system. Finally, a short conclusion proposes a brief outline of the story told in this work, before highlighting some issues for further research, particularly the issue of meetings, defined as specific settings where collective action is decided upon.

Chapter IV − A SMALL GUIDE FOR A BIG REFORM

"It is important to understand two things about [the] ways of expounding scientific knowledge and securing assent: that they are historical construction and that there had been alternative practices. It is particularly important to understand this because of the problem of the giveness and self-evidence that attend the institutionalization and conventionalization of these practices." (Shapin, 1984, pp. 509–510).

INTRODUCTION

The *Guide Towards Better Mental Healthcare by the Realization of Care Circuits and Networks* is the policy document supporting the complete reform of the Belgian system for addressing personal problems, launched in May 2010. As a policy document, it inscribed the knowledge held by Belgian policy makers directly prior to the reform. The guide had both communicative and regulative purposes: it was designed to improve local actors' knowledge regarding the community-based model they were asked to implement; the reasons why policy makers decided in favour of a complete reorganisation of the system; and their role in realising that reorganisation. The schedule of the reform and specific policy instruments conceived by policy makers to evaluate and support the implementation of the community model, especially by training local actors to new professional roles, were also defined in the guide.

The first part of this case study focuses on those aspects: it relates what the guide told local actors about the context in which the reform took place; the functional model to be implemented through the reform; how that model should be implemented at the local level; and specific means used to evaluate and to finance the reform.

However, as a document in which knowledge held by particular people has been inscribed, the guide involved the distillation of far more knowledge than was eventually made visible to its audience through explicit references and explanations. Other kinds of knowledge not explicitly referred to in the document nevertheless influenced concepts and instruments inscribed in the guide. Such implicit knowledge included, for instance, knowledge of negotiations leading to an agreement on the policy document and particular ideas and interests expressed through those negotiations, and possibly cast aside in the final agreement. Although the policy document does not explicitly refer to knowledge of negotiations involved in its creation, this knowledge was nonetheless inscribed at the core of the care model to be implemented through the reform and associated policy devices. This implicit knowledge was likely to become visible through successive enactments of the document, and thus to impact on the course of collective action.

Given the above, the second part of this case study is devoted to the analysis of the creation of the guide. It first explains how those who wrote the guide perceived the context in which a complete

reform of the system became possible. Second, it introduces the task force and the think tank (the two working groups created to write the guide) along with their respective roles and the personal trajectories of their members. Third, it relates the process of writing the guide, explaining how members of the think tank reached an agreement on the definition of a new mental health care model and the obstacles they met when attempting to express it in language both comprehensible and acceptable to a wide range of stakeholders. Fourth, it presents selected instances where the strategy endorsed by the think tank to implement the reform became particularly visible.

It then relates the initial enactment of the guide. Initial enactments occurred during and just after the public event where policy makers presented the documents to local actors. The local enactments of the documents that followed will be set out in the two following case studies, presented in chapters 5 and 6 respectively. To conclude, we will highlight particular aspects of the policy document, including knowledge and logics of actions inscribed in it, which make it appear as a specific product of the reformist network;

1.   WHAT THE GUIDE TELLS US

The guide is a 35 page book translated into Flemish, French and German, and signed by seven ministers. The French version of the guide, specific to the Walloon Region, was signed by: the Vice-Premier and Federal Minister of Social Affairs and Public Health; the Walloon Minister of Health, Social Action and Equality of Opportunities; and the French community Minister of Culture, Audio-visual, Health, and Equality of Opportunities. It is entitled *Guide Towards Better Mental Health Care by the Realization of Care Circuits and Networks*. Six logos are represented on its blue cover. The logo of the reform, which was designed by a professional training centre, is represented alongside those of the Federal State, the Flemish-, French- and German-speaking communities, and the Brussels-Capital Region.

The document is composed of ten chapters. The "historical background" and the "present situation" are first presented. These sections are designed to help the reader in understanding "why act now". The following chapters explain "which model must be introduced", before mentioning how policy makers conceived of "the local implementation" of the new care model, the "follow-up of the projects", the "formation and research", and the "legal and financial issues". Finally, the two last chapters outline the "communication plan" that policy makers intended to reinforce the coherence of the information disseminated.

1.1. Why Act Now?

The historical background describes mental health as a dynamic sector, characterised by a long-standing commitment to improve the balance between mental healthcare provision and the particular needs of services users. The documents specifies that the specialisation and diversification of the

system had significantly improved during the fifty past years, before presenting successive policy measures which encouraged a decrease in residential treatments. It explains that those measures gave rise to alternative mental health services, providing care in the community, for instance the CMHS, ISH, and the PNH. The 1980 moratorium on hospital beds planning is also evoked, as a policy decision that put an end to the continuous growth of residential facilities.

In contrast to that past period, the guide presents the current situation as being the logical "next step", characterised by the intention to replace a supply-driven and residential system by a demand-driven and community-based system. Two documents are viewed as turning points between the original model (i.e. where the residential model was the rule and community services the exception) and the present attempt to reorganise the entire system according to the community model.

The first document examined is the 1997 NACH advisory notes on the reconversion of psychiatry. The second is the *Joint Declaration* agreed on by the Interministerial Conference in 2002. The latter is presented as the response of the executive power to the NACH advisory notes. In that respect, the guide first highlights that:

> "According to this Declaration (and its amendment in 2004) both acute and chronic mental health care will be organized in the future through care circuits and care networks, bringing mental health care as close as possible to the needs and demands of people with mental health problems." (Guide, p.4)

It goes on to explain that the *Joint Declaration* opened a period of phased changes, during which several pilot projects were implemented with the aim of "creating new specific forms of care" (e.g. psychiatric home care), "extending a consultative function around individual patient" (Therapeutic Consultation) and "a consultative function at the level of the network of health care providers" (Cross-Projects Discussion) (idem). The guide stresses that those pilots were devised to "lead to a reform of the current legal framework for programming, licensing, financing, reimbursing the use of mental health care provision, and patient rights" (Guide, p.5).

Following those pilots, the Interministerial Conference decided in favour of a global reform. The guide insists that when the IMC made that decision it assumed that such reform would require systematic consultation between the federal state and the federated entities, and would "respect the existing provision, [to] promote a consensus between care providers … [and] allow a gradual adaptation of the provision, under acceptable conditions for professionals" (idem). The guide then sets out the reasons behind the IMCs decision, including past changes in the Belgian system for addressing personal problems and international experiences proving that community models improved the quality and effectiveness of mental health care systems. Among other instances, it refers to reforms carried out the United Kingdom, where the "suicide rate dropped sharply", following a significant increase in "the number of mobile teams treating and supporting people with mental health problems in their home environment …" (Guide, p.6).

The guide then argues that scientific evidence supported the reform, presenting both a 2004 health survey which showed that "within the population aged 15 years old and older, one person on four is suffering from psychological distress" (idem), and the 2008 KCE report showing that in 2003, "4.730 adults stayed more than one year in a T-bed" (idem), meaning that "psychiatric hospitals still make insufficient efforts to reintegrate these patients into society" (idem, p.7).

Finally, the guide refers to the WHO recommendations, indicating that the WHO encouraged policy makers to realise the reform by highlighting that Belgium had one of the higher ratios of psychiatric beds per inhabitants in Europe, with 152 beds per 100 000 head of population (WHO, 2008). Moreover, the "new understanding" (WHO, 2001) of mental health promoted by the WHO since the early 2000s stimulated a policy reflection in relation to mental health. Finally, the guide assumes that WHO documents such as the *Call for Action* (WHO 2001b) and the *Declaration and Action Plan* (WHO, 2005a, 2005b) played an important role by highlighting "the importance to society of the increase of mental health problems and the urgent need for expansion and a better organization of mental health supply" (Guide, p.7).

1.2. A Functional Care Model – A Global View of Personal Problems

"A significant trend toward socializing mental health care is observed at the international level. This leads to increased needs for cooperation and coordination between actors belonging, or not, the mental health sector. Belgium too has taken that direction, through an integrated and global reform." (Dr. Benedetto Saraceno)

The fourth chapter of the guide defines the mental health care model to be institutionalised following the reform. It states that:

"The model we wish to introduce, with a global vision as starting point, ensures the integration of the resources of hospitals and the resources of (ambulatory) services exiting in the community. Such a model implies that all actors within a specific, defined area must be involved in the organization of the model." (Guide, p.8)

The model presented by the guide is based on integrated care networks performing five functions in precise catchment areas. Those networks are defined as means to improve mental healthcare accessibility and to help people with personal problems to stay in their social environment. They entailed the development of multidisciplinary and flexible responses to address personal problems. The five care functions supplied by local networks included mental health prevention and promotion, mobile teams providing acute and chronic psychiatric follow-ups, intensive residential treatments units and alternative housing facilities.

The guide suggests short definitions of the five functions and a schematic presentation of different care circuits that should be supplied to people with personal problems.
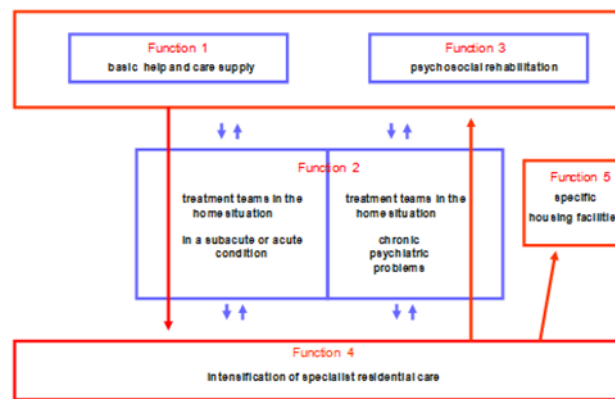
Figure 3 – The Functional Model[22]

The short definitions of the five functions are as follows:

- **Function 1** consists of "activities on prevention and promotion of mental health care, early detection, screening and diagnostic activities" (Guide, p.8). Primary care options, especially GPs, are central to the development of that function.

- **Function 2** involves "ambulatory teams offering intensive treatment for both acute and chronic mental health problems" (idem). These mobile teams relate to "the creation of a mobile service, immediately and intensively intervening in crisis situations" (idem). They are expected to provide rapid, appropriate responses, situated close to the living environment, as alternatives to residential treatments. They offer basic and short term interventions to people with (sub-)acute or chronic psychiatric problems. "Based on the individual needs of the client and with the objective to achieve continuity of care" (idem, p.9), they work in connection with the other functions, to which they bring rapidity and expertise.

- **Function 3** involves rehabilitation teams focusing on recovery and social inclusion. It "belongs to the field of psychosocial rehabilitation" (idem) and entails the supply of a dynamic and continuous process of skills development, designed to enable people to achieving "independent functioning in daily life" (idem). Rehabilitation processes are based on specific programs, focusing on skills training and participation in community life, and supporting the development of new cultural, social or professional roles. Those programs are viewed as complementing functions one, two and four.

- **Function 4** consists of residential intensive treatment units for acute and chronic mental health problems. These units offer specialised care to people who have such severe mental illness that they are temporally unable to live in their social environment. It includes small units offering short-term but highly intensive treatments. These units must remain connected to the other

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[22] (2010) *Guide Towards Better Mental Healthcare by the Realization of Care Circuits and Networks*, p.10

functions and the social network of services users, in order to increase service users'
opportunities to reintegrate into community and social life.

- **Function 5** consists of alternative housing facilities offering continuing care to people "with
limited opportunities for integration into the community" (idem, p.10). It includes sheltered
housing initiatives, supervised apartments and other housing facilities focusing on improving
the autonomy of services users.

1.3. How to Implement the New Model at a Local Level?

The guide also outlines the means that should be used by public health authorities to cope with
local implementation of the reform, starting by specifying that close attention would be paid to the
compliance of local actors with the global philosophy of the reform and the particular conception of
mental healthcare networks implied by that philosophy.

Regarding the process of implementing the functional model, the guide first states that the
reform must be progressive: "the current organization of mental health services should gradually
evolve" (Guide, p.11) along with the operationalisation of each care function at the local level. The
operationalisation of the five functions had to be achieved through local exploratory projects. To
enable local actors to bring their "creativity and originality" (idem) into the change process, policy
makers imposed "only a minimal framework" (idem). That framework defined actors and methods
involved in the change process (see below). The guide nevertheless insisted that "the overall
philosophy of the reform should particularly be taking into account" (idem).

Second, the guide presents the "integrated and global" policy approach prevailing to the reform.
That approach entailed that changes introduced in the system in the course of the reform had to fit in
with "a complementary totality" (idem) encompassing "cooperative networks"; that is, a "form of care
where all actors have to work together at different levels" (idem). In this respect, the document
highlights that such a global approach implies cooperative relationships between mental health
professionals, services and institutions.

Third, the guide states the policy makers' commitment to define the notion of networks "very
precisely" (idem), as "collaborations between structures and resources that, in a real partnership, will
lead towards a common finality and common functioning and goals, with the purpose of ensuring an
effective follow-up of patient, a better continuity of care, and a better provision and quality of care"
(idem). It also insists that networks are necessarily based on the basic philosophy of the reform.
Accordingly, they should take shape through "individual programmes", respecting "the free choice of
the patient" and resulting in "individualized therapeutic trajectory" offering "adjusted response in
every situation" (idem).

1.3.1. *Key Actors*

The guide specifies that the "network coordinators" had to play a very important role in the building of local networks. Network coordinators had to be appointed by the members of local exploratory projects, according to a profile briefly defined in the guide and further detailed on the website devoted to the reform. Assuming that the success of the reform depended on the work performed by network coordinators, public authorities had also inscribed a detailed definition of the multiple competencies and tasks they had to perform in their work contracts.

This profile of network coordinators mentions a wide range of skills and knowledge required to cope with the "strategic and policy work and organizational and managerial duties" (Guide, p.12). Two sets of skills and knowledge can be distinguished in this profile. The first one relates to knowledge of local care systems and particular skills acquired by being involved in that local system for several years. That local knowledge includes cross-disciplinary, -institutional and -sectorial knowledge and a good understanding of power relationships between local actors and organisations. The second set relates to managerial knowledge and skills. It includes: the ability of the network coordinator to endorse the role "of facilitator for the creation of a network" (idem); "know-how and communication skills" required "to join all forces of the network" (idem); "personal leadership" required to motivate the network partners; "team leadership" helping to support the creation of coalitions; "organizational leadership" needed to set conditions stimulating reflection, learning, and the continuous improvement of network procedures; "political leadership" required to deal with discussions and negotiations and to efficiently use the available resources and time; and an "ethical and visionary leadership" relating to the integrity and self-discipline of the coordinator. Finally, (s)he was supposed to embody a particular "way of viewing the world" and to be sufficiently innovative and creative to be able to put his/her ideas in practices.

In the view of the public health authorities, network coordinators holding these knowledge and skill sets should be able to cope with their mandate, which primarily consisted in leading the local operationalisation of the five care functions and the creation of new work procedures. Next to that global objective, their mandate included the following tasks: to map the organisational and human resources of the work area targeted by their project; to support the creation of the strategic working group (see below); to make sure that services' representatives communicated the right information to their organisations; to define a programme plan (see below) and to ensure that this was implemented; to inform all the relevant stakeholders in the health, social, cultural, judicial and employment sectors about the existence of the local network; to reach a formal network agreement between the network partners; to participate in training and research activities organised by the federal authorities; and to provide them with annual reports outlining the stage reached in their network's development, the means employed to achieve further objectives, and the related work schedule.

The second category of actors with a key role in the process was composed of front-line professionals appointed by their organisations to participate in the local operationalisation of the five functions. Those actors then became *services representatives*. They were responsible for maintaining "the functional link between the actions defined in the constructing of the network and their practical realization in the field" (Guide, p. 11).

Decisions regarding the building of the network were made by five "committees of function", each of which gathered the network coordinator and services representatives engaged in the operationalisation of one of the five functions. Services representatives chose the appropriate committee of function according to the kind of mental health and psychiatric services from which they came. For instance, a social worker appointed by his/her CMHS to participate in the building of the network would be involved in the operationalisation of the first function (prevention), and possibly the third one (social insertion), but should not participate in the fourth committee, which focuses on intensive residential treatments, as this falls outside his/her area of expertise.

The five committees of function were requested to meet at regular intervals to consider new work instruments and procedures through which the functions would be translated into concrete practices. The decisions made by the committees of function had then to be communicated to local care providers on the one hand, and to the "strategic working group" on the other. That group was composed of the network coordinators as well as one or two representatives of each committees of function, known as "function representatives". The strategic working group was responsible for looking at the coherence of the decisions made by the five committees and, in practice, for making the whole network "operational in the defined working area" (Guide, p.12).

1.3.2. *Key Methods*

The guide encouraged network coordinators to use particular methods in building local networks. The main method was the programme plan, specifying "the finality to be achieved (operational development of the network), the general objectives leading to this, the actions to be undertaken, the means or resources to mobilize, a calendar, a feedback analysis (permanent evaluation of the results)" (Guide, p.12). Thus, the programme plan was conceived as supporting the participative development of local networks, in a way that enables to "strengthen cooperation, which is the actual purpose of the whole network of actors" (idem).

The participative development of instruments had three dimensions. The first ("pooling practices") consisted in improving network partners' understanding of each other's' everyday reality through, amongst other means, "the practice of immersion" (idem, p.13). The second dimension was the "introduction of consensus procedures" (idem), which had then to be inscribed in *charters* or *collaboration agreements*, constituting "the operational framework of working in a network, explaining very clearly and understandably who does what and when" (idem). The third dimension was the collective endorsement of a "common working methodology" (idem). In this respect, although

the guide assumed that that methodology had to be adapted to the specificities of local care systems, it also emphasised that the *individualised care plan* was "the most formalized method" (idem) mentioned in international literature.

The last method put forward by the guide consisted in implementing the function of the "reference person", which is indispensable to care networks centred on the needs of services users. By focusing "their actions on the patient" (idem), the reference persons had to ensure the link between the patients and the five care functions performed by local networks., and to use the network procedures according to the specific needs of their client group.

1.4. **Evaluation, Research, and Communication**

Chapter 6 to 10 of the guide describe evaluation and research programmes and communication plans devised by public authorities. Regarding the evaluation, the guide distinguishes between: 1) self-evaluation conducted by network coordinators to assess whether (s)he and other services representatives had reached their objectives; and 2) the follow-up of exploratory projects managed by the federal authorities. That follow-up was combined with scientific research, producing evidence used to inform the whole process by providing public authorities and local actors with: 1) knowledge of good practice mentioned in international literature; and 2) specific innovations achieved by the ongoing exploratory projects.

The first aspect of the follow-up managed by public authorities consisted in supporting care providers wishing to develop a local exploratory project, with the aim of ensuring that they fully understood the overall concept underlying the reform. Public authorities intended to reach that objective through global information sessions targeted to all stakeholders, coupled with more specific meetings with the "candidate promoters" (Guide, p.15). The term "promoter" thus designated care providers, in this case psychiatric hospitals (see below), who decided to support the development of a local exploratory project by making material and human resources available to further the five functions.

The second aspect of the follow-up was the training and coaching of network coordinators. The guide defined the training of network coordinators as a collective and general process, focused on the overall concept and the main objectives of the reform, the meaning of the five functions, and "methods in networking" (idem). In contrast, their coaching formed part of "the longitudinal monitoring of the projects" (idem). It consisted in personal support brought to network coordinators by the federal "guidance committee" (idem) and research teams.

The third aspect was to provide networks coordinators and front-line professionals responsible for the new mobile teams with "continuous education", achieved through repeated immersion in French, British and Swiss mobile teams as well as training courses provided by national and international experts as Benedetto Saraceno, clinical psychiatrist, expert in psychiatric rehabilitation and ex-director of the WHO department of mental health and substance abuse. Training courses

included, for instance, conferences and workshop on psychiatric mobiles teams, the reference person, the programme plan and the notion of psychiatric rehabilitation.

Concerning the scientific research, the guide distinguished three phases. During the first phase (April 2010-May 2010), researchers were asked to review international scientific literature to determine criteria related to working area, network organisation and collaboration. The guide specified that public authorities would use those criteria to select the exploratory projects which would be authorised to participate in the reform. Thus, during the first phase, the role of scientific research was to inform policy decision. During the second phase, from June to October 2010, researchers were requested to focus on territorial approaches and to stress key elements in relation to "the development of a collaboration plan, methodological steps in developing care programmes … evidence-based practices regarding working around the client in mobile teams … and indicators measuring success in mental health care reform." (Guide, p.15-16) To reach that objective, researchers were asked to review scientific literature and to carry out qualitative and quantitative analyses of the initial developments of the selected exploratory projects. The third phase, unfolding from January 2011 to January 2014, consisted in assessing the reform, by focusing on "process- and outcome-measures, process- and impact-evaluation, modalities and financing and cost study related to collaboration models" (Guide, p.16).

Finally, the guide stated that communication plan was intended to strengthen the coherence of the information. It stated that public authorities wanted communication to be systematic and proactive, both bottom-up and top-down. A help desk providing quick answers to frequently asked questions and a web site (www.psy107.be) devoted to the reform should support communication in general. More specifically, public authorities endorsed a global communication strategy jointly managed by federal, regional and community authorities; it implied the gradual transfer of information, "from the global to the specific" (Guide, p.24), with a view to providing the right information to the right people, in a context-specific way.

1.5. **Legal and Financial Issues: Article 107**

The chapter 8 particularly focuses on legal and financial issues. This chapter explains how the legislation on hospital facilities should be used to support the reform, and how it will be adapted to fit in with future changes brought into the Belgian system for addressing personal problems by the reform process. The guide assumes that those explanations provide institutions with the "legal and financial certainty" they needed to engage in the reform (Guide, p.16).

The guide first highlights that the legal basis for the organisation of care circuits and networks were inscribed in Article 11 of the Royal Decree coordinating the law on hospitals and healthcare facilities (July 2008). That article made it possible, from 2008 onwards, to create care networks and circuits for particular target groups. It also specified that Article 11 suggested a definition of care

networks which emphasised both the autonomy of care providers in organising their work and the freedom of patients in using care services:

> "The network is a structure in which autonomous care providers commit themselves to organize a coherent and complementary care supply for a certain target population, without compromising their autonomy. Also, the patients' free choice is not restricted. The obligation imposed on the network, in order to provide a comprehensive range of care, doesn't require the patient to make use of all services, nor does it require the patient to stay within one single network." (Guide, 2010, p.16)

According to the guide, the most obvious means to implement Article 11 was *reconversion*, which entailed closing psychiatric beds and using the released budget to develop community-based mental health care services. However, using that technique would have led to a reform "organized by individual hospitals, without the necessary cooperation between different institutions and across sectors" (idem). This strategy would contradict the "basic philosophy of socialization of care which characterizes the whole initiative" (idem). Therefore, as the guide put it:

> "The sectors choose to realize circuits and networks on an experimental basis and in collaboration with all involved actors. It is this technique that was recorded in the Article 107: it becomes possible for a hospital to use a part of the bed related budget to realize functions 2, 3 and 4 of the functional map described in point 3 above." (Guide, 2010, p.16)

The decision to use Article 107 implied the exploration of care modules (care modules supply services users with adequate responses by combining various mental health and psychiatric services in specific ways) in an experimental context over a given period of time, with a view to inscribe them (following the exploratory phase) into Article 11. In contrast with the technique of reconversion, the exploration of care modules not only involved all stakeholders in the system for addressing personal problems, but also concerned its general organisation. Thus, the guide underscored the need to distinguish the exploratory projects from previous pilots projects, which were intended to test out specific care functions with a limited number of partners.

Finally, the guide reassured local actors of the intention that the legislation applying to hospital services accreditation would be modified to fit in with changes introduced through the reform. Indeed, given that some hospital staff would have to stop working in their current units, the use of Article 107 was likely to cause "a problem in terms of the accreditation standard, in particular the minimum number of staff required per hospital unit" (Guide, p.17). The guide mentioned that public authorities committed themselves to modify that measure, instead applying the accreditation standard to the institution as a whole, including its different units and mobile times.

2.   THE MAKING OF THE GUIDE

The following narrative regarding the making of the guide includes three parts. The first part defines the global and specific context in which the guide emerged, as perceived by the actors who wrote the guide. It particularly stresses how that context explains, according to the proponents of the reform, the particular features of the policy programme. The second part relates the writing of the guide. It emphasises elements that helped the think tank to reach an agreement on its content as well as particular challenges involved in translating that content in words acceptable to the stakeholders of the system for addressing personal problems. The third part highlights strategic decisions, key learning and knowledge lying at the core of the care model and policy devices inscribed in the guide.

2.1. A Unique Process of Change?

Key actors involved in the writing of the guide assumed that key ideas pertaining to the reform were consistent with past changes in the system. Their discourse presented the reform as the "next step" of a linear change process that started just after the WW2:

> "This is consistent with the sector development. Psychiatry has been recognised as public health issue only from the end of the World War Two. Before that psychiatry belonged to the Ministry of Justice and the idea was to protect society. After that, during the 1970s, psychiatry departed from asylums. One can still speak about closed psychiatry, but this does not exist anymore subsequent to 1975. Then, during the 1980s, we went further towards the social model: the ISH and the PNH were created. Later, with the therapeutic projects, the idea was to organise consultation between patients and professionals to determine patients' needs. This was something new, implying that psychiatrists would not tell the patient what he was supposed to do. From that time onwards, we also started having good relationships with associations representing services users and their relatives. This was necessary to be able to direct our policy toward the patients' needs." (Interview with the director of the psychosocial department, FPS PH, 2013/02)

That discourse described the development of the system as a straightforward, logical, and quite natural process. By contrast, regarding the specific circumstances leading to the conceptualisation of such a global reorganisation, the discourse of the proponents of the reform instead emphasised heterogeneity and the contingency of that process:

> "The reform was supposed to start in 1997, but we had to wait until to 2002 for a first draft agreement, which was changed to 2004, and finally, we had to wait again until 2009, when the Inter-Ministerial Conference said, 'Ok! We are going to start now.' Meanwhile, the WHO Ministerial Conference had taken place in Helsinki, and we had started considering doing something like that in Belgium. Thus, the NACH started thinking about it, and it issued

advisory notes supporting the development of psychiatry closer to society." (Interview with the director of the psychosocial department, FPS PH, 2013/02)

The proponents of the reform thus emphasised that, during the period between 1997 and 2010, the change process became more complex and uncertain. They described it as dependant on the production of different kinds of documents, events taking place in different contexts and negotiations involving various actors. According to them, the wider dimensions of recent sub-processes of change lay at the basis of the global character of the reform. By requiring the involvement of the IMC in the decision-making process, the global character of the reform would also provide the associated policy decisions with certain stability. In turn, the global and possibly stable character of the reform would make it a unique case among current reforms of OECD-countries mental health systems:

> "It started in 1997… which is the proof that this happened very slowly. But, on the other hand, it is now built on an agreement between seven Dutch- and French-speaking ministers belonging to different political parties. Thus, the reform is based on a quite stable agreement; it is not like in England, for instance, where policy is liable to move when governments change. We have visited Birmingham, Lille, Trieste, and Lausanne. The objectives of those projects are quite similar to those of our reform. However, they remain very local projects. For us, the objective is to concern the whole country…I think that the 107 is the first initiative intended to bring together all the existing things." (Interview with the director of the psychosocial department, FPS PH, 2013/02)

2.2. Engaging Policy Makers in the Change Process: Visiting Birmingham

According to civil servants and the Federal Coordinator, a visit to Birmingham was central to explaining why the ministers involved in the IMC agreed to start the reform. They presented that visit as a turning point in the interessement process conducted by the FPS PH:

> "I think that the visit to Birmingham gave a significant impetus to the reform. There, our ministers saw that it [the alternative care model] was working and how it worked." (Interview with the director of the psychosocial department, FPS PH, 2013/02)

> "It is not trivial that our ministers had visited Birmingham together. I meant the several ministers having competencies in public health travelled abroad to see how other peoples were working. In my view, that indicated that we were going to start an ambitious reform, at last!" (Interview with the Federal Coordinator, 2012/02)

Following that visit, the IMC committed to start the policy process leading to a complete reform of the Belgian system for addressing personal problems:

"When we were in Birmingham, we remarked that a true political will to reform the system was growing; and that political will seemed to result from the fact that over there in Birmingham, they came to know that all actors agreed on the need for reforming the mental health system. It was in 2009, and they decided to start working together." (Interview with the Federal Coordinator, 2012/02)

That decision caused the creation of different kinds of working groups, and marked the beginning of a sustained process of negotiation that resulted, finally, in the writing of the guide: "and, even if it did not perfectly fit with what we were expecting, we were particularly pleased that the guide came into existence!" (Interview with the director of the psychosocial department, FPS PH, 2013/02)

2.3. After Birmingham: Setting the Context for the Writing of the Guide

Following the Birmingham visit, the IMC first decided to use Article 107 of the Law on Hospitals and Healthcare Facilities to reform the system for addressing personal problems. From this point onwards it started conceptualising the reform as leading to the creation of mobile teams for chronic and acute mental health problems, rehabilitation teams working for social inclusion, and intensive treatment units. Then, on the 14th December 2009, it took a step further through a series of decisions, namely: to launch a call for projects and an information campaign on the creation of a new mental health network on the basis of the Article 107; to set the schedule of the reform and to define the communication plan; to conceive of a strategy that would engage the interest of the residential, community and rehabilitation ecology in the reform, in spite of their falling under the jurisdiction of different levels of power; to implement Article 107 in psychiatric hospitals and psychiatric departments of general hospitals; to limit the first phase of the reform to one target group (adults, including young people from the age of 16 upwards); and to improve social inclusion of people with mental health problems by encouraging partnerships between the mental health system and social housing, work and economy. This set of decisions suddenly accelerated the process, injecting an urgency to translate the IMC declaration into an action plan. That task was allocated to the think tank, which started working in connection to the task force from January 2010.

2.3.1. *The Role of the Task Force*

The task force was originally set up by the IMC in 2002. It was composed of federal, regional and community mental health policy advisers and civil servants. The group's function was to prepare the work of the IMC, drafting the policy guide supporting the reform and preparing the ground for its local implementation. The decision of the IMC to start the reform meant a sharp increase in the meetings of the task force:

"In 2009, our involvement in Reform 107 directly resulted from the decision of the IMC… I remember that the task force met very often at that time. We, the federate entities, and I think that the federal as well, became aware of the importance of the reform as the process was unfolding. The scope of the project had significantly enlarged, and that brought about a deeper interest of each of us in the reform. I think that the federal authorities managed the process well and that federate entities agreed to work hard in that framework. It happened that the sharing of responsibilities in mental health slowed the process down, but this did not succeed in stopping the reform …" (Interview with a regional mental health policy adviser, 2013/03).

For the writing of the guide, federal authorities were committed to work in close cooperation with regional authorities. According to the Director of the Regional Public Health Department, regional authorities had never before been so heavily involved in federal public health policy making. The Director felt that the change resulted from the involvement of the Federal Coordinator (who had a background in psychosocial rehabilitation in the Walloon Region) in devising the reform.

Moreover, both federal and regional authorities insisted that the former needed the latter's specific knowledge of the regional system for addressing personal problems. For instance, the Director of the Regional Public Health Department mentioned in interview that the 2009 reform of the community mental health services caused important changes in their organisation at the regional level. Those changes were consistent with the global policy objectives of the reform, but they increased the difference between CMHS situated in the Flemish, Brussel and Walloon Region. Those differences had to be incorporated into the versions of the guide specific to each region. Thus, the guide went back and forth between the federal and regional authorities, and its successive versions were discussed during the meetings of the task forces:

"Each of us had been asked to think about region-specific issues and each of us stressed elements of particular concern; for us, it was the 2009 Walloon Decree on mental health services. … Our discussion concerned every word, sometimes it focuses on issues of translation, but there are no simple words, there are concepts that express something, and sometimes it was not sufficiently precise and explicit. It was matter of nuance, a painstaking task; every word was transformed according to each other's concerns and there was a constant suspicion about what the others wanted ..." (Interview with the Director of the Regional Public Health Department, 2014/02).

This joint participation of the federal and federate entities raised challenging issues which made it necessary to plan more and more meetings. The task force, "continued to meet until the problem was sorted out. There was a true will to keep working together and to start the reform: that was our common goal. And I think that that motivation was sufficient to go beyond several obstacles" (Interview with a regional mental health policy adviser, 2013/03).

For his part, the Federal Coordinator stressed that the interventions of regional actors helped the members of the think tank (see below) to adjust their aims to account for regional peculiarities previously unknown to them. Furthermore, the involvement of regional actors made sense in relation to the absolute necessity for federal actors to engage regional authorities in the reform, and to ensure that they provided incentives to care structure falling under their scope of competencies to participate in the reform (Interview with the Federal Coordinator, 2012/01).

2.3.2. *The Think Tank*

The think tank was the second working groups responsible for devising the reform. It was composed of the Federal Coordinator, the mental health policy adviser of the Federal Minister for Public Health, the Director of the Psychosocial Department, Federal Public Service Public Health and Social Affairs, and his counterpart at the NIHDI. This committee authored the guide, under the leadership of the Federal Coordinator:

> "The Federal Coordinator was in charge of writing the Guide, but it was not his own idea! At the very start, there had been the WHO Declaration …, then the NACH advisory notes and the draft agreement of the IMC. We started working on that basis, in dialogue with the federal, regional and community public health ministers and administrative department. Of course, there was someone who held the pen, but many were telling him what to write!" (Interview with the director of the psychosocial department, FPS PH, 2013/02)

The above quotation indicates the different kinds of elements that impacted on the writing of the guide. Among those elements were: past moves in the global and specific context and their resulting inscriptions; negotiations with the regional and community public health authorities; and knowledge held by those who wrote the guide. The following section presents the professional trajectories of the Federal Coordinator, policy advisers and directors of federal departments involved in the writing of the guide. Those details will help us to identify the kind of knowledge involved in the writing of the guide. As demonstrated in the following section, the contingent assemblage of this collective knowledge came to support "the organic growth of the guide …" (interview with the Director of the Psychosocial Department, FPS PH, 2013/02).

a)   The Federal Coordinator: Local and International Knowledge of Mental Health Reforms

The Federal Coordinator had been trained in educational therapy. He had a professional experience of a bit more than thirty years in the mental health sector" (Interview with the Federal Coordinator, 2012/01). He spent most of his career working in a big inter-municipal association (see "the association" presented in the third case study) holding 94 social, psychosocial and healthcare services situated in the Red Province: "I started to work in rehabilitation services for children. Then,

my duties in the association had gradually evolved towards a function of coordination" (idem). More recently, his mandate had consisted in coordinating the professional network gradually developed by the Association, ensuring that about 700 workers shared a global approach to mental health.

The experience embodied by the coordinator in building that network is not explicitly referred to in the guide. However, it is clearly reflected in the conception of how to build local networks underpinning the guide. The following quotation (drawn from a professional review which interviewed the coordinator about his work in that organisation in 2006) shows the similarities between the way in which he conceived of the network construction in the framework of the Association, and the procedures put forward in the guide: "The network mainly depends on working groups made of referents appointed by their own structure and who share resources (practices) in order to build a consensus (procedure) about the use of a common methodology (the individualized care plan)." (Confluences 2006: 38-39).

Alongside procedural knowledge of how to build a local network, the Federal Coordinator referred to his longstanding involvement in international NGOs (among others Euro Psy Rehabilitation and the World Association for Psychosocial Rehabilitation) as the source of his conception of how to reorganise the Belgian system for addressing personal problems. According to him, if "the 'European work' is more significant the one could imagine" (Interview with the Federal Coordinator, 2012/01), it is because it improved his ability to learn from what other people do, to share practical experiences, to negotiate, and to reach consensus on shared conceptions:

> "My generation has taken advantage of pioneering participation in the European Horizon, and then Leonardo Da Vinci Programs. Those projects have not only reinforced our belief in the efficacy of community psychiatry, but led us to consider that our approach to mental health was not necessary the best one …and that the wealth of several approaches was preferable to the certainty of our own views." (Interview with the Federal Coordinator, 2012/01)

In that respect, his preferred project was the Horizon Project, because: "it was the very beginning of that kind of projects and, at that time, they included exchange between practitioners and long immersion courses; it had to be long and intense because it was intended to train trainers!" (Interview with the Federal Coordinator, 2012/01)

He insisted that European projects allowed him to "learn about ways of working that one could not imagine before travelling to other countries" (idem). He mentioned in passing that he remembered a therapeutic consultation that took place in the middle of a very small and remote village in the Greek mountains. This consultation involved only one mobile team, the patient and his relatives, the local priest and the mayor of the village; and, according to the Federal Coordinator, it provided the patient with effective responses, adequate to his particular needs.

He also stressed that such European experience provided many occasions "to meet famous people; people whose lives leave marks on your own life forever" (idem). In this way, he took

advantage of working with a number of well-respected international experts: Professor Sakellaropoulos, who significantly influenced the reform of psychiatry in Greece; with Protelli, who is one of the Basaglia followers in Italy; and with J-L Roelandt who is well-known in French psychiatry. These relationships came to constitute an efficient network, willing to provide him with adequate resources to promote change in his own country: "those people are continuously interacting; exchanging something in some way…The very idea of recovery entails that of networks opened to the community and a considerable willingness to share resources" (idem).

Last but not least, his international experience afforded the coordinator the opportunity to learn from others' mistakes. He explained, for instance, that the Greek and Italian reforms had been implemented too fast, without considering the needs of mental health professionals and people with personal problems. Those reforms caused distress to professionals as well as services users, and increased the gap between the public and private sectors. Accordingly, he thought that "the transformation of the residential facilities into community services must be achieved gradually, by involving people who already have professional expertise in the community" (idem).

The individual trajectory of the Federal Coordinator accounts for the development of his professional knowledge (which included training in educational therapy and experience in rehabilitation services), and of procedural knowledge regarding how best to build mental health care networks at the local level and how to reform national systems for addressing personal problems. It also explains his conception of what constitutes good mental healthcare and his conviction that such care is better delivered in community settings. In his view, that experience is both "the result of several years of work …and the starting point of [his] involvement in the reform" (idem).

The story of his employment as Federal Coordinator involved a series of meetings with policy makers and public health authorities, who asked to think about the complete reorganisation of the system. According to the coordinator, the latter had heard about the association where he was working and wished to know about its network organisation. When they came to visit the association, they asked him if he would be willing to devise a global model for the reorganisation of the system and to outline an action plan based on existing documents (i.e. advisory notes and the draft agreement).

"There were existing texts and documents. I rather focused on devising the concept and methodology for the reform. During the first phase of my work, I had been wondering how to go as close as possible to a global vision of mental health care. The question was: how to succeed in formalising that vision … But, in fact, we drew from different kinds of sources, national and international ones." (Interview with the Federal Coordination, 2012/01)

"I'm not sure that I had all the relevant documents at my disposal, but I have progressively met with different kinds of actors who, such as myself, had contributed to part of the process. In think that we did not create something completely new, we drew from what other people had

done in the past and we adapt it to the present situation." (Interview with the Federal Coordination, 2012/02)

Thus, the proposal developed by the coordinator was a first assemblage between his personal experience, inscriptions produced by the NACH and the IMC and various working and advisory groups, and knowledge embodied by actors who had taken part in past change in the system. Some time later, the federal authorities asked him to become federal project leader under the title of "Federal Coordinator". In his view, their decision was motivated by his practical experience and his conception of the reform: "I think that my "practical" experience and the proposal I made to enlarge the project of reform drafted in existing documents both explained their decision to appoint me as Federal Coordinator" (idem).

He insisted that their decision meant an implicit endorsement of his proposal to broaden the scope of the reform. Indeed, the Federal Coordinator deplored that existing documents focused on transferring part of the means allocated to residential facilities towards community-oriented services, instead of involving both residential institutions and "the community fabric" in the reorganisation of the system. Given his conviction that such reorganisation must necessarily involve people having experience and expertise in community services, he suggested that it was necessary to "broaden the concept" (idem). In turn, that enlargement in the scope of the reform required involving multiple actors in the writing of the guide and the implementation of Reform 107:

"[The] challenge was: how to succeed in formulating those ideas, how to write down a well-balanced project that would be both sufficiently comprehensive to allow for the participation of different kinds of services and enough precise to ensure that the global philosophy would resist attempts of turning the reform away from its objectives." (Interview with the Federal Coordination, 2012/02)

The Federal Coordinator, together with the other members of the think tank, had to take up that challenge during the short period between January 2010 and April 2010. Indeed, a meeting of the Interministerial Conference was planned on the 26th of April, and federal authorities expected that the decision to launch the reform would be taken on that occasion.

b)   The Delegates from Federal Departments and Administrations: Policy Learning and Administrative Knowledge

The delegates from the FPS and the NIHDI brought their experience of mental health policymaking to the process. Thanks to their involvement in past policy initiatives, including psychiatric home care and therapeutic projects, they knew what was doable and thinkable in the context of the existing system. Their knowledge of past initiatives helps in understanding their decision to set only "a minimal framework" making room for "the creativity and originality of the

actors" (Guide, 2010). Concerning that decision, the Director of the Psychosocial Department, FPS stated:

> "It is not a reform where the government stated: 'you have to do that'. Rather, we built a model and local actors are going to test that model, to check whether it works in the same way in [city X] or [Y]; and it is not going to work in the same way: to be able to plan, program and finance mental health care by relying on a new model we have to know about local needs." (Interview with the Director of the Psychosocial Department, FPS PH, 2013/02)

Their participation in past initiatives allowed the delegates to know that local actors would attempt to implement the exploratory project in a way fitting with their particular objectives: either the protection of the residential ecology or the expansion of competing ecologies. The delegates' knowledge of dominant games directing the change process helps us in understanding the emphasis placed on the global philosophy of the reform, the need for developing collaborative relationships between care providers, and on working in the interests of services users. Orenbuch had expressed such requirements as early as in 1981: "without a clear objective of collaboration in the interest of the whole system (i.e. the interests of the patients) and not part of it, changes in the services offered would have turn the two sides into competitors" (Orenbuch, 1981, p. 117).

Finally, as explained by the Director of the Psychosocial Department, his knowledge of the rules applying to the financing of hospitals was necessary in thinking ahead to solve structural problems that the implementation of the reform would raise. The use of such administrative knowledge is illustrated in the guide, which mentions a change made in hospitals' accreditation criteria to enable the displacement of human resources from hospital departments to mobile teams. In that respect, the Director of the Psychosocial Department also considered the presence of his counterpart at the NIHDI was essential in adapting the legal framework to the concrete practices induced by the exploratory projects.

> "For instance, due to the way in which we finance the reform, we are obliged to remunerate psychiatrists managing mobile teams through a financial package allocated to psychiatric hospitals. We cannot continue to work in that way much longer. Another instance is the intervention of mobile teams at home. For now, it is free! And when the same patient goes to community services, he has to pay. That's not right. We have to know how much the intervention of mobile teams does cost and which part of this cost must be paid for by the patient, before of working with the NIHDI to sort that issue out." (Interview with the Director of the Psychosocial Department, FPS PH, 2013/02)

c)   The Policy Adviser of the Federal Minister for Public Health: Knowledge of
Political Issues and the Residential Ecology

As stressed by the Federal Coordinator, the systematic participation of the Policy Adviser of the
Federal Minister for Public Health was noticeable: "It was lucky that we have such a good relationship
with x [the policy adviser], who was committed to succeed in reforming the sector" (Interview with
the Federal Coordinator, 2012/01). This involvement gave the think tank essential contextual
information regarding what was politically realistic and achievable at that particular time, and in that
particular context. Given the governmental crisis unfolding at time, that context was particularly
uncertain. The political support brought to the project by the policy adviser helped the think tank in
maintaining the engagement of federate entities in the writing of the guide, and in gaining the IMC's
endorsement of the guide on the 26th of April 2010 (that is, the day before the collapse of the federal
government).

The personal trajectory of the Mental Health Policy Adviser is also worth noting. Indeed, before
becoming a policy adviser, she worked at the Federation for Hospital Institutions. Therefore, knowing
the strategies employed by the traditional coalition to oppose change in the system, she was able to act
as a relay between the most powerful spokespersons of the residential ecology and federal authorities
in charge of the reform.

2.4. The Writing of the Guide

The process of writing the guide was a short but intense process, unfolding within and between
different working groups, ecologies and levels of action. It directly led to the policy decision to launch
the reform:

> "The deadline to have a complete version of the document finished was the 26th of April,
> because it was the date of the Interministerial Conference. The guide absolutely had to be
> finished. Thus, it had been an intense period of work." (Interview with the Federal Coordinator,
> 2012/01)

The first objective of the think tank was to agree on the global conception of the reform, before
refining it to take into account the respective expertise of its members. It thus entailed assembling their
political, administrative, practical and professional experience and expertise:

> "It was rather easy to work together. We had a clear view of where we wanted to go. We have
> refined the concept; we have refined it in a way to be able to bring the different pieces of our
> expertise together: that of x who had a deep knowledge of the system and the way in which past
> reforms had unfolded; that of y who was responsible for representing "the thing" at the political

level; and my local and international experience." (Interview with the Federal Coordinator, 2012/01)

As explained by the Federal Coordinator, the assemblage of those different kinds of knowledge implied adapting them to each other and to the context in which the resulting assemblage would eventually be enacted:

"I have learned from the European projects that one can never transfer a good practice … without having thought about its adaptability to the situation. I heard people who said 'you are transferring the Birmingham model', but due to historical contingencies and the existence of three regions and two communities, it was impossible to transfer that model." (Interview with the Federal Coordinator, 2012/01)

Second, the think tank had to adapt that body of collective knowledge in response to the remarks expressed by the task force. Those remarks mainly concerned issues of translation and requests to consider regional specificities of the system for addressing personal problems. To the extent that they risked causing different applications of the reform, those specificities had to be taken into account.

"The think tank made decisions and then the document was submitted to the task force. From there, we came to know a series of unexpected effects, which included disagreements on how a given part of the guide had been translated in German, French or Flemish … and requests to adapt the content of the guide to the regional particularities ... For instance, concerning the community mental health services, the Flemish ministers decided to devote 10 percent of their budget to the realisation of the reform. In contrast, the Walloon minister thought that the implementation of the reform felt under the scope of the 2009 regional decree on CMHS …. And there was also the NIHDI, which was managing the testing of therapeutic consultation. Thus, they perceived connection between their action and the reform. The matter at hand was to take those remarks into account and to imagine how those different things would come to fit with each other into a complementary totality." (Interview with the Federal Coordinator, 2012/01)

Therefore, when important issues such as the involvement of the CMHS in function one were raised by some members of the task force, the Federal Coordinator met with them as many times as needed to find a compromise position which could be formalised in the guide: "We took advantage of those meetings to work again on specific concepts, to take the time to agree on their meaning, and to rewrite them in the guide." (Interview with the Federal Coordinator, 2012/01)

Third, the think tank had to seek precise kinds of expertise to clarify difficult issues. The Federal Coordinator expressed that the think tank did not always succeed in coping with very specific

and technical notions such as psychiatric emergency or psychiatric crisis. With a view to clarifying the meaning of those issues and to capture that meaning in the guide, the think tank invited or visited national and international experts on the subjects in question.

Fourth, the think tank had to regularly present the drafted document to the spokespersons of the residential, community and rehabilitation ecologies, to see whether the content of the guide seemed acceptable to them:

> "We made a considerable groundwork … We heard the positions of psychiatrists, GPs … We met trade unions, hospital and psycho-social institutions federations … We wanted to tell them where we were going and to hear their reactions. Afterwards, one can always say that he had not been consulted." (Interview with the Federal Coordinator, 2012/01)

Fifth, the last task of the think tank consisted in bringing those different pieces of knowledge together in a way that fit with the nature of the document, a policy guide which had to be:

> "… neither too short, nor too long; neither too precise, nor to vague. … We had to succeed in devising a model that was both comprehensive enough to allow different kinds of actors to find their way when enacting the guide and precise enough not to have as many reforms as there were local systems for addressing personal problems." (Interview with the Federal Coordinator, 2012/01)

2.5. Inscription of the Think Tank's Strategy in the Guide

The strategy of think tank might be defined as assembling different kinds of knowledge and institutions together, in a way that fit with the global conception of the reform shared by its members. Such assemblages incorporated elements characteristic of policy devices used to support past changes in the system, providing the actors of the system with a feeling of continuity and encouraging them to participate in Reform 107. The joint use of the Articles 11 and 107 of the law on hospital facilities, as legal bases for Reform 107, illustrates that strategy.

The use of the Articles 11 and 107 accompanied a shift in the objectives of the change process. As emphasised by the discourse of its proponents, Reform 107 made sense in relation to previous moves in the system for addressing personal problems: it was a possible outcome of, or step in, the longstanding process of change that started following WW2. However, it was by no means the only possible outcome. Another possible policy decision would have been, for instance, to implement network and care circuits without developing the five care functions. Thus, if we compare Reform 107 to other recent moves in the system, we must observe that Reform 107 transformed the objective of the preceding policy initiative (i.e. the reorganisation of the system according to the concept of care circuits and networks) into a means to reach the global objective of the socialisation of psychiatry. The NACH was at the origin of the concept of care networks and circuits, which involved an assumption in

favour of independent institutions. As a knowledge broker linked to the residential ecology, it did not endorse the objective of socialising psychiatry. Indeed, as previously emphasized (see chapter 2), social psychiatry is public psychiatry (R Freeman & Rowe, 2011); it induces direct management of mental health and psychiatric services by regional public authorities and a focus on primary care. These two characteristic are conflicting with the principle of institutional autonomy specific to the Belgian Public health system on the one hand, and the interests of medical psychiatry on the other.

By assembling the concept of care networks and circuits and the objective of socialising psychiatry, the guide came to involve working concepts and global objectives that are possibly conflicting. At the beginning of Reform 107, that assemblage helped its proponents in presenting it as the logical result of the global change process. Accordingly, it had reassured the various actors involved in the system regarding their ability to deal with the reform in a way suitable to their ecological interests. Subsequently, however, the practical enactment of those conflicting concepts made the reform process increasingly uncertain. Instances of misunderstanding caused by the enactment of conflicting conceptions inscribed in the guide are provided in the two following cases studies.

That shift in the objectives of the process of change, from the generalising of mental health care circuits and network as organisational principle to socializing psychiatry, had been accompanied by a shift in the use of Articles 11 and 107. Following past changes in the system, the inscription of the concept of care circuits and networks in Article 11 reflected the success of the traditional coalition in framing that process of change (i.e. by imposing its conception of how the system should be reorganised) through the intermediary of the NACH and the many documents it produced from 1997 onwards (see chapter 3, sections 5 and 6). At the outset of Reform 107, however, proponents of the reformist networks were determined to themselves reframe the change process. They therefore had to find a means of substituting their alternative conception of how the system should be reorganised (which involved the functional model and the associate care modules) for the NACH conception. Consequently, as explained at the very end of the guide, the authors decided to use Article 107 to put their conception of change into practice, before inscribing the resulting knowledge in Article 11. In other words, the exploratory phase of the reform might be seen as consisting in an attempt from the reformist network to change the legal basis of the change process, which had been painstakingly built up by the traditional coalition over the preceding two decades. As we shall see through the second case study, that explicit connection/implicit disconnection of Reform 107 to past moves in the system resulted in throwing local systems for addressing personal problems into confusion.

More specifically, four aspects of the guide offer contrasting instances of the inscription of that strategy in the document itself. These aspects are detailed in the following sections. First, concerning the policy device, the definition of the exploratory project inscribed in the guide illustrates a delicate balance struck between the pattern of past change in the system and the emphasis put on the compliance of local actors with the global philosophy of the reform.. Second, the function of

coordination reflected an attempt to combine learning from past changes in the system with learning from the implementation of community systems in OECD-countries. Third, the integration of the idea of mobile teams to functions 2 and 3 illustrated the need for the think thank the take into account existing inscriptions and projects as well as learning attained by visiting the Lausanne's, Lille's and Birmingham's community systems. Fourth, the training programme illustrated the combination of procedural knowledge held by the Federal Coordinator with policy learning achieved by other members of the think tank.

2.5.1. *From Exploratory Projects to a Functional Model*

The decision to start the reform process through exploratory projects reflects the pattern of past changes in the system. This strategy relied on the assumption that local actors need to be given the agency to translate policy programmes according the local needs, while policy makers need the input of local actors in order to improve their own knowledge of local systems for addressing personal problems. As explained by the director of a psychosocial service: "It is not a reform where the government says 'you have to do that'".

However, members of the think tank learned from past shifts in the system that the creativity of local actors often caused significant discrepancies between the original intent of a particular policy programme and its final outcome. Thus, the think tank insisted on philosophy of the reform: "The standardisation rather lies in the philosophy, in the global concept, which supposes a willingness to work together and to reverse the culture, in order to use mental health services and institutions in the interests of services users, and not the other way around." (Interview with the Federal Coordinator, 2010/01) Furthermore, knowing that past pilot projects had supported the development of unbalanced networks, dominated by a few partners, the guide insisted that the "notion of network" had to be defined "very precisely" as "collaborations between structures and resources that, in a real partnership, will lead towards a common finality and common functioning and goals" (Guide 2010, p.11).

The think tank used two particular means to ensure that the global philosophy would be observed. First, the training programme reflected its commitment to enforce that philosophy at the local level through the intermediary of local coordinators and front-line professionals. Second, the way in which the think tank defined the relationship between public authorities and local actors (both in the framework of the selection process and the jury's visits) reflected its desire to keep an eye on the local versions of the guide and the way in which they were enacted. The case study presented in the following chapter shows that the jury used the selection process extensively to bring local translations of the guide closer to the global philosophy of the reform.

Moreover, the functional model inscribed in the guide was designed to disrupt the social process that directed past initiatives by providing a wider range of actors with the opportunity to influence the course of collective action. The broadening of the model also enabled the think tank to take advantage of the many resources existing at the local level and to incorporate them in a complementary totality:

"With the 107, we attempted for the first time to put every existing thing together … the global idea is to cooperate in given a catchment area with all that exists there" (Interview with the Director of the Psychosocial Department, FPS PH, 2013/02).

> "Our model is a global model that includes both the residential and the ambulatory resources… Whether we have focused on precise services and institutions, we would have let aside specific resources included in local systems for personal problems. Therefore, we have preferred to define inclusive functions fitting with our global approach and in which every relevant resources could find its place." (Interview with the Federal Coordinator, 2012/02)

2.5.2. *The Function of Coordination: The Missing Piece of the Puzzle*

According to Orenbuch, an element missing from the 1974 reform of psychiatry was a kind of "travelling salesman" who would go back and forth between the community and residential ecologies, relating the two approaches to personal problems and the corresponding systems of action with one another. In a similar way, the Federal Coordinator contended that what was missing from recent reforms implemented in other countries was a formalised coordination:

> "If you remember what M-J Fleury said about our reform, you know that she stressed two main differences between their [Canadian] reform and our reform: that there, there are only two levels of powers, here there are at least 25 levels powers; well, we know that... But she also said that the Canadian reform did not formalise the function of coordination. Her words were clear: coordination-formalisation. She said that, in order to ensure that the coordination would be performed effectively, that role should be given to a particular person who should be requested to formalise the function; the idea is that the coordination must survive the coordinator." (Interview with the Federal Coordinator, 2012/02)

Moreover, the importance of the function of coordination was also one of the most important points of learning achieved through the horizontal consultation. Thus, based on those observations, the think tank decided to create a function of coordination and to give local coordinators a central role in the reform:

> "To a large extent, the success of the reform depends on the coordinator. We have written down a very detailed description of their function and we are expecting that they succeed in attaining a series of objectives. They have to achieve the building of integrated networks with clear processes and procedures, to give users the right response at the right time, and not only institutional responses." (Interview with local coordinator, 2012/03)

> "The coordinator is the conductor of the process. He has no power over the institutions and services part of his network. But he has to find something common to the different kinds of

services partner of the local network and build common instruments based on the user.*"* (Interview with local coordinator, 2012/03)

However, the think tank was aware that the coordinators would be in a difficult situation: they would have to deal with their mission of building the network and simultaneously cope with attempts by local actors to make use of their function, with a view to lead them to focus on other projects than those defined by federal authorities. Thus, they decided to provide coaching to ensure that coordinators would keep focusing on their mission.

"Local coordinators have a challenging position. If we put too much pressure on them, they risk collapsing. But they have to observe some requirements. We will try to cope with that situation through the coaching … But I do not know the extent to which we are able to influence them, in comparison to the influence of promoter hospitals." (Interview with local coordinator, 2012/03)

The following cases studies show that, in spite of the coaching provided by federal authorities, the influence of the promoters remained significant. Moreover, the vagueness of the care model inscribed in the guide increased the difficulties met by network coordinators when attempting to enforce it at the local level.

2.5.3. *The Mobile Teams: Something from Another Planet?*

The idea of developing mobile teams was inspired by community models implemented in other countries, for instance the Lausanne's model. Nevertheless, that idea was also implicit in many discussions unfolding in the system for addressing personal problems over a number of years prior to this reform. In 2009, the Federal Minister for Public Health had been asked by service user relatives' associations to support the development of psychiatric mobile teams. Their request followed the Termonde incident, where a psychotic person had shot children in a day nursery.

Following this, the Minister had set up working groups to consider the development of psychiatric mobile teams. She had also immediately released the necessary budget to support their development. "That attempt did not result in the development of mobiles teams, but the budget and the idea remained unchanged." (Interview with a psychiatrist (P4), 2011/12)

One year later, services users' groups involved in the participation project (one part of the horizontal consultation, see chapter 3) inscribed the development of psychiatric mobile teams in their proposal for a future reform. Thus, when the proponents of Reform 107 started thinking about the new care model, the project of developing mobile teams already existed, services users groups involved in policy making explicitly supported that project, and the necessary budget was available.

 Accordingly, reform proponents integrated the idea of crisis and emergency mobile teams in an encompassing model, including the entire "community fabric":

"I think that there is a global model, which includes two aspects: there is the transformation of hospital beds into community facilities - I'm thinking of the mobile teams - and there is the integration of the existing 'community fabric' into the global model." (Interview with the Federal Coordinator, 2012/02)

Although public health authorities were thinking about developing mobile teams for a few years prior to the reform, local actors were not accustomed to dealing with that concept. As we shall see, this aspect seemed to them to be the main innovation brought by the new reform of the system. Accordingly, not only did they perceive the origin of that idea to lie in international inspirations only, but they tended to focus their primary attention on developing mobile teams, without paying as much attention as the think tank had expected to the integration of the "community fabric". Indeed, in the view of the Federal Coordinator, the major innovation rather lies in the global, functional model.

2.5.4. *Training Front-line Professionals to New Roles and Functions*

The think tank devised the training programme as a way to empower front-line professionals and to make them the spokespersons of specific approaches to addressing personal problems as inscribed in the guide. The first part of the programme focused on the network coordinators, "to ensure that they endorse their role" (interview with the Federal Coordinator, 2012/03). The second part focused on the members of the new mobile teams, and the third part on front-line professionals enacting the function of rehabilitation. Each part of the programme entailed a precise process composed of several steps, including: a kick-off meeting; conferences by international experts on the subject; meetings with those experts; immersion courses in mobile or rehabilitation teams; and finally, a general meeting with all the involved actors to see what they learned through their training. The organisation intended to ensure that front-line professionals embody the knowledge resources, helping them to influence the development of local networks in a way suitable to the global conception set out in the guide.

"We must regularly meet local actors; the network coordinators meet every month and we organise staff training … We also planned immersion courses in Lille, Birmingham and Lausanne. In such cases, they are not together, but they learn the same things. Our intent is that they move in the same direction." (Interview with the Director of the Regional Public Health Department, 2014/02)

This effort was also directed toward encouraging front-line professionals to take the risk of exploring unknown professional roles and to share the knowledge they embodied in that way with other professionals involved in the reform:

"I found that it is rewarding. At the very least it gives them a common identity, because we have to keep in mind that the mobile teams are asked to do a kind of work that they do not know, and

we cannot afford to train every member of every mobile team. Thus, our idea is also to train trainers; we hope that those who are going to do immersion courses are the right persons and that they will learn many things and transfer their knowledge to the other members of their teams." (Interview with local coordinator, 2012/03)

The specific organisation of the training programme reflected the personal experience of the Federal Coordinator. It resulted from the inscription in the guide of techniques used by international organisations to stimulate the development of psychosocial rehabilitation across the world. Moreover, those techniques seemed appropriate to other members of the think tank, who learned from past changes that opportunistic and strategic appropriations could cause local systems for addressing personal problems to develop in different directions. Meanwhile, since it entailed the involvement of public authorities in deciding on the training provided to front-line professionals, that strategy represented an innovation in mental health policy-making.

3.   INITIAL ENACTMENTS OF THE GUIDE: THE PUBLIC INFORMATION EVENT AND SELECTION PROCESS

The guide moved from public authorities to local actors during the public information event[23] that took place in Brussels on 21st May 2010. It was distributed to local actors before they entered the conference room.

During the conference, federal, regional and community public health ministers and members of the think tank followed one another to present different aspects of the guide. They seemed to be very pleased to be there, enacting the document resulting from their work. Next to the great challenge involved in reaching an interministerial aggreement on a comprehensive reform of the system, the current political situation explained their satisfaction:

"There was something special, the deadline for the guide was the 26th April; it was just before the collapse of the governement. Thus, on the 21st May, we had a governement which was only

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[23] The photographs of the event presented below are available at http://www.psy107.be

conducing the day-to-day matters, and we were confronting a important political crisis. Under such circumstances, it was not bad to show that we had been able to work together on a project that involved every level of power. However, at that moment, we did not know that we were going to work under those conditions for such a long time!" (Interview with the Federal Coordinator, 2012/03)

For their part, local actors listened carefully to the presentation of the different chapters of the guide. As we mentioned at the end of the part one, they did not know exactly what to think of the new reform. The programme seemed interesting to them, but they have been disappointed by the way in which the therapeutic projects and the horizontal consultation had unfolded. According to the Federal Coordinator, the presentation of the guide worried local actors:

"We heard different kinds of reactions such as 'that is, at last, an ambitious reform!' or 'you are going to close psychiatric hospitals?! That's nonsense!" Those reactions were reflecting what people were living at that particular time, they reflected their particular point of view … But I was confident. Because I knew that it was the result of months and years of work." (Interview with the Federal Coordinator, 2012/03)

At the end of the public event, federal authorities announced the call for projects: local actors were invited to apply to develop an exploratory project at the local level. To do so, they had to submit a declaration of intent by 30th June, and their full application document by the end of October. That document had to explain to the jury (composed of members of the think tank and the task force) how they planned to implement the guide at the local level. Following the submission of the declaration of intent, the jury planned an initial meeting with local actors to help them to improve their project.

During that period from May to October 2010, the first enactments of the guide (i.e. local actors thinking of how to translate it into a proposal for a local exploratory project) evidenced the need for further detailing of some aspects of the guide. The most important issues concerned the financing of the projects. Following the presentation of the guide, in fact, local actors argued that the budget released by freezing psychiatric beds would not enable them to cope with additional running costs which would result from the implementation of the functional model, especially functions 2 and 3.

They contended that they would be unable to compensate for the cost of the medical function. They stressed that, by implying the displacement of psychiatrists' core activities from consultations paid for by patients to the management of the new mobile teams, the realisation of functions 2 and 3 would cancel the system of fee-sharing agreed on by hospitals and medical specialists.

The public authorities finally responded to local actors through a *Note on Financial Aspects*[24], specifying that the local projects selected by the jury would receive a complementary budget including: general running costs (400 000 Euros); costs of the coordinator (100 000 Euros); and costs of the medical function (225 000 Euros). From that point onwards, what was at stake for local actors in the selection process was not only to be authorised by public authorities to freeze a given number of beds, but to win the complementary budget.

As those interactions between local actors and public authorities unfolded through different kinds of intermediaries (including the website, help desk, e-mails and meetings) the former had been writing their versions of the guide. The resulting twenty-two local versions of the guide were submitted to the jury at the end of October.

The evaluation of the application documents involved five main steps. First, the documents were sent to international experts who had been requested to make a qualitative appraisal of the content of the project, without knowing the context in which it would develop. Second, those international experts met the members of the jury, as well as national scientific experts, to agree on criteria according to which the final evaluation of the projects would be conducted. Third, the jury and national and international experts made an independent assessment of the project. Fourth, the jury ranked the 22 projects according to their evaluation, before submitting that ranking to the Interministerial Conference, which was responsible for the final decision. Fifth, by December 2010, the IMC decided that only the project ranked first would be authorised to start. The projects ranked second were asked to carry out small revisions in their projects; those ranked third to do major modifications; and the two projects ranked fourth were not authorised to resubmit their proposal.

Following this decision, local actors tried to improve their proposal by taking into account the remarks made by the jury. The second version of the 19 projects ranked 2 and 3 were then resubmitted to the jury. The re-submission included the oral presentation of the new project and the rewriting of the document. Those steps enabled the jury to judge whether its remarks had been taken into account, before of establishing a new ranking. That ranking led the IMC to decide, in June 2011, to authorise ten additional projects to start and to request the nine remaining projects for additional changes in their proposals. This decision resulted in new meetings between the jury and local actors involved in the nine projects and the re-writing of part of their application documents. Their third application was examined by the jury and then the IMC which decided, by June 2012, to authorise those ten projects to start (June 2012).

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[24] Unpublished document available at http://www.psy107.be

On the whole, the selection process was very long and uncertain. Initially, in fact, "the jury had decided to be particularly harsh, to ensure that the local exploratory projects complied with all the criteria listed by national and international experts" (Interview with the Federal Coordinator, 2012/03). Later, the degradation of the political situation made the context increasingly uncertain, and budgetary constraints imposed by the European Commission worsened the situation. Consequently, when the final nine projects submitted the third version of their project, the jury was not in position to know if the IMC would agree to finance them. In this context, the only thing that the jury could do was to keep policy makers and local actors interested in the reform. With a view to ensure that local actors kept enacting the guide at local level, the jury first convinced policy makers to financing the ten local coordinators. To be sure: the jury granted the ten projects with only a part of the complementary budget devoted to finance the coordination function (100 000 Euros), without giving them the formal authorisation to freeze psychiatric beds and the start to implement their projects.

> "Ten projects were working and nine additional projects had recently received the insurance that the financing of the coordination would be maintained over time. It confirmed that public authorities considered that work performed by local actors would improve their project. That means that the projects classified by the jury are in the running and that it is not a question of quality but a question of budget!" (Interview with the Federal Coordinator, 2012/03)

Then, with a view to convince the IMC to make a decision concerning the nine projects, the Federal Coordinator and other members of the jury sought evidence that the reform was working and improving the effectiveness of local systems for addressing personal problems:

> "From the very beginning of the process, we had been explaining to the scientific teams that we were seeking some little positive things, which would enable us to show to everybody … that we were in something processual. … I think that everybody supports the reform and that the decision of the IMC depends on budgetary questions. However, if we had little examples to show them that the reform has positive effects, it would be easier for us to explain why it would be better to move from ten to 19 projects." (Interview with the Federal Coordinator, 2012/02)

Scientific teams did not provide the Federal Coordinator with such examples. For their part, however, local actors promoting the nine remaining projects increasingly lobbied for the authorisation of the IMC. As we shall see in the following case study, their feeling that the selection process relied on ideological criteria and that they were enduring the consequence of various circumstances independent of the internal quality of their project, and therefore beyond their control, led them to take a series of actions "to help the IMC to make a good decision" (observation, exploratory project A, steering committee, 2012/06)

4. CONCLUSION

To some extent, the policy objectives and means inscribed in the guide reverberated past shifts in the system for addressing personal problems. Through multiple references to key documents and actors involved in devising past changes, the documents connected Reform 107 to the global change process unfolding in the system from the early sixties onwards. By employing key concepts such as networks and care circuits and the function of coordination, it also related the reform to very recent moves, thus reassuring actors who had participated in those moves about their ability to cope with the new reform.

Moreover, by describing policy instruments as making room for local actors' creativity and the mobilisation of the great diversity of care structures existing at local level, the guide meant local actors had the possibility to translate it at the local level, in a way consistent with the particularities of local care systems, as they were already accustomed to doing. In that respect, the exploratory project devised by the guide can be viewed as a "boundary object" (Löwy, 1990; Star & Griesemer, 1989), designed to help multiple actors with specialised knowledge to agree on common work procedures.

However, the guide also drew on different kinds of embodied knowledge, especially knowledge embodied by the Federal Coordinator through managing the local development of integrated care networks (when he was responsible for the coordination of the "Association") and by being involved in international organisations, in addition to knowledge embodied by key actors of the FPS PH through participating in past changes in the system. This knowledge inspired specific policy decisions relating, for instance, to the training of front-line professionals, the coaching of local coordinators and the communication plan, which reflected attempts to avoid obstacles that prevented past initiatives to reach their objectives. Regarding those instruments, it must be emphasised that the guide involved an attempt to exert control over the context in which it had to be implemented, by incorporating the aspects of that context known by its authors (John Law, 1986).

As mentioned in the methodological chapter, boundary objects designed to help different kinds of actors to work together and instruments designed to eliminate uncertainties from particular contexts of action induce different kinds of relationships between the involved actors; respectively power-share relationships and relationship of domination. Thus, on the whole, the guide involved ambiguities, or at least imprecisions, in relation to the extent to which it allowed local actors to adapt the functional model at a local level. In a way similar to the ambiguity involved in the juxtaposition of the objective of implementing care circuits and networks and that of socialising psychiatry, conflicting conceptions of the autonomy of local actors in implementing the model were not made explicit. In other words, although conflicting instruments were inscribed in the guide, their differences were neither made explicit nor immediately perceptible on reading the document. By contrast, they appeared very clearly when the guide started to be jointly enacted by local actors and federal authorities. The harsh selection process just related was the first consequence of the ambiguities involved in the guide; it was used by

the Jury to bring the written projects submitted by local actors closer to the model inscribed in the guide. The following case studies will show that the severity of the jury caused significant misunderstandings between the public health authorities and local actors. They will also provide many other illustrations of the way in which conflicting views of the change process implicit in the document impacted on the course of the reform.

By relying on our story of the making of the guide, it is possible to argue that the inscribment of those conflicting views in the guide resulted from the joint writing of the guide by actors embodying logic of action specific to the traditional coalition on the one hand, and to the reformist network on the other hand. Indeed, although the members of the think tank certainly agreed on "where they wanted to go", they had quite different personal trajectories, according to which they developed contrasted understandings of the change process. Although key actors of the FPS PH were committed to a change process aimed at the objective of socialising psychiatry, they embodied a vision of change in the system which was consistent with that involved in past changes. For his part, the Federal Coordinator embodied procedural knowledge unknown to the actors of the system. He drew this knowledge from experiences gained in a local system entirely managed by proponents of the reformist network (see the "Association" in chapter 6) and by participating in mental health reforms in in different OECD-countries. On the whole, the logic of action enacted by the federal coordinator was characteristic of the knowledge regime specific to the international context (see chapter 2). This knowledge regime recently stressed the significance of practice-based and procedural knowledge. It involved a commitment to strategic planning of change process and an emphasis on personal and political skills, which is particularly reflected in the definition of the network coordinators' profile.

In this respect, compared with previous initiatives whose devising was conducted by representatives of the traditional coalition, the involvement of the Federal Coordinator in the making of the guide can be considered the most innovative aspect of the reform. Stated otherwise, by allowing him to take part in the devising of the reform, policy makers enabled the use of knowledge resources specific to the reformist agenda to support change in the system. Those resources included the creation of ad hoc committees composed of heterogeneous actors representing different ecologies but sharing global ideas and values in relation to changes in the mental health system. They also included the mobilisation of actors, drawing *know-that* and *know-how* from practical and situated experiences attained by traveling across Europe and by participating in different reforms of mental health systems. By moving from one reform process to another, those actors became able to efficiently use means employed by international organisations to support change in mental health systems across the world, for instance on-the-job training, the collective definition of networking procedures, the implementing of instruments such as the individual care plan, and the empowerment of service users' groups and front-line professionals.

Consequently, it might be argued that, by succeeding in inscribing his knowledge of instruments specific to the reformist network in the policy guide, the coordinator was able (at least theoretically) to

define a context likely to facilitate the change process, i.e. to bring it closer to the objective of socialising psychiatry. In the meantime, it must be emphasised that the writing of the guide provided a good illustration of an instance where the participation of actors embodying particular knowledge in collective action became a strategic means to direct it toward new objectives.

Chapter V – **THE TRADITIONAL VERSION OF THE GUIDE**

SUMMARY

The first case study relates the story of an exploratory project called "REST". This project had the particularity of being implemented in a rural region where a psychiatric hospital had historically played a central role in the local system for addressing personal problems. The head and head doctor of that hospital directed the local conception of the project, making it a somewhat medicalised version of the care model drafted in the policy guide.

Accordingly, policy makers attempted to prevent local actors from implementing their project by refusing to give authorisation to release the necessary budget by closing a given number of psychiatric beds, until they had met particular requirements. Those requirements included the enlargement of the local network to an increased number of community and social services and, crucially, a stipulation that the leading hospital must jointly promote the project with another institution located in the south-east of the region.

Local actors (including the network coordinator, the head and head doctor of the promoter hospital) devoted much effort over a period of more than two years to rethinking their projects and to building the necessary alliances to refine the new model of care locally. Next to that sustained work of interessement and mobilisation of new partners, those actors regularly met with their special partners; that is, managers of partner organisations involved in the first version of the project, with the intention of reaching an agreement on a network convention on the basis of which they might quickly put their project in practice once awarded policy authorisation. For his part, the network coordinator was equally involved in a work of interessement directed to front-line professionals. It consisted in asking them about their particular needs in relation to the local system for personal problems and informing them about the functional model and the local exploratory project.

However, neither part of the interessement achieved its objectives, respectively the signing of the network agreement and the enrolment of front-line professionals. In fact, the continuing refusal of public authorities to acknowledge the value of the project suggested by local actors caused many disappointments and mistrust among the partners. The coordinator also experienced difficult working conditions through being caught between the strong desire of local actors to put their view of the reform into practice, and the expectations of public authorities, which opposed in many respect to local conceptions.

The project was finally awarded policy authorisation, thanks to an alliance made between the initial promoter, a private hospital, and a public psychiatric hospital. The policy authorisation was immediately followed by the replacement of the initial coordinator, who no longer felt able to manage the project's implementation. From that time onwards, local actors succeeded - with the help of the new coordinator - in developing common projects that included new professional roles and care structures.

These concrete achievements resulted from local assemblages bringing together the local version of the project, key aspects of the model devised by public health authorities and particular ideas and concerns expressed by the new partners. Furthermore, they represent balanced-innovation assembling traditional and reformist ideologies and knowledge in a way suitable to the local care system. They also represent a collective achievement of great worth, since their work involved passing through several steps where the values, knowledge, and position of the involved actors were profoundly questioned.

INTRODUCTION

In keeping with our central assumption that things do not happen in a social vacuum (Corbin & Strauss, 2008), this case study starts by setting the local context in which sustained enactments of the guide took place. It will particularly stress past developments and recent changes which brought about embodied and inscribed individual and collective knowledge that influenced the local version of the guide.

Second, assuming that enacting the guide locally meant bringing those pieces of knowledge together, it details the nature of this knowledge and the professional trajectories of those holding it. Knowledge holders include the head and the head doctor of the Peter Brothers hospital as well as the coordinator of the local exploratory project.

Third, this case study presents the new inscription –the *Project intended to form an agreement in the framework of Article 107 of the Law on Hospitals and Care Establishments*, produced by local actors in response to the guide. It looks at the basic philosophy of mental health care inscribed in the local project and the defining characteristics of the local network outlined in the corresponding proposal. Those characteristics include the geographic area, target group, network partners, organisational structure and governance model. It particularly draws attention to the guidance platform, network agreement and bilateral convention, which were essential to the local version of the guide.

Fourth, it moves on to focus on the first enactments of the local version of the guide. The timetable at the beginning of the section summarises the main events and documents involved in the first enactments. It then relates these first enactments, which occurred in parallel to the (re)writing of the local version of the guide and the selection process directed by the federal jury, to show how they produced a competing context in which both mental health care and governance models underlying the reform became increasingly uncertain. It stresses that the uncertainty of the context culminated with the request of the jury to build unthinkable alliances (i.e. cross-pillar and inter-ecological alliance).

Fifth, this case study relates the enactment of the guide and its local version in collective settings; that is, during successive meetings of the steering committee and function committees created in the framework of the reform. It distinguishes three sequences of enactments. All the sequences start with a timetable recapitulating the various meetings they included. The three sequences indicate differences in the extent to which, and the manner in which, the guide was enacted at the local level. Thus, they also denote changes in social relationships and collective knowledge of the reform prevailing at the local level. The first sequence involved extensive enactments of the local version of the guide, which were conducted by the head and head doctor of the promoter hospital (the Peter Brothers' (PB) hospital) and the local coordinator. During the second sequence, the arising of new actors questioned the centrality of the local version of the guide and its producers. It brought about sustained enactments of the guide, but in conflicting ways and opposite directions. Those opposite

enactments succeeded in completely disconnecting the local version of the guide from the federal framework. The third sequence was characterised by the incoming of a new local coordinator, who embraced the role of spokesperson for the guide and started painstakingly and carefully reconnecting the local and initial version together.

This case study concludes by highlighting three empirical, analytical and methodological learnings made by observing the local enactment of the guide. It first summarises various changes in the organisation of the local system for addressing personal problems, including its social and structural configurations. Second, it raises the question of the influence of the traditional and reformist coalition and network, as well as the three ecologies identified at the end of part one. Third, it highlights key analytical findings regarding the role of embodied and inscribed knowledge in collective action.

1.   SETTING THE CONTEXT

The context involves a set of "conditions" (Corbin & Strauss, 2008) relevant to the understanding of the enactment of the guide at the local level. This section summarises past developments in the local care system, before of mentioning recent changes in the internal administrative and medical management of the PB psychiatric hospital. Following this, it identifies embodied and inscribed knowledge existing in that context and examines their meaning with regard to the local perception of Reform 107.

1.1. Past Developments in the Local System for Addressing Personal Problems

In 1875, the PB Hospital bought a castle situated in the countryside of the Green city. They intended to devote that site to the care of mentally ill patients. In 1877, the Belgian government gave them the authorisation to open a psychiatric institution and, in 1889, asked them to create a ward for maniac patients. After WW2, the PB Hospital felt under the jurisdiction of the public health ministry. From that point onwards, it was concerned with the successive policy initiatives related in the first part of our story.

In 1974, when the bars were only just being removed from the windows, the hospital implemented the standards A and T created through the first reform of psychiatry, launched by the Minister De Saeger (see chapter 3, section 3). At that time it housed 310 men, of whom 240 were confined. The same year, a non-profit association was created to replace the Peter brothers as head of the hospital. That change did not prevent the brothers from continuing to live on the clinic site; it only implied a transfer of the decision making power to a laic assembly, acting in the interest of the institution. That shift was followed by a set of measures directed toward modernising and professionalising the clinic.

Between 1975 and 1980, these measures succeeded in establishing a gender mix, decreasing the total number of patients, and putting an end to the confining of most patients. 60 beds were also transformed to comply with the new standards and, finally, the hospital obtained accreditation for 60 A-beds and 180 T-beds. From 1980 onwards, the hospital started creating new facilities inside and outside the clinic walls. Following these innovations, including the creation of a new ward for functional rehabilitation and of 30 part-time hospitalisation beds, the accreditation of the PB Hospital increased to 90 A-beds, 180 T-beds, 30 Vp-beds (beds for geriatric patients requiring neuropsychiatric treatment). In the second half of the 1980s, the hospital yet again increased its capacity with the opening of two new wards of 60 beds and a day hospital.

The moratorium imposed by Minister Dehaene put an end to that expansion in 1980. It was quickly followed by the Busquin reform (see chapter 3, section 4), which made it possible to transform part of the hospital's resources in alternative housing facilities. The PB Hospital took that opportunity to create, in 1993, a sheltered housing initiative in a small neighbouring town. In 1999, it also implemented the second phase of the Busquin reform by intensifying an increased number of psychiatric beds.

In the early 2000s, the head of the PB Hospital became aware of the emergence of new policy orientations in psychiatry and mental health, and of the need to moving towards a new organisational model based on the key concepts of networks, care circuits and target groups (Interview with the (ex-) Head of the PB Hospital – H1, 2009/08). Accordingly, it endorsed a "jumping on the bandwagon strategy" (idem), previously defined as an organisational strategy consisting in taking advantage of every opportunity of testing new ways of working, in order to participate in the definition of new care model instead of being obliged to implement a care model conceived by other people in other place (see chapter 3, section 6).

Based on that strategy, the hospital implemented a Psychiatric Home Care Project in 2002 and Therapeutic Consultation from 2005 onwards. As reported in the first part of this work, by participating in therapeutic consultation, the hospital's psychiatrists and paramedical staffs had the opportunity to question their professional and organisational routines, to test new kinds of relationships with their patients, and to meet more regularly with general practitioners and community mental professionals and social workers. On the whole, the pilot not only blew a wind of change in traditional professional practices but it supported the development of privileged partnerships with GPs and some community services. Moreover, it provided the local coordinator with further knowledge and experience of the change process at the local level. In that context, the PB Hospital "naturally responded to the call for projects (project 107) launched by the federal power in 2010"[25]. Changes in the general and medical management of the hospital also contributed to that decision.

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[25] Gilles, R. (2012/01/13), Liège: Des soins psychiatriques à domicile ? C'est possible. L'avenir: http://www.lavenir.net

Indeed, at that time, the psychiatrist who had headed the hospital for more than forty years had just announced his retirement. The general head of the hospital was also about to be replaced by a manager who had previously occupied key positions at the Federation of Hospital Institutions (FIH) for several years. The new head doctor already worked in the hospital. He advocated for a medical project entailing a complete reorganisation of the hospital, and which could fit in with the framework of the reform. For his part, thanks to his past positions in the FIH, the new head of the institution was informed about the general orientations of Belgian policies for addressing personal problems. Thus, he knew that the transformation of the role of psychiatric hospitals would be central to his mandate. He was willing to endorse the traditional "jumping on the bandwagon" strategy as well as the medical project suggested by the head doctor. As we shall see, both agreed on a rather medicalised vision of the reform, in which psychiatric hospitals played a leading role, alongside general practitioners, who stood as the hospital's privileged partners within the community.

Consequently, the local coordinator, who was still managing therapeutic consultation and participating in cross-project discussions, travelled to Brussels to attend the big public event held by federal public health authorities on 21st May 2010. In common with other local coordinators of therapeutic projects who attended the event, he appeared to be surprised by some aspects of the new care model put forward by public authorities, which was not fully consistent with the did not reinforce the continuity of the therapeutic projects or the NACH advisory notes.

1.2. Embodied and Inscribed Knowledge Relevant to the Local Version of the Guide

In the context just described, enacting the guide meant bringing it together with another inscription (i.e. the medical project of the new head doctor) and different kinds of embodied knowledge, including knowledge of the local change process embodied by the coordinator, and knowledge of the global process embodied by the new head of the hospital. In the course of the local enactment of the guide, these kinds of knowledge mediated the relationships that local actors established between the guide and local needs and resources, making it a less linear process than in the case of the therapeutic projects (see chapter 3, section 6). In turn, the inscription of such personal knowledge in the local proposal caused a singular attachment of local actors to their project.

1.2.1. *The New Head of the Peter Brothers' Psychiatric Hospital*

The new head of the institution had a clear-cut view of the reform, including its origin, its purpose, and the process that might make it successful. Thanks to its longstanding involvement in the FIH, he knew a lot about past developments in the system for addressing personal problems, the concrete functioning of the Belgian public health system, and the creation of the reform.

First, he thought that the reform was necessary. According to him, health was a precious commodity in Belgium, and mental health had benefited significantly from its link to public health. He insisted on the need for preserving that link but simultaneously assumed that mental health professionals and institutions had to change their way of dealing with the associated resources. Indeed, in his view, the responsibility of a profession was not only a judicial responsibility; it also included a social responsibility, which currently meant being able to send psychiatric patients back to their homes. Recognising that the therapeutic ideal was very high in Belgium, he thought that the reform must lead mental health professionals to adapt the therapeutic ideal to the patient, and not the other way around (Interview with the head of the PB Hospital – H2, 2011/04).

Second, he was convinced that the idea of the reform came from the professional ecology. He assumed that professional federations had been thinking about the reform for more than ten years, while the Federal Minister for Public Health had been concerned with the project for only four years. In his view, established professions and institutions had conceived of the reform and they had a leading role to play in its implementation.

Third, that division of work was consistent with his view of the role of the state in the professional domain. The role consisted in organising legal and structural frameworks and financing some 20 percent of the related costs. But it stopped there: insofar as the content and the application of mental health care were concerned, the state had only to give incentives to move in particular directions. In response to such incentives, professions and institutions had to think of innovative practices and modes of organisation to issue proposals to public authorities. Their proposals had then to be sanctioned by the Public Health Insurance Committee of the NIHDI. That process was, according the head of PB Hospital, the only valid way of producing a care model fit to apply to professional work. Consequently, he conceived of the role of the hospital in the reform as consisting of putting the model proposed by local authorities to the test of the local reality and adapting it to professional requirements (idem).

1.2.2. *The New Head Doctor*

The new head doctor was committed to reform the organisation of the hospital, and was convinced that such reorganisation fitted with the framework of the reform. He was a psychiatrist and psychotherapist trained at the University of the Red city. His particular interest in behavioural therapies led him to become an active member of the European Association for Behavioural and Cognitive Therapies. At the beginning of the 2000s, he started a PhD in medical science, with a view to apply as head doctor of the PB.

His project for the hospital consisted in moving from an organisation based on stable psychiatric units with definite staffs and equipment, toward an organisation based of responsive and flexible departments able to provide psychiatric care in different contexts, from the hospital to the patient's living environment, with mental health professionals moving from one department/context to another,

depending on the work load and changes in care demand (Interview with a psychiatrist – P2.2, 2012/05).

According to the head doctor, that reorganisation implied an increase in the polyvalence of the hospital, the interchangeability of medical and paramedical professionals, and the exercising of an outreach function, displacing part of the psychiatric care towards community settings. Regarding medical and paramedical staff, that new organisation meant a greater uncertainty and less comfortable work conditions. For those reasons, he acknowledged that most hospital's psychiatrists and psychiatric nurses were at first glance opposed to that change. However, the interest of newcomers and young psychiatrists in the challenge of diversifying therapeutic activities and working in teams made him confident about his project. Regarding the PB Hospital as a whole, that organisational model entailed improving its connection to community services. The "guidance platform", which was central to his project, was designed to support that connection. In his view, the platform represented the support the hospital was lacking to improve communication with community services and continuity of care (Interview with a psychiatrist – P2.1, 2009/07).

As explained later in this section, the platform constituted a site enabling GPs to work directly with psychiatrists, organising pluridisciplinary meetings to evaluate a patient's situation and to propose an adequate care plan, through mobilising the different care functions involved in the new model. Thus, the concept of the guidance platform appeared to be wholly consistent with the objectives of Reform 107 (Interview with a psychiatrist – P2.2, 2012/05), which supposed, in the view of the head doctor:

"A radical transformation of hospitals staffs, including psychiatrists as well as nurses. At present, the organisation of the psychiatric hospital has nothing to do community work, thus, we will have to work on two tasks, delivering intensive care inside the hospital and developing our activity outside the hospital." (Speech of the head doctor of the PB Hospital at the Psychiatry Working Group of the Red city, 2011/01/17)

1.2.3. *The Local Coordinator*

The local project coordinator was a psychologist convinced of the need to reform Belgian psychiatry (Interview with the coordinator – C1.1, 2008/12). Accordingly, he participated in initiatives directed toward that objective, both outside the hospital (especially through his involvement in the NACH psychiatry working group), and inside the hospital, by taking the leadership of pilot projects at a local level.

As a member of the psychiatry working group of the NACH, the local coordinator was usually well informed about the concepts underlying new policies for addressing personal problems. He had been particularly interested in the definition, a few years before, of the concept of mental health care

circuits and networks. His involvement in that defining process provided him with embodied knowledge which resolutely influenced the way he coped with the development of the local networks.

According to him, that knowledge also influenced his way of dealing with the federal framework locally. For instance, in the case of the therapeutic projects, he was perfectly aware that the project initially originated from the FPS PH, which had been encouraged and helped by the NACH in devising the initiative. However, the FPS PH lacked the necessary budget for financing the therapeutic projects. Thus, it associated with the NIHDI, which became involved in negotiating the administrative framework of the initiative. Those negotiations resulted in making the NIHDI responsible for the financing of local pilots, and thereby for checking their compliance with the administrative framework. For its part, the federal department remained responsible for the financing of the horizontal part of the initiative, including cross-project discussions, the scientific evaluation, and the participation project. In the view of the coordinator, knowing of the existence of that arrangement helped him to deal with the ubiquity of the policy device. Assuming that the original intent of the FPS PH was to test innovative practices, he did not hesitate to relativise the NHIDI administrative control, and to develop a "makes it work strategy" to cope with the rigid framework ultimately imposed on the projects (Interview with the coordinator – C1.1, 2008/12). In the case of the present reform, however, it seemed to him that some pieces of the puzzle were missing. He did not have complete knowledge of the process of developing the guide and, consequently, he misunderstood some aspects of its content. He also noticed that traditional actors, such as the NACH and the Mental Health Care Dialog Platforms, seemed to play a role of lesser importance in this than in previous reforms (Interview with the coordinator – C1.2, 2010/09).

At the local level, the involvement of the coordinator in the Psychiatric Home Care and Therapeutic Projects allowed him to build a network of relationships with primary care and mental health community services, which were essential partners to succeed in implementing the new network. Such personal acquaintances meant a network of key actors who were already enrolled in the change process. Moreover, those experiences provided him with knowledge of the strategic aspects of the local change process. In that respect, the most important point concerned the relationship between GPs and psychiatrists. The therapeutic projects proved that many GPs in the local area were lacking adequate resources to deal with patients' personal problems. Accordingly, they had been very interested in therapeutic consultation, which allowed them to meet their colleagues and better understand their therapeutic decisions. With regard to psychiatrists, the local coordinators insisted that psychiatrists found the most interesting aspect of therapeutic consultation to be discussing patients' situations with GPs. Thus, he assumed that GPs and psychiatrists were inevitable actors and that the network should be based on and organised around their relationship (Observation, evaluation meeting, 2011/04). That view was consistent with the guidance platform devised by the head doctor.

2.   MOVING FROM GLOBAL TO LOCAL INSCRIPTION

The decision to participate in the reform had to be taken very quickly. In fact, local actors had to declare their intent to develop an exploratory project by 30th June 2010, only one month after the public presentation of the guide. Moreover, they were invited to meet with the jury in August 2010 to defend their project. Thus, the time for conceiving of the local project and writing the proposal was very short.

On 29th October 2010, the first proposal was sent to the jury. The PB head and head doctor drafted a short cover letter to accompany the proposal, outlining their decision to propose an original and personal project, their commitment to achieve the professional and organisational changes required by its implementation, and their openness to further discussion with the delegates from the FPS PH and the experts it appointed to participate in the jury. This initial proposal was rejected by the jury, which asked local actors to make significant changes in their project. The local actors resubmitted a modified version in May 2011. The jury rejected their proposal a second time. However, at least in the view of the jury, its second appraisal caused secondary remarks only. Local actors responded to those remarks through an addendum, which came to complete the final version of the local project. It is that final version of the guide that is presented below.

2.1. The Traditional Version of the Guide: the REST Project

The proposal for the REST network was a 32 page document[26], plus appendices (19 pages) and addendum (14 pages). It was entitled: "*Project intended to form an agreement in the framework of Article 107 of the Law on Hospitals and Care Establishments*". The subtitle was: "*Toward better mental health care*". The layout was very simple: the logo of the promoter psychiatric hospital was inscribed on the cover, and each page was headed "Eastern Belgium Mental Health Network". The main document was dated May 2011 and the addendum November 2011.

To introduce their proposal, the PB Hospital head and head doctor mentioned that the basic philosophy and the global objectives remained unchanged, consistent with the expectations of the Federal Public Health Services and the local partners in relation to the reform. They also restated their commitment to be accountable to public health authorities and their conception of the building of the network as a gradual change process:

> "We will do what we committed ourselves to do, without false promises, by moving forward gradually. We do not want to reform mental health care at once; we insist on using existing care facilities to better address the needs of people with mental health problem. There are many steps to be taken in that direction; we intend to do that progressively but very surely." (REST 2011, p.2)

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[26] *Project intended to form an agreement in the framework of Article 107 of the Law on Hospitals and Care Establishments, "REST 2011" in the remaining of this chapter.*

Thus, according to the authors of the REST project, the main changes introduced in their proposal following the remarks of the jury consisted in developing further relationships with actors from the social ecology.

2.1.1. *The Local Vision of the Reform*

"There is no compelling argument or scientific evidence that favors a mental health care model based on hospital care alone. On the other hand, there is also no scientific evidence that community service alone can provide satisfactory comprehensive care. Available evidence and accumulated clinical evidence in many countries support a balanced care model that includes elements of both hospital and community care." (Thornicroft et al. 2003)

The "local vision" (REST 2011, p.4) of the reform was set out through several references to moves in the local and global context. First, the quote from the WHO on the balanced care model is said to summarise the basic philosophy of the local version of the guide. By relying on that quote, local actors put forward that the main objective of their project consisted in developing mental healthcare rooted in the community through the intermediary of GPs, and in developing residential and community facilities more specific to the needs of local service users and mental health professionals. They argued that the involvement of the promoter hospital in local pilots implemented in the course of the last decade made it knowledgeable about such local needs.

Second, local actors "adhered to the values put forward by the NACH through its advisory documents" (REST 2011, p.4). By drawing from the NACH advice to promote tailored care and to improve mental healthcare continuity and accessibility, they suggested developing follow-ups responsive and specific to the patients' needs, to practice therapeutic consultation, and to develop mobile teams providing psychiatric home care, "as expected by the FPS PH" (idem).

Third, they mentioned having travelled to the Netherlands, Switzerland, United Kingdom, France and Quebec, to improve their knowledge and experiences of community care models. That knowledge led them to take particular care not to impose predefined care circuits on to services users. In fact, in their view, the patients' freedom of choice must remain a priority.

Finally, local actors endorsed the priorities set out by the Walloon Regional Minister responsible for mental health, including a primary care policy, mental health services integration, and improving the understanding of mental health.

2.1.2. *Defining the REST Network*

The document presented the REST Project as being directed to young adults, adults and elderly people with psychological or psychiatric problems, including peoples with judicial protecting measures. With the intention of not overlapping with specialised care functions performed by existing

services, the network was designed to focus on complex situations with medical, psychological, social and judicial aspects.

The REST project was planned to develop in the district of Green city, situated in the Province of Red, in the Walloon Region. This district is a 2.016,22 square meters area with 280.203 people living in 20 French-speaking and 8 German-speaking municipalities. It recognises different kinds of mental health care structures and facilities spread over the territory, though the highest concentration of facilities is established close to the Green city. Among those structures, the promoter psychiatric hospital "attracts a considerable part of the population (59%) and fulfils a real role of regional health service" (REST project, 2011, p.15).

The REST was intended to complement the functions performed by pre-existing structures and networks, but under no circumstance does it intend to encroach on their professional jurisdiction. Finally, the promoter hospital was currently developing sustained relationships with care structures and networks from the German-speaking community, through meetings with the coordinator of the German Mental Health Care Dialog Platform.

2.1.3. *The Network Partners and Their Roles*

The proposal distinguished between four categories of partners. First, the medical level was composed of: psychiatric hospitals; day hospitals; general hospitals; sheltered housing initiatives, psychiatric nursing homes; NIHDI conventions; community mental health services, psychiatric home care mobile teams; specialised structures for specific target groups; the German and French-speaking GP's associations; and medical health centres located in the different municipalities. Second, the social level was composed of: alternatives housing facilities for adults and disabled people; non-profit housing societies; and one local social service and labour offices. Third, the rehabilitation level was composed of home care and integration services. Fourth, services users' groups, including local association belonging to "Similes" and "Psytoyens", represented the patient level. Details regarding the number of structures involved in each category were given in appendix of the document.

The document made clear that only two psychiatric hospitals existed in the area. The former was the private hospital at the origin of the proposal for the REST network; it was located close to the Green city, the biggest city in the area. The second was a public hospital belonging to the Province of Red, established far from the Green city, in the extreme south east of the area. As the document put it, attempts were made by the promoter hospital to get in touch with the second hospital (the Wood Hospital) with a view to discussing the opportunity to jointly promote the project. The second hospital responded that it was unable to take such a decision at that time (the refusal of the Wood Hospital is explained in the next section).

Most specialised mental health care facilities, especially the ISH, PNH and PHC were related to those two hospitals. Alongside psychiatric hospitals, there were five general hospitals of which two were located in the Green city, two in the German-speaking community, and one in a small city of the

south-east of the area, close to the German speaking community. The spread of community mental health services over the territory was very similar to that of general hospitals.

Following this, the documents defined the different roles that would have to be performed by the network partners. At the patient level, GPs had the role of coordinating medical aspects of the care circuit alongside the care referent, who was responsible for the coordination of the whole network of the patient. At the network level, the partners had to appoint service representatives to participate in the building of one or more care functions. The role of service representatives was defined on the basis of the short definition provided by the guide, which made services representatives "the functional link between the actions defined in the constructing of the network and their practical realization in the field" (Guide, 2010, p.11).

The document specified that service representatives must help the network coordinator to build the network. Concerning the role of the coordinator, the document assumed that it was sufficiently detailed in the guide. Thus, it moved on to introduce the steering committee, which had to meet every semester to ensure that the basic philosophy of the reform was taken into account and applied in a way that fit with the particularities of the area. The role of that committee was further detailed in the section of the document devoted to management functions, which stated that "the steering committee is like the network's board of governors" (REST project, 2011, p.24). The steering committee was composed of the heads of partner organisations which engaged in the network's development by signing the declaration of intent submitted to the Federal Public Service Public Health. They acted as co-promoters of the network. Depending on their participation in building the network and according the precise procedures, other organisations might become part of the steering committee. The committee had to be informed about the network's development, and it supervised decision making for the REST network. The link between the committee and working groups composed of service representatives had to be ensured by network coordinator.

The document then established the concrete division of work among the partners. It put that the CMHS, GPs, health care centres and services users' groups would participate in the creation of function 1. Function 2 would be realised by the new acute mobile teams, emergency services of general hospitals, and the CMHS. Function 3 would be jointly performed by NIHDI conventions, home care services, and the new chronic mobile teams. Psychiatric hospitals and day hospitals would be responsible for the implementing of function 4. Finally, the ISH, PNH, non-profit housing societies and alternative housing facilities would be in charge of the fifth function.

The working procedures of the new mobile teams were described as follows. Their intervention was always requested by GPs. That rule was intended to maintain their pivotal function in care circuits. This was followed by an appraisal of the patient's situation, which was realised by a pluridisciplinary team (see the guidance platform, below). Following that appraisal, either the patient was referred to particular service part of the network, (including CMHS, day hospitals, psychiatric hospitals, and so on), or (s)he was followed by one of the two teams.

Depending on their focus on rehabilitation or acute treatments, the interventions of those teams had different durations and involved different kinds of mental health professionals. The acute mobile team provided psychiatric home care for people with severe mental health problems. Its interventions were conditioned by a medical decision, and the development of the situation was reported the psychiatrist. The chronic team was defined as exporting psychiatric expertise into the patient's environment, and focused on rehabilitation. In that respect, the document put that the rehabilitation plan was jointly defined by the multidisciplinary teams that made the initial evaluation of the situation and the partners involved in the follow-up. It was based on "a mix of assertive community treatment and case management, such as it is practiced in Lausanne" (REST project, 2011, p.22).

2.1.4. *Specific Instruments for Global Objectives*

The proposal stated the intent of the REST project to make the most of existing mental health facilities to increasingly diversify mental health services and to promote care accessibility through the mutual recognition of the specific skills of different mental health professionals. Two kinds of conventions (the network agreement and bilateral conventions), and the guidance platform were the specific means put forward by local actors to reach those objectives.

a)   Network Agreement and Bilateral Conventions

The REST proposal defined the network agreement and bilateral convention as two means to give concrete existence to the network, either by formalising and stabilising existing partnerships, or by creating new work relations. More specifically, it defined the network agreement as representing the engagement of the network partners to support the development of global mental healthcare. It was not compulsory; neither did it limit institutional self-determination. It instead focused on global values shared by the partners of the network. In contrast, bilateral conventions defined precise missions, roles, network procedures and tools agreed on by two or more institutions, in order to strengthen their partnerships. The partners who agreed on such a convention were compelled to observe the particular relationships it established.

b)   The Heart of the Eastern Vision: the Guidance Platform

The guidance platform performed guidance and counselling functions. It supported the use of existing facilities and the development of new partnerships enabling the creation of mental health care circuits responsive and specific to service users need. Alongside that global purpose, it offered a wide range of services ranging from mental health prevention and promotion to treatment decisions and the training of mental health professionals to new roles induced by networking.

Primary care professionals, emergency services and mental health professionals can reach professionals working at the platform every day from 8am to 6pm. The platform's team of professionals were psychiatrists, (psychiatric) nurses, social workers and psychologists. Other

professionals working at the psychiatric hospital, such as speech or occupational therapists, would also be asked to join the platform's team for specific interventions.

The mobile teams were based in the platform. The professionals of the platform participated in both the appraisal of a patient's situation preceding the mobile team's intervention and, generally, in the intervention itself. The psychiatrist responsible for the platform supervised the team's work and the training of the mobile teams' members to prepare for their new job.

To conclude, the document asserted that the platform would contribute to the objectives of the network by supporting the realisation of care circuits suitable to every patient's particular needs, and the development of new professional skills and organisational partnerships. In this way, it should allow for the devising of new work procedures whose raison d'être, scope and limits would be known by everyone.

c)   Communication Tools, Management Model and Strategic Plan

The document devoted little attention to communication tools. In fact, it only mentioned that they consisted of four kinds of documents whose development was ongoing. Following this, except for the definition of the steering committee and the network agreement ("fixing the context in which the network takes place and the principle on which every partner agrees" (REST project, 2011, p.23)), the presentation of the management model was rather short. It particularly stressed that the network must be transparent to the partners who, in turn, must preserve their institutional autonomy

The strategic plan document did not disguise the intent of local actors not to start building the network before receiving federal authorisation. Indeed, though it summarised past steps taken by the promoter hospital toward the complete reorganisation of the system for addressing personal problems, it only mentioned planned future actions, which would be taken if the jury acknowledged the need for developing a network in the surroundings of the Green city.

2.1.5. *How to Finance the REST Network?*

When considering the budget devoted to the development of the local network, the document distinguished between the additional budget expected from the federal authorities and the budget released by the hospital by freezing 20 T-beds in a first time, and 10 additional beds in a second time. The federal budget concerned the financing of the network coordinator, running costs and the medical function. The budget realised by freezing 20 psychiatric beds would serve to pay about ten workers who would stop doing their traditional job in the psychiatric ward to integrate into the multidisciplinary teams of the guidance platforms, and thus the mobile teams.

2.2. The Addendum: Important News for the Network

The addendum stressed the aspects of the proposal that had been modified to respond to the remarks of the jury. Most sections opened by stressing that "what follows had already been explained in the previous proposal", highlighting the weariness of local actors. Nevertheless, it also mentioned three new elements that would prove to be central to further moves in the local project. First, it stipulated that local actors now admitted that the function and strategic committees should play a central role in implementing the reform:

"In the previous proposal, we put the emphasis on developing the mobile teams. In fact, they appeared to us as the main innovation in the framework of the reform. Now, we also know that mobiles teams will not be able to transform the system on their own: such transformation depends on a long-term process implying changes in attitudes … we acknowledge that working groups (by function) and the strategic committee might significantly contribute to that change …" (REST, 2010, p. 23)

However, local actors limited the role of the strategic committee to coordinating the decisions made by the various function committees, staying directly accountable to the steering committee, which held the decision making power for the REST network as a whole.

Third, the section devoted to the planning mentioned that the promoter hospital had finally reached an agreement with the psychiatric hospital of the south-west of the area. That agreement meant additional resources, approximatively ten full-time workers, were made available for the development of the network. Thanks to the decision of the second hospital to freeze 20 beds, which added to the 30 beds frozen by the initial promoter, 25 workers would stop working in hospital wards to focus on developing the mobile teams.

2.3. Conclusion

By relating their local version of the guide to specific documents, local actors situated it in relation to competing understandings of how the system for addressing personal problems should be reorganised. They emphasised their knowledge of the specific needs of local service users and professionals, thus inferring that they could play the role of knowledge broker by translating the federal guide in a way suitable to local needs. They also argued that knowledge acquired through the development of local pilots and knowledge acquisition trips abroad to learn about community care systems significantly improved their ability to perform that role. Moreover, they positioned themselves in relation to community models by: referring to the balanced care model; by drawing from leading values supported by the NACH; and by insisting on the defence of patients' freedom of choice. These references helped them to relate the local version of the guide to the approach to change advocated by the traditional coalition. Their apparent conviction that the guide needed to be translated locally to fit

in with empirical reality also brought them in close alignment to the knowledge model claimed by the NACH.

In terms of the roles of individual actors within the network, the document stressed not only the central role played by the promoter hospital in the local care system but its commitment to develop new relationships with actors from neighbouring ecologies (the social world), other pillars, and the German-speaking community. Consequently, it expressed the commitment of the PB Hospital to expand the local system, in a way which crossed traditional boundaries hindering the development of a global approach to addressing personal problems.

The document also specified the nature of the relationships between the system's actors; these relationships would be based on shared values and global objectives, thereby ensuring that the network partners would contribute to the development of a global approach to personal problems, without questioning their institutional and organisation autonomy. That conception was clearly inscribed in the main instruments defined in the REST proposal: first, the network agreement was described as defining global values prevailing to the network without decreasing the partners' autonomy; second, specific conventions were conceived as means for self-determining institutions to improve their contribution to the network's global objective; third, the guidance platform was defined as a means to regulate the circulation of people and knowledge through the network. Its location on the PB Hospital site, in the small building which was inhabited by the last Peter brother a few years before, was justified by the role usually played by the hospital in attracting a significant volume of local people with personal problems and in translating the federal initiative locally.

Thus, on the whole, the local version of the guide appeared to be internally and externally consistent. On the one hand, its ideological, relational and instrumental aspects were consistent with one another; on the other, such socio-technical assemblage was consistent with personal knowledge and organisational knowledge embodied by the promoter, thanks to its involvement in past changes in the system for addressing personal problems. In that context, the successive rejections of the proposals by federal authorities seemed like both an individual and organisational challenge, if not a crisis.

Moreover, as we shall see, events that occurred during the initial enactment of the local version of the guide gradually increased the visibility of the political and strategic aspects of that challenge. The mention, in the addendum, of the need to empower the network committee was directly related to these aspects. Indeed, it resulted from the requirement made by the Federal Coordinator that local actors should focus on building the network instead of limiting the project to the development of the new mobile teams:

> "Yesterday, I spoke to the coordinator of the REST and I realised that he was waiting for the FPS PH to allow the hospital to freeze its beds and to launch its mobile team to start building the network, but it is not the intention of our decision to give to more chances to projects which failed in the selection. If those projects are still in the running it is because we are giving them

the incredible opportunity to keep working: the network has to be built up, whether there are mobile teams or not!" (Interview with the Federal Coordinator, 2012/04)

The mention, in the addendum, of the strategic committee (i.e. the network committee) also reflected the Federal Coordinator's desire to displace the decision making power from the centre to the periphery (John Law, 1986), or at least to ensure that the power was equally shared by the members of the network:

"According to our model, there must be a network committee. We know that some projects have created intermediate levels. Thus, the jury, of which I am a member, said 'no! There must be a network committee.' We assume that the network committee does not have the power to decide on new work procedures. Instead, within the network committee, the functions representatives continuously conceive of new work procedures, together with the network coordinator. Then, they bring those procedures back to their services or institutions. At that level, the management has the opportunity to say if it works or not. The procedure must permanently shuttle between care structures and the network committee. Their steering committees are composed of the promoters; the promoters are the most important institutions and they say that it is necessary that they agree on new procedures. I agree, but everybody must agree, not only them!" (Interview with the Federal Coordinator, 2012/02)

These two mentions at the very end of the local version of the guide indicated that local actors understood the requirements made by the jury and that they attempted to comply with them. In turn, they made clear that what was at issue in the project was a conflict around the sharing of power the between the hospitals and "the network". That conflict directly involved representatives of the traditional and reformist coalitions, but both refused for a long time to acknowledge that they were playing at a large scale power game. As we shall see, they preferred talking about knowledge of personal problems; the former arguing that they could only trust in academic knowledge, and the second relying on international evidence and experience.

3.   INITIAL ENACTMENTS OF THE REFORM: FROM PROFESSIONAL DREAMS TO POLITICAL REALITY

During the period from 21st May to the application at the end of October 2010, local actors felt increasingly uncertain about the reform. In September, the local coordinator seemed confused about the intent of public authorities. He highlighted that the latter initially declared that every hospital was invited to participate in the reform. Then, perhaps because they received a surprising number of declarations of intent, they started limiting the number of projects.

The attitude of the public authorities brought about competition among regional hospitals and that competition was impairing their relationships, particularly in the framework of the Red Platform.

The rejection of the first proposal, on 20th December 2010, and that of the second proposal, on 6th June 2011, made the global environment and the local context increasingly uncertain. In an attempt to increase their control over that environment, local actors sought to improve their understanding of what public authorities were expecting from them, and they devoted much effort to building new alliances, both in response to the requirements made by the jury and to increase and diversify the range of actors supporting the local version of the guide.

The following timetable mentions the main events and documents that marked out the project development during the period from June 2010 to September 2011.

Date	Events	Documents
03/062010	Declaration of intent	
08/2010	Meeting with the jury	
29/10/2010	Submission of the first application to participate in the reform	First version of the proposal for the Eastern Belgium Mental Health Network
20/12/2010	Rejection of the first proposal; policy makers requested local actors to introduce significant changes to their proposal	
10/05/2011	Submission of the second application	Second version of the proposal for the Eastern Belgium Mental Health Network
06/06/2011	Rejection of the second proposal; policy makers requested local actors to introduce slight changes to their proposal	
07/07/2011		The FPS PH detailed the reasons of its refusal in a letter addressed to the PB
05/09/2011		Letter from the deputy of the Province to the PB to indicate that the PHL is not able to participate in the reform for the moment

Three aspects of the uncertain and competitive context in which the project developed are considered below. They include: the growing competition among local care providers; the uncertainty characterising the care model; and particular challenges caused by the request of policy makers to create alliances *across* ideological lines.

3.1. A Competing Context for Strong Personal Projects

The attitude of the public authorities brought about competition among regional hospitals, and that competition was impairing their relationships, particularly in the framework of the Red platform. Because of its situation in the Red Province, the PB Hospital was a member of that platform. In the Red city there were big psychiatric hospitals; these were equally members of the platform, and equally applied for developing an exploratory project. Given their size and their situation at the centre of the province, those hospitals significantly threatened the REST project. Moreover, one of those hospitals,

a private hospital aligned with the Catholic pillar, had attempted to enrol the PB Hospital as partner of its own project, *PRIPH* (see the following case study). Indeed, it seemed logical to the head doctor of that institution to conceive of a project at the scale of the province, in a way consistent with traditional ideological lines. On the contrary, the head and the head doctor of the PB Hospital were thinking that the area of Green city was a sufficient and sufficiently particular part of the Red Province to develop a specific project.

> "According to a kind of public health evidence which is growing at the international level, mental health care must be provided to people as close as possible to their living environment. Thus, it was nonsense to merge with a hospital situated in the Red city […] Moreover, if you look at the number of partners already involved in the project of the Red city, you will understand that we would have had nothing to say. Anyway, the Green Area must have a specific network, because it is constitutive of the Green city to be different. There are many arguments in terms of local device." (Interview with D2.2, 2012/01)

At that time, however, the president of the platform was the head doctor of the Red city hospital whose invitation had been refused by the PB Hospital.

> "I was the president of the platform, and my dream was a single project expanded to the territory of the platform; one project that would involve the whole platform. I was really sad that the PB distinguished itself by saying: 'we do not wish to take part in your project PRIPH, we want to do our own project in the east of the province'." (Interview with a psychiatrist, P3, 2011/11)

Indeed, although a permanent coordinator was responsible for the daily management of the platform, it was alternatively presided over by its members. Thus, at least initially, the platform demurred to support the REST to public authorities. Given the platform's role as intermediary between local care providers and public authorities, that situation was very harmful the REST project.

3.2. Uncertain Models of Care and Governance

In that competitive context, local actors were also increasingly wondering: what do public authorities want from the reform?

During their meeting with the jury, local actors had been continually asked to explain how the local coordinator had been chosen, how they envisaged implementing the coordination function, and so on. The local coordinator wondered:

> "Why pay so much attention to the function of the coordinator? Well, it is important, and ok, the key role of local coordinators was the main conclusion of cross-projects discussion! But our project has many other aspects! By the way, do you realise that they draw their arguments from

the cross-projects discussions' proposals that they pretended to ignore?" (Interview with C1.2, 2010/09)

He also remarked that there were few references to the NACH advisory documents and to the concrete experiences and international standards that had inspired the new model. In the course of our interviews he remembered that in 2007, in the arena of policy decision making, everybody was talking about the Birmingham model. In 2009, when the spokesperson of the Federal Minister for Public Health stated that model at a meeting organised by the Federation for Hospital Institutions (for the reminder, that federation represents the lion's share of the residential ecology), it caused a strong protest from hospital managers. From that time onwards, it became "just impossible to know from where the model they expected us to implement comes from!" (idem).

The head of the PB agreed with the coordinator to notice that "traditional consultative bodies and intermediary actors are not working! Now, there are only big public rituals!" (interview with D2.2, 2012/01). Moreover, regarding the model, he confirmed that, in this initial period, talk was not only of the Birmingham model, but of Lausanne and Lille's models too.

"The Association was supporting Lille's model, Flemish care providers the Birmingham's model, and the FIH the Lausanne's model … because the English jargon made more sense to French-speaking psychiatrists such as assimilated by Swiss psychiatrists. All those models existed and all of them were worth considering. It was healthy to keep the three models in play, it made room for reflection." (Interview with D2.1, 2011/04)

However, in the view of local actors, though the guide made room for reflection, the selection process was squeezing out the diversity of models. They felt as they were submitted to "a politico-administrative jury telling X [the head doctor] how to manage hospital admissions …" (interview with D2.2, 2012/01).

Interestingly, those feelings expressed by local actors corresponded to precise aspects of the political strategy endorsed by the federal coordination. As we explained in the previous case study, not only the attention paid to the role of coordinator but also the definition of a unique and global model and the severity of the jury were strategic decision made by the think tank, based on policy learning gained through past initiatives and relating to the working of protective and offensive games and related strategies.

3.3. **Enforcing Unthinkable Alliances**

In the course of the selection process, the PB Hospital became aware that the jury considered the number of psychiatric beds the hospital had decided to freeze was insufficient to realise the policy programme. Indeed, given the size of the hospital, its board of governors allowed the head and head doctors to freeze only a limited number of beds. The PB Hospital also knew that public authorities had

a solution in mind: they wanted the PB Hospital to ally with another psychiatric hospital located in the south east of the area to promote the project. That second hospital (the Wood Hospital) could also freeze a given number of beds, thereby increasing the resources available to the whole project.

Such an alliance represented a big challenge. First of all, the two hospitals were different kinds of institutions belonging to different pillars. The PB Hospital was a private institution linked to the catholic pillar, and the Wood Hospital was a public institution held by the Red Province. Accordingly, it was managed by the provincial power, which had been successively exerted by the liberal and socialist parties during the preceding decades.

The fact that the two institutions belonged to different ideological worlds raised fundamental difficulties:

"The PB came and knocked on the door very early in the process, but do you know what it means when a private institution ask a public institution to work together? Well, that means that they give you part of the work but keep the associated resources. I swear that it always happens that way. Thus, initially, there was a political, stupid opposition to the PB's invitation." (Interview with the temporary head of the Wood Hospital – D3, 2010/06)

Then, the situation got worse. In fact, the Wood Hospital was enduring significant financial problems which reached such an extent that the hospital's accreditation was threatened. Those problems were not new. In 2006, the Walloon Region (responsible for applying the hospital standards defined by the federal power) had audited the Wood Hospital, and enjoined it to carry out fundamental reforms. That situation repeated itself in 2008. In the meantime, the provincial power paid no increased attention to the institution:

"You know, the true problem of the Wood Hospital is that it had always been managed as an administrative department, not as a hospital! It happened that medical or paramedical staffs, and sometimes the head of the institution, expressed their will to launch new projects, but the provincial power always preferred investing in other, more visible projects. One time, they had to choose between investing in renovating part of the hospital's building and modernising the gardens of the castle; they choose the gardens." (Interview with D3, 2010/06)

In 2010, the Walloon Region called a halt to this situation: either the Wood Hospital really started fundamental reforms, or they would supresses its hospital accreditation. The call for exploratory project launched by the FPS PH took place in that context. Nevertheless, three social workers from the institution were motivated by that reform, and started writing a proposal. Conversely, the head doctor was not really motivated by the reform, "particularly in the context of that institutional crisis which questioned the very foundations of our institution" (Interview with the head doctor of the Wood Hospital – P4, 2012/01). Finally, "the head of the hospital forgot to inform the

board of governors of the existence of the project, and nothing else happened until the end of June"
(idem).

At that time, public authorities remarked that the Wood Hospital did not declare its intent to
take part in the reform. "The Federal Coordinator asked the provincial deputy why and, in turn, the
provincial deputy turned against the head of the institution!" (idem). The latter was approaching
retirement, and he did not take any concrete action to change the situation. For their part, "public
authorities wanted that the Wood Hospital remained a public psychiatric institution" (interview with
D3, 2010/06). Accordingly, it had been decided that an expert would be appointed by the socialist
sickness fund to manage the integration of the Wood Hospital into another hospital group, considered
likely to provide it with an adequate framework for its continued operation.

That expert, who had been very close to the Federal Ministry of Public Health from 1993
onwards, was appointed as temporary head of the Wood Hospital in June 2011. He managed the
redefinition of the institutional project, the integration of the institution into a big public hospital group
of the Red city, and finally, the association with the PB in the framework of Reform 107. In fact,
since he was convinced that the Busquin reform was already concerned with changing the dominant
paradigm for addressing personal problems, the expert believed that the system had reached a turning
point, where a series of factors were converging towards a more radical change (Interview with D3,
2010/06).

His conviction did not prevent him, however, from taking into account the specificity of the
institution. In that respect, things were a bit more complex. First, sections of the medical and
paramedical staff consisted of petty bureaucrats. They had enjoyed very comfortable work conditions
for decades, and they were not willing to engage in overly radical changes. Second, there was a strong
local culture: the PHL had been founded during the 19th century to create facilities comparable to
those existing in Gheel[27] in the French-speaking part of the country. It was located in the countryside
and the edge of the Red Province:

> "In the Wood village there is nothing except for the hospital and some shops which survive
> thanks to the hospital. And some workers have been working there for generations. This caused
> a strong attachment to the institution and a great concern for what the institution had always
> been doing …. There, the psychiatric patients enjoy a considerable esteem from local workers.
> And local workers are committed to preserve their specificity." (Interview with D3, 2010/06)

The head doctor of the institution was one of those local workers. He was rather opposed to the
reform. He thought that the community structures which had been created several decades before (see

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[27] Gheel and the Wood Village were large "colonies", respectively located in the Flemish and Walloon countryside, where
family cares were provided to mad people. Those colonies were created during the nineteenth century. They were viewed as
abolishing imprisonment: "Gheel substitutes freedom for imprisonment, it allowed the insane living in freedom, close to
family life and in touch with common sense and rationality"(Wouters & Poll, 1938, p. 53)

chapter 3, section 3) did not effectively carry out their work: "why should it be done at the expense of psychiatric hospitals?"

"Moreover, they [pubic authorities] considered us to be messy workers. I would like them to stop injuring us and give us scientific justifications for their model instead of peremptorily stating that everybody knows that … could you imagine that they are federal administrations which are assessing our project. That is Kafka! … Medical councils had not been consulted; the practical details related to the exercise of our professions had not been taken into account." (Interview with P4, 2012/01)

The head doctor of the Wood Hospital was likewise not convinced by the model of care put forward by public authorities. He was not opposed to the five functions, but he was concerned about the idea of reintegrating psychiatric patients into society. He insisted that for the last 20 years he had been caring for psychiatric patients who were so badly affected that they would have been absolutely unable to integrate back into the community. He thought that residential treatments were absolutely necessary when individuals became unable to live on their own; the institutional walls were, in his view, like prosthesis on a broken leg. He was also afraid about the alignment of the model suggested by the public authorities to behaviourist approaches. According to him, since the DSM started to grow in importance, people have tended to focus on symptoms; that is, on visible dysfunctional behaviours. In that respect, what was disturbing him was the implicit assumption that people with dysfunctional behaviours were mentally ill. It sounded to him like a totalitarian position regarding behaviours considered as different: in relation to the difference: "we are breaking the walls of our institutions to make them go into the civil society." (Idem)

This situation caused him to think that psychiatry was undergoing the same phenomenon than undergone by religious congregations several decades previously, when psychiatrists replaced them at the head of institutions: "It always started with a critic against the social control exerted by a group over mentally ill patients, and it always ended with other groups exerting increased social control" (idem). In the meantime, he said, "psychiatry has its source in intelligence and they are imposing us a reform which has no intelligence, or, if I am wrong, they prevent us from knowing it." (Idem)

In spite of that opinion on the reform, the head doctor understood that, in the view of the temporary head of the institution, there was no other solution than to participate in the initiative. Thus, he was resigned to consider it along with his colleagues.

4.   ENACTING THE EASTERN VERSION OF THE GUIDE

From September 2011 onwards, the local version of the guide started to be regularly enacted in collective settings; that is, different kinds of meetings: 1) the steering committees involved the head of the promoter hospitals, the management of partner services and institutions, and the network coordinator; 2) the committees of function and different kinds of (information) meetings involved the

network coordinator and front-line professionals; and 3) the network committees involved the members of the steering committee and the function representatives (front-line professionals appointed by their structures to participate in the committees of function). We have distinguished three different sequences of enactment according to the degree to which, and the way in which, the guide and its local version were enacted during those meetings.

During the first sequence of enactment, when waiting for federal authorisation to start their project, local actors enacted the local version of the guide extensively, but they almost completely ignored the original guide itself. During the second sequence, local actors generally enacted the local version of the guide, in a way which completely disconnected it from the initial inscription. During the third sequence, thanks to a radical shift in the style of the network's coordination, local actors agreed to enact the local version of the guide in a way which reconnected it to the initial inscription, i.e. the original guide.

In the three following sections, we will relate these different kinds of enactments of the guide, by stressing progressive change in the composition and relationships of the system of actors involved, and the resulting shifts in the federal appraisal of the REST project. In so doing, we will notice that the federal view of the project moved from rejection (Oct 2010 to June 2012) to authorisation (June 2012) to recognition (September 2014). The timetables suggested at the beginning of each section recapitulate the various meetings involved in each sequence.

4.1. The First Sequence of Enactment: Waiting for Federal Authorisation

The first sequence of enactment unfolded along with the successive rejections of the local inscription by the jury. Given the decision of local actors not to start implementing the network before receiving formal authorisation, the purpose of these meetings was not exactly to *enact* the guide. Instead, they were directed to keep traditional partners interested in the network and to build alliances with new partners, with a view to support the local version of the guide.

In the course of those meetings, the head and head doctor of the PB Hospital shared their understanding of the reform with partners, and explained their positioning in relation to the public authorities. Their endeavour led to the elaboration of a discourse on the value of the local version of the guide, which gradually supported the collective endorsement of the meaning and relationships inscribed in that local version.

The network coordinator also expressed his understanding of the reform and of his mandate within that framework. His interventions highlighted a particular style of coordination, drawing neither from the original guide nor from its local version, but from the NACH vision of change in the Belgian system for addressing personal problems.

Those two kinds of enactments alternatively involved the steering committee and function committees. In both case, they allowed for some collective learning, which could have induced some displacements in the local version of the guide. However, they were continuously diverted from the

objective of building the local network by a trial of strength involving conflicting models for change in the Belgian system for addressing personal problems.

That conflict became increasingly explicit with the successive rejection of the local proposal and the resulting, and increasing, annoyance of local actors. When federal authorisation finally came, the conflict had reached such a point that local actors received the news rather negatively. In fact, their collective experience during the first sequence appeared so tiring that it arguably motivated their implicit decision to rely on the federal authorisation to start moving further away from the guide.

14/09/2011	Information meeting organised by the PB for local public authorities
09/11/2011	Steering Committee
16/11/2011	Function Committee (F5)
17/11/2011	Submission of the third application
18/11/2011	Function Committee (F3)
30/11/2011	Meeting with French and German speaking Psychiatric Home Care teams
08/12/2011	Meeting with the working group on practices of networking
14/12/2011	Meeting with key actors at the Wood Hospital
09/02/2012	Steering Committee
14/03/2012	Steering Committee
25/04/2012	Therapeutic Projects: internal evaluation meeting
25/04/2012	Steering Committee
18/06/2012	The IMC decided to authorise the project REST to start
20/06/2012	Steering Committee
19/12/2012	Steering Committee

14/09/2011

Information Meeting

N=10

This information meeting was organised by the PB Hospital to inform local powers about the project. The presence of actors (including care providers and local powers) from the German-speaking community indicated the PB Hospital's will to engage them in the local project. Their enrolment was a necessary condition to develop a public discourse on the specifics of working in a large and rural area composed of two communities speaking different languages. The local coordinator and the head doctor respectively explained the local version of the guide and the strategy on which they intended to rely to defend it to policy makers.

During the first part of the meeting, the coordinator presented the local vision of the reform. He started by insisting that the name of "Reform 107" only indicated the means of financing the reform:

"The content of the reform is inscribed in Article 11; Article 107 only includes the means of financing Article 11. That name means that money is the sinew of war, not that psychiatric hospitals are attempting to interfere with the jurisdiction of the other local care providers."

He continued his presentation by explaining that the main innovation brought by Reform 107 was to displace psychiatric care from the hospital to the people's living environment. In this

respect, he reminded attendees of the existence of the psychiatric home care that pioneered, in 2002, the mobile teams which formed part of the new reform.

He then endorsed the incorporation of the exploratory project into the PB Hospital head doctor's medical project, by stating the flagship of the local project was the guidance platform, which was defined as a new modality of the hospital's organisation. Finally, he presented the five functions by relating them to particular kinds of care structure existing in the area. In so doing, he remarked that there was currently no structure whose mandate fit with function 3 (rehabilitation).

During the second part of the meeting, the head of the PB Hospital explained the political situation contextualising the local inscription. He stressed the need for defending the local project against attempts by the larger scale project of the Red city to take over the local care system.

He explained to the participants that what was at stake was to show the specificity of the area to avoid being obliged to merge with the project of the Red city, which was a large scale project focused on urban issues, in which local actors would have little to contribute; "Our local care system is respectable, specific to the rural area and able to bring effective responses to the particular needs of the population."

He continued by explaining that, given the size of the PB Hospital and the financing system of psychiatric hospitals, the hospital was not able to freeze more than 20 beds in 2010, to which 10 additional frozen beds could be added in 2011. In the view of public authorities, this was not enough. The solution was to reach an agreement with the Wood Hospital. He told the participants that the PB Hospital had proposed joint promotion of the project to the Wood Hospital twice, in May and September 2011. He reported the refusal of the Wood Hospital, before summarising the intricate situation that that institution was facing. Under such circumstances, he understood that the Wood Hospital was not able to consider the exploratory project. In the meantime, the PB Hospital could do no more than commit itself to freeze 10 additional beds in 2011 and to keep fighting to lead the public authorities to recognise the specificity and the value of the local care system.

During that meeting, the head of the PB Hospital and the local coordinator invited local powers and care providers from the German-speaking community to endorse a particular version of the guide, along with its associated strategy. They also outlined the discourse that they were going to enact again and again to interest local partners in their project.

09/11/2011

Steering Committee

N=18

This meeting was attended by the management of local services and institutions which agreed, from the start of the writing of the local proposal, to become partners of the REST project.

The head of the PB Hospital started by relating the story of a sustained effort of mobilisation directed to an increasing number of different kinds of actors. From the second rejection of their proposal, the promoters of the project attempted to ally with the Wood

Hospital; an endeavour which involved several meetings with the deputy of the Red Province. This had involved: trying to interest a general hospital and local powers of the Green city in the project; meeting with key actors of the NIHDI, the Catholic Sickness Fund and the temporary manager of the Wood Hospital; and negotiating with the board of governors and the medical boards of the PB Hospital to get their authorisation to freeze ten additional beds. In the meantime, they came to know that the NIHDI Insurance Committee intended to intervene in the financing of ten additional projects in 2012, and they signed a convention with the FPS PH ensuring the continuing financing of the network coordinator for 2012. These represented some encouraging developments.

The network coordinator confirmed that a convention with the FPS PH ensured the financing of his function for one more year. By relying on that convention, he contended that his role was to build the network, and mentioned the activities he had so far realised to this end. He particularly emphasised that he had reached an agreement on a bilateral convention with a public general hospital. The purpose of this agreement was to improve the management of psychiatric emergencies. In the view of the coordinator, that convention was important because it gave concrete expression to the network.

Following this, he moved on to present how he conceived of the organisational structure of the network. The participants did not agree on that structure, which they rapidly termed "the flowerpot". Instead, they started discussing what the network should mean to the partner organisations, in terms of rights and obligations, and to wonder which kind of organisational structure might better represent their conception of the network.
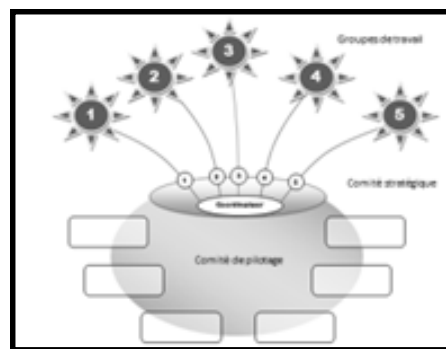
Figure 4 – REST Network-Proposed Organisational Structure

They spent a lot of time in formulating a bilateral convention (defined as constraining mutual agreement on a particular matter between two institutions) and the network agreement (the so-called "charter") by which the network partners committed themselves to defend a particular conception of the care for addressing personal problems. They agreed that bilateral conventions should give the network a legal basis, while the charter should define its global policy orientation. They also evoked the status of the guidance platform, which should "be unitarian, but not monopolist". In fact, the participants assumed that they would have to pay particular attention to the protection of the patients' freedom of choice, the therapeutic freedom of medical doctors, and the organisational autonomy of the partner services and institutions.

"The flowerpot", including the five functions and the different parts of the network, was not referred to again during that meeting, except for the warning that it would be necessary to distinguish between the power of decision held by the strategic committee and that of the steering committee, which was the only place in the network where decisions entailing changes in the working of partner organisations could be taken.

That meeting first evidenced that the forming of strategic alliances required by the development of the REST entailed many displacements across ideological lines and ecological boundaries. It

showed that the understanding of change in the system required inter-ecological perspectives. It also showed that the federal convention financing the coordination function encouraged the network coordinator to present his conception of the reform to the partners of the REST project. The development of the collaboration agreement and its inscription in bilateral conventions seemed to be essential to his conception of how to develop the REST network. Thus, at this stage, the coordination function both emerged from and resulted in conventions establishing new connections between existing actors; the FPS PH and the PB Hospital on the one hand, the PB Hospital and other local care structure on the other. On the whole, by enacting their conception of the network, which was consistent with that inscribed in the local proposal, the participants in that meeting reinforced the local version of the guide.

16/11/2011

Committee of Function 5

N=10

The participants in this meeting were the network coordinator and front-line professionals coming from social services, the psychiatric home care team attached to local ISH, the ISH, the PB Hospital, social housing services, home care services, and a reception centre for men and women.

The coordinator started the meeting by imparting some news about the project's current situation to the participants. He mentioned that an agreement was about to be reached with the Wood Hospital, which might freeze a sufficient number of beds to respond to the remarks of the public authorities. He also mentioned a meeting with key actors of the NIHDI who told the promoters that all the conditions were met to obtain the authorisation of the jury. The future of the project remained, however, uncertain, given that it ultimately depended on the decision of Interministerial Conference to release the necessary budget to finance the project. He thanked them all for being there in spite of that uncertainty.

Following this he defined his role of coordinator as consisting of "attempting to create connections between the different partners", before asking the participants what they expected from a local network centred on mental health.

The service representatives successively explained their needs in relation to addressing personal problems. Those needs included the ability to rapidly make contact with key actors from the local system for addressing personal problems, their need for training to improve their relationships with people with personal problems and to know how to behave in relation to other professionals from the system, and their wish to create new conventions and agreements framing collective action in relation to addressing personal problems.

The coordinator summarised those points before presenting the "flowerpot". In so doing, he insisted that the idea was to create that structure gradually, by connecting what already existed to the model suggested by federal authorities.

That meeting provided a first instance of the shifts achieved by the coordinator from the top of the residential, community and rehabilitation ecologies to the level of concrete practices. By moving throughout the whole network's territory and across ecological boundaries, he expected to interest many actors in the local version of the guide and to collect their expectations in relation to the REST project. Following this, he intended to assemble those expectations in a way to ensure their integration into the building of the network, through the operationalisation of the five functions. In this respect, it is noticeable that he used exactly the same methodology that was used few years before to interest local partners in the therapeutic project. This methodology was consistent with the NACH conception of the development of local care networks, composed of self-determining professions and institutions and emerging bottom-up. This conception was furthermore inscribed in the flowerpot. However, in contrast to that past situation, he was now working in an uncertain situation. His way of dealing with that uncertainty was - in a way similar to the head of the promoter hospital at the steering committee - to describe both the risky nature of the political context and the many developments already achieved by the promoter to support the local project. In the course of those meetings, the coordinator also stabilised his representation of the coordination function.

18/11/2011

Committee of Function 3

N=9

This meeting was attended by front-line professionals, including psychologists from CMHS located in the south of the area, social workers from another CMHS situated in the centre of the area, social worker from the PB Hospital, the leader of the social cohesion project of the Green city, psychologists from a social insertion service in the south of the area, a psychiatric nurse form the psychiatric home care teams, and social workers and nurses from home care services based in a little town close to the PB.

> The coordinator started by sharing some news about the project's current situation: "the PB had done everything it thought it had to do to be allowed to start the project, now it was a budgetary question, and budgetary questions are political questions."

> Following this, he defined his mandate as consisting of building links among the existing services and networks, and in centring the network on mental health issues. He insisted that he worked for the Federal Public Service Public Health, and not for the PB Hospital: "it is very different."

> Afterwards, he requested the participants to express their needs in relation to addressing personal problems and to explain how the new network could help them better addressing such problems. The participants raised: the need to rebuild the social network of the patient instead of imposing a psychiatric network onto him or her; the need for increased interactions with professionals from the system for addressing personal problems willing to help the network partners when they were facing complex situations; and the need of home care workers for

training directed at the improvement of their relationships with people with personal problems. Given those needs, the participants agreed that the link with the guidance platform was essential.

Following that reflection, the coordinator was obliged to specify that, currently, only GPs and medical professionals were authorised to call the guidance platform. Otherwise, the platform's teams would already have been overloaded.

A participant reacted: "Ok, and where are the beneficiaries of the network if the network does not support its own members?" Other participants went on to mention practical situations where they would have needed the intervention of the guidance platform. The coordinator concluded by stating that, in any of those situations, the partner services might get in touch with the platform through an intermediary: i.e. the GP of the patient.

Then, noticing that they had spent almost an hour detailing situations in which they would have need the help of the guidance platform, he suggested that the participants move on to focus on defining the notion of rehabilitation (the focus of function committee 3). He gave them a sheet of paper on which a definition of rehabilitation was inscribed before of reading it. In doing so, he explained that psychosocial rehabilitation was a specific technique involving key values and particular attitudes to personal problems; He stressed that the main point was not to consider personal problems as an illness but to focus on social roles that the person might still play.

A psychologist interrupted him: I'm sorry but I cannot work with concepts such as 'objectives, evaluation and outcomes', be they defined with the patient or not. That is horrible. That carries on a cult of performance that I cannot acknowledge. Most people with whom we are working are simply unable to have objectives; I think it is less discriminating to consider them as mentally ill as to tell them that it is not normal not to have objectives!"

Just after that interjection, another participant worried: "What is the role of the mobile teams in relation to rehabilitation, do they want to supervise the work performed by our teams?"

The coordinator reinsured them by specifying that the mobile teams would work to complement existing services rather than supervising or replacing them! As the meeting was coming to its end, he asked the participants who still wished to be involved to fix the date of the next meeting. He also suggested changing their methodology. He asked if they would prefer to work on the basis of concrete situations and to think together about how to improve their resolution.

This meeting first evidenced that the local version of the guide seemed far less consensual to front-line professionals than to the management of the partner organisations. Second, itraised the coordinator's awareness that it would be easier to produce a new definition of rehabilitation by relying on concrete situations experienced by front-line professionals than to seek for equivalencies between his definition of rehabilitation and their concrete experience and embodied knowledge. Third, it highlighted that some conceptions implicit in particular tools and documents were able to influence the course of the meeting. In this respect, some participants revealed the social configuration inscribed in the guidance platform, expressing their refusal to endorse an instrument that reinforced that configuration, which they saw as perpetuating the dominant position of psychiatric institutions and established professions. Some participants also stressed the normative aspects of the definition of

rehabilitation in justifying their decision not to endorse it. Fourth, by questioning the role played by the mobile teams, front-line professionals made it clear that the protection of their particular relationship to addressing personal problems was, alongside the improvement of that relationship, of great concern to them.

30/11/2011

Meeting with French and German-speaking Psychiatric Home Care Teams

N=5

This meeting was attended by psychiatric nurses working in the Psychiatric Home Care (PHC) teams that had been based in the French and German-speaking parts of the area in 2002, on the occasion of the Psychiatric Home Care pilot project. Before the beginning of the meeting they talked about the added-value of working outside the hospital's walls and how the psychiatric home care project changed the way they related to patients' personal problems. That discussion indicated that the actors participating in that meeting were, to a certain extent, already engaged in the local change process.

As usual the coordinator started by defining his mandate and by specifying that he had no power to compel the network's partners to change their ways of working. However, he expressed his feeling that coordination of the PHC projects existing in the area was an absolute necessity. Accordingly, he was committed to protect projects' specificity, their existence, and to discover with them how best to use their competencies and integrate their work in the framework of Reform 107. He mentioned that the best way to proceed might be to compare the concrete functioning of the French and German-speaking teams.

The participants started discussing: their admission procedures; their target groups and the territory to which they limited their interventions; the way in which they were dealing with crisis situation; and their relationships with GPs and psychiatrists. This exercise first revealed that one team which was supposed to coach home care workers to improve their relationships with people with personal problems was instead directly involved in providing psychiatric home care. Second, it evidenced that specific parts of the territory targeted by the REST project, and particular target groups were excluded from the jurisdiction of both French and German speaking teams. That observation led participants to infer the limits of the jurisdiction that could be given to the new mobile teams. Moreover, the two teams noticed that their respective procedures highlighted different aspects of their work. Thus, by assembling their combined work procedures, they could not only raise a comprehensive framework but also inspire the procedures endorsed by the new team. The coordinator asked them to send him the existing procedures and suggested considering their possible integration into a single framework. The participants agreed to that proposition.

Before leaving, participants mentioned that they were very pleased to be consulted about the implementation of the policy programme and that they expected the coordinator to maintain this way of working. Indeed, they wished to protect their specificity, their experience and - in particular - to ensure that people with personal problems would not be compelled to follow particular care circuits.

This meeting illustrated the methodology finally chosen by the network coordinator. It consisted in specifying what the existing services and networks did, with a view to optimising their connections in a way consistent with the decision taken by the network as a whole. That strategy seemed to address three specific challenges met by the coordinator. First, the particular development of the system for addressing personal problems (following strategic appropriations giving it different forms at the local level) required the coordinator to start by detailing the content of every network partners' work. Second, the logic of action inscribed in the local proposal implied the redefinition of every care function according to specific local needs. Third, this approach helped the coordinator to cope with ecological strategies directed toward the protection of particular relationships to personal problems by giving their representatives the feeling that their specificities were taken into account.

08/12/2011

Working Group on Networking Practices

N=15

This meeting was attended by members of the working group on networking practices, which is a grass-roots group of front-lines professionals from the south of the area. There were 15 people in attendance, including social and psychiatric nurses, social workers and psychologists coming from the residential, community and rehabilitation ecologies. The coordinator thought that that group was a good starting point to interest actors from the south of the area in the project of the PB.

> He started by speaking on the change process in the system for personal problems as a whole, the pilot projects that had succeeded one another over the previous decades, and the global orientations of the associated public policies. Then, when moving on to present the current policy programme, he explained that Article 11 set out the objectives of the reform whereas Article 107 provided the means to reach those objectives.

> The participants asked him a series of questions on the policy programme: are psychiatric hospitals obliged to take part in the reform; how many hospitals applied to develop a local network; what is the meaning of function one? They also expressed their concerns about the role to be performed by the mobile teams.

> The coordinator responded to those questions by alternatively taking the role of spokesperson for the policy programme as a whole and for the local project in particular.

> His explanation of the guidance platform raised questions: why did they decide to establish it on the PB Hospital's site? How should it be used? Etc. The leader of the working group mentioned in passing that, as mental health and social care professionals working in the very south of the area, they were always looking for opportunities for their patients to benefit from a wider range of services than those available locally. Accordingly, when participating in a project, they wanted reassurance that the facilities which would result from that project would be available to people living in the south of the area. The coordinator took note of that point.

Finally, the coordinator explained the political context of the project and the clinic's decision to do its best to participate in the reform: "because we prefer building a local project wherein each of us is important than to be a little thing in a big provincial project." The project was currently waiting for the authorisation of the jury to start working on the basis of their third proposal. In the view of the coordinator, that uncertainty put him in an awkward position: "I am the coordinator of a non-existent network; that is the reason why I'm embarrassed about talking of the network with you, and telling you, 'Come! We are going to create a network, but please, do not come immediately!'" … fortunately I'm too old to develop schizophrenia […] however that may be, as I understand it, my job is to see which services want to participate in the network and to build collaborative agreement, but I have no power."

That meeting highlighted the prospective dimension of the interessement process. Not only did the coordinator move across the area to present the project to different kinds of actors, but he took note of the conditions under which those actors would agree to take part in the network. The attention paid by the coordinator to their expectations showed that, in his view, the network had to emerge from negotiations with front-line professionals. The functional model inscribed in the guide and the local version inscribed in the proposal were only working assumptions; the network would arise from the "flowerpot". However, working assumptions inscribed in the guide and those inscribed in the local proposal were not very consistent with one another. Neither were those assumptions consistent with those involved in the "flowerpot". As we observed on the occasion of the committee of function 3 (18/11/2011), it happened that a participant questioned the coordinator about these inconsistencies. Moreover, such conflicting working assumptions gave rise to different approaches to the building of the network: in the view of the Federal Coordinator, the local coordinators must use the incredible opportunity they had to build their network. By contrast, in the view of the promoter, to the extent that they had been requested to submit a project before being authorised to start, it was out of question to start without the authorisation of the jury. Consequently, the network coordinator was urged to move a step further in the building of the network on the one hand, and, on the other, was encouraged not to progress more quickly than the steering committee. Those conflicting assumptions were responsible for the awkward position of the coordinator

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12/14/2011

Meeting with Key Actors at the Wood Hospital

N= 10

At the end of December 2011, sixth months after the rejection of the second proposal, local actors felt more confident about the expected policy authorisation. The future of the Wood Hospital was by then clearer: on the one hand, the institution was being incorporated into a big grouping of public hospitals of the Red city, and on the other (where the reform was concerned) they preferred to ally with the PB Hospital, whose project appeared better adapted to the vast and rural territory in

which they were located. The network coordinator thus visited the village of Wood to learn how the working group responsible for the project inside the institution perceived the REST project. That working group was composed of social workers interested in the reform, in addition to psychiatrists and other professionals from the institution who were rather opposed to the reform, but were nonetheless obliged to think about its local implementation since the temporary head decided to ally with the PB Hospital. In order to prepare for the discussion, the network coordinator had sent the local proposal to these actors, and he was keen to know their reactions.

The coordinator stated that he had no power at all, before of insisting that issues relating to the respective investment of the two hospitals in the project would be sorted out by their heads.

Afterwards, he remarked that: "The main particularity of the REST project is the guidance platform. It is an idea of the head doctor. The basic idea is to bring the network (that is, all professionals and care structures part of the network) closer to the psychiatric expertise. It was also the main demand that I've noticed by meeting with different kinds of partners over the last months."

The participants raised various aspects of the concrete functioning of the guidance platform. The head doctor of the Wood Hospital asked: "Are we going to divide the platforms into two entities respectively established on the PB Hospital and the Wood Hospital's sites, or are we going to merge? If we divide the platform up, we need two psychiatrists; if we merge into the existing platform, the Wood Hospital's psychiatrist will be obliged to move 60 kilometres away from here to play his role in the reform. Given that we already have great difficulties to recruit psychiatrists, that solution seems quite difficult to me."

A social worker responded by mentioning that, according to him, "That decision would depend on the extent to which the workload would increase over the coming months." In passing, he also said, "I think that the project is too much centred on the hospital." The temporary manager responded to the social worker's pragmatic reasoning with: "This would depend on how the project is practised!"

With regard to the concrete practices, the head doctor of the Wood Hospital asked, "Is everybody authorised to call the guidance platform?" As previously, the coordinator responded that, for the moment, access was limited to medical professionals, to avoid the platform having to cope with an overwhelming workload. That response corroborated the feeling of the social worker, who suggested that other professionals should also have direct contact with the platform.

The head doctor of the Wood hospital disagreed: "We must be realistic, if GPs asked for that privileged relationships with psychiatrists, we must give them satisfaction, at least for an initial period." The coordinator agreed with that opinion; he reminded participants that it was thanks to the therapeutic projects that the relationships between GPs and psychiatrists had been so substantially improved. The temporary head of the Wood Hospital concluded: "The Psy107 must enable to federate many things that already exist; those things will come on top of what is called Psy107."

The head doctor of the Wood Hospital reacted to that statement: "What about the Community Mental Health Services?" The coordinator responded that they would participate in function one, just as the public authorities expected them to do. The head doctor thought that they had a greater role to play in the reform; he had the feeling that the reform was going to

reorganise the whole system to complete a device (the settlement by division of work settled in 1975) which had not worked properly! Now, every institution would have to work harder but CMHS would be almost free to remain outside the reform!

A GP who attended the meeting expressed interest in this issue. He asked the coordinator whether CMHS were involved in the project, and what role they had to play in the local network according to conception of the reform put forward by the PB Hospital? The coordinator responded: "They are represented in the steering committee, I do not know if we take their expectations into account, but they are there… neither do I know if our project is centred on the hospital, but it is centred on medical aspects, for sure. We are concerned about care for mental health problems, not about social difficulties in general. We agree to use the 107 to improve the functioning of the hospital, but not to demolish the hospital."

The head doctor responded in kind: "That fear is shared by many people; it should be observed that public discourse and writings suggest that hospital care are harmful to people with mental health problems; that there are better ways to treat them away from the hospital. Me? I'm just illustrating the fear, and the fear has always a raison d'être. The fear of psychiatric hospitals in relation to the reform should be taken into account."

This meeting revealed the existence of two groups of actors inside the second promoter hospital, the first enacting a logic of action consistent with that of the Federal Coordinator, and the second enacting a logic consistent with that inscribed in the local version of the guide. The successive interventions of the temporary head of the second promoter hospital showed that he understood those contrasted logics perfectly, and that he was accustomed to mediating their interactions. For his part, when performing such mediating interventions, he clearly relied on the pragmatic logic proper to the reformist network. His intervention in the following steering committees gave further instance of that pragmatic logic.

Concerning the network coordinator, he seemed to lose the control of the discussion, which was quickly moving from one participant to another, without giving him the opportunity to explain his view on the network. Finally, he concluded the discussion by endorsing the local version of the guide, in spite of the remarks expressed by some participants in the course of the meeting

4.2. The Second Sequence of Enactment: Forgetting the Guide (?) and Stabilizing Local Alliances

Before relating the second sequence of enactment, which took place between January 2012 and July 2013, we must describe the rise of three kinds of inscriptions resulting from a significant reinforcement of the process of mobilisation conducted by local actors. Then, after having briefly outlined the relational, political and organisational context in which that reinforcement took place, we will move on to consider further enactments of the guide.

Most of these enactments occurred during meetings of the steering committee. Indeed, during that second sequence, global uncertainties relating to the future of the project and changes in the coordination function caused discontinuities in the working process of the committees of function.

These committees eventually started work only at the beginning of the third sequence, with the appointment of a new coordinator who succeeded in stabilising the REST project.

Regarding the steering committee's meetings occurring during the second sequence, it is worth mentioning that they were all directed toward taking the local version of the guide far away from the initial inscription. That move started in a context characterised by the worsening of the relational, political and organisational environment in which the project was developing. Alongside that context, local actors started conceiving of solutions to finance the project on their own. That idea of moving outside the political framework was quickly followed by the idea of moving outside the conceptual framework inscribed in the guide. Those successive moves were not really opposed to by the network coordinator, who decided to take early retirement at the end of 2012. The weakness of the coordination function made room for the complete appropriation of the local version of the guide by the heads of the two promoter hospitals. In this respect, that appropriation might be understood as a necessary step to reinforce their "alliance against nature". As we shall see, the process of taking the local version far away from the guide reached its peak in May 2013, when the heads of the PB and Wood Hospitals organised a public event intended to support the collective endorsement of a refined conception of the local version of the guide.

4.2.1. *Interlude: January-March 2012, the Situation Worsens*

As showed by the following table, during the period from the end of 2011 to March 2012, successive actions taken by the PB Hospital gave rise to a series of inscriptions, including newspaper articles, an article in the *Journal du Médecin,* and an exchange of letters between local actors and policy makers. Those inscriptions reflected changes in the mobilisation process, which moved at an accelerated rate and took on wider dimensions. In turn, they reflected the worsening of the relationships between local actors and policy makers.

19/12/2011	Letter from the promoter hospital to the Federal Minister for Public Health
23/01/2012	Newspaper article: *Psychiatric home care? It is possible.*
10/01/2012	Article in the *Journal du Médecin*
11/02/2012	Newspaper article: *It is possible, but it is blocked!*
20/03/2012	Letter form the Red platform to policy makers
20/03/2012	Response from the federal minister to local actors

a)   Key Inscriptions

These inscriptions had different intents and were directed to different publics.

The first kind of inscription comprised newspaper articles directed to lay people living in the geographic area targeted by the local network. The first article intended to promote the local undertaking to the general public. It stated that the PB Hospital was developing innovative mental health care facilities in the context of global orientation of national and international mental health

policies. It stressed that those new facilities would certainly improve the effectiveness of the local mental health care system.

Following this, the second newspaper article told the general public that the innovative undertaking prompted by the PB Hospital had been blocked for budgetary reasons. It stressed the negative impact of that situation on the motivation of the new teams – "the motor is running but the wheels don't turn" - before emphasising the necessity for the local project to be authorised to start by the Interministerial Conference as soon as possible.

The second kind of inscription was written for the *Profession of Medicine* (Freidson, 1988), enacting the profession's public discourse against the political strategy underpinning the reform. Through his article, the head doctor of the PB Hospital told his colleagues that the reform that was unfolding in the domain of psychiatry was challenging the core values of the profession: the model to be implemented had neither scientific nor academic legitimacy; it was imposed on professionals by the policy arena; and it relied on a governance model involving market-based regulation mechanisms conflicting with *The Logic of Professionalism* (Freidson, 2001). Consequently, it did not ensure the maintenance of principles proper to the health care system, especially the principle of universalism.

> "Is confusion reigning over our societies? … We could answer that question by evoking the handicraft – not to say bricolé, project for the future of mental health …. Although that project is neither financially nor symbolically rewarding, and although the actual number of psychiatric beds per inhabitants is very different from what had been put forward, the mobilization of institutions to participate in that project had been driven by logics of competition, dear to our consumer society. Induced by models whose singularity is matched only by their extremism, the management of that project never considered local actors, be them psychiatrists or GPs, leading to a selection of the applicants strictly based on arbitrary judgements …. Now, Belgium is actually divided up between a series of territories which are developing particular models of care, and another series of territory which is not benefiting from that opportunity. Practically, this means that a care system that is viewed as particularly efficient will be, or won't be, available to their respective population …. Would the right to health be limited to the winner of a competition whose rules are particularly unfair, and thus opened to criticism? … But the problem of governance does not end there, it expanded to dialog structures [i.e. the mental health care dialog platforms] which had been diverted for their mandate to such an extent that they came to act in way that sanctioned an unequal resources sharing. Would it not be easier to allow applicants to participate in the reform by sharing the available resources rather than keeping those resources for wealthy applicants?" (*Journal du Médecin,* 2012, p.26)

The third kind of inscription consisted of letters addressed by actors representing parts of the local system for addressing personal problems to the Federal Minister for Public Health.

The first letter was signed by the PB Hospital. It reminded the minister of the context in which Reform 107 took place and outlined its recent developments, before suggesting that, if the local project was not recognised and financed by policy makers very soon, local actors would stop the progressive move toward networking that they had initiated two years before.

The second letter was signed by the local Mental Health Care Platform. It was written in the name of a wide range of care providers who were members of the platform. Through that letter, the platform expressed both its satisfaction that the FUL project (see following case study) succeeded in the selection process in May 2011, and its disappointment about the failure of the REST project. It mentioned that the platform was aware of the uncertainty brought about by budgetary issues. However, it wanted to stress that the PB Hospital had devoted significant efforts to change its project according to the remarks of the jury. Thus, by considering the quality of that project and assuming that it would be more consistent if care providers from the whole territory of the platform (the Red Province, including the surrounding of the Red city [FUL project] and surrounding of the Green city [REST project]) had equal opportunities to participate in the reform, it asked the Interministerial Conference to allow the project to start as soon as possible.

b)   Relational, Political and Organisational Context

These three kinds of inscription took place in a particular context. Three aspects of that context are worth noting. First, the relationships between local actors and policy makers were worsening. To the extent that they complied with all the requirements made by the public authorities, local actors perceived the successive refusal as particularly unfair. They expressed their feeling of injustice by highlighting the inadequacy of the composition of the jury and the arbitrary and subjective judgements on which the selection process was relying:

> "We feel like we were judged by a political and administrative court. We are wondering about the competencies of the jury to judge us. Could you imagine that they asked to X (the head doctor) how he was doing his admission! He will do it as he has always done it! …Qualitatively, our project is neither better nor worse than other projects. The reasons are political." (Interview with D2.2, 2012/01)

The head doctor corroborated that feeling. He was amazed that professional bodies were not involved in the selection process, and he directly questioned the Federal Coordinator's ability to cope with that process. For his part, the head of the hospital could understand that the Federal Coordinator's objective was to promote psychiatric rehabilitation, but he was deeply upset by what he perceived as the complete confusion of that objective with those of the reform.

Second, in December 2011, shifts in the political context resulted in concrete opportunities for the jury to complete the selection process. In fact, from the beginning of the process in April 2010, Belgium was undergoing the longest governmental crisis of its history. The crisis made the context in

which the Federal Coordinator and his colleagues were working increasingly uncertain. Consequently, they did not know which the budgetary decisions of the next government would be, and had no way of knowing whether those decisions would enable them to continue with the reform. Faced with this context, they decided to encourage the applicants to keep improving their local version of the guide while waiting for a stable governmental agreement. The response of the federal minister to local actors, in March 2012, confirmed that policy decision: it stated that the continuing financing of local coordinators evidenced her commitment not to halt the change process that was - thanks to their work - taking place at the local level. In December 2011, however, a government agreement had finally been reached, and local actors therefore felt that there was no longer any reason to wait. Accordingly, they increased the rate and the scope of their mobilisation process. In so doing, they created a situation where the policy decision (for which the different kinds of actors targeted by the mobilisation were now waiting) had to authorise the project's start. That mobilisation process reached its peak in June 2012, when local actors visited Brussels and protested under the windows of the Federal Service for Public Health until what they perceived to be the right decision was taken.

Third, the involvement of the head and head doctor of the PB Hospital was causing a growing discontent among the hospital's medical and paramedical staffs. They thought that the new head of the institution was more interested in that uncertain and external project that in its internal management (Interview with C1.4 2011/12/14). The head of the institution felt it was essential to sort that situation out very quickly. Not only was the motivation of the hospital's workers involved in the project decreasing, but the other workers were wondering about its relevance and the board of governors was urging him to take a decision. In his view, however, given the alliance with the Wood Hospital and managerial decisions taken over the last two years, the hospital had arrived at a point of no return. He therefore had no other choice than to convince the jury to authorise the financing of the local version of the guide.

4.2.2. *Enacting the Local Version of the Guide Against the Political and Conceptual Framework Inscribed in the Original Guide*

09/02/2012	Steering Committee (first committee with the head of the promoter hospital 2)
14/03/2012	Steering Committee
25/04/2012	Internal evaluation of the therapeutic projects Steering Committee
05/2012	The coordinator announced his early retirement
20/06/2012	Steering Committee
19/12/2012	Steering Committee with the new local coordinator and the Federal Coordinator
03/02/2013	The new local coordinator gave her resignation to the network
05/2013	Kick off

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02/09/2012

Steering Committee

N=12

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This meeting took place in the context just described. The presence of the temporary head of the Wood Hospital was accounted for by the alliance that had been reached at the end of 2011. The discussion set in opposition the head and head doctor of the PB Hospital (who denounced the incompetency of the jury and the lack of objectivity in the selection of the project), and the temporary head of the Wood Hospital, who suggested endorsing a pragmatic logic of action: starting the project without waiting for the authorisation of the jury.

The head of the PB Hospital first told the participants that he was going to update them on the project's current situation very briefly, because, "All of that has become very irritating." He first mentioned the decision of the NIHDI to give local care providers the opportunity to create psychosocial rehabilitation centres (PRC) where structures of that kind did not already exist. He was surprised that the NIHDI had taken such measures in relation to Reform 107, which had been decided for by the FPS PH. Second, he told the participants that the local platform had finally agreed to support the local version of the guide. Third, he started questioning the quality of the jury, by highlighting that its members: "are all civil servants, there are neither clinicians not representatives of [hospital/professional] federations."

The temporary head of the Wood Hospital stopped him: "We can always deplore that situation, but now we have to wonder how to conceive of our project, by taking into account the fact that it will not be financed by the Psy107!"

The head of the PB Hospital retorted: "That is an interesting piece of information!" In response, the temporary head specified that it was not information but reasoning. He was simply but absolutely convinced that the interministerial decision depended on budgetary questions only. He stated that the federal minister had a positive attitude to the reform: "At the beginning, they sincerely thought that they would be able to support the initiative over time, and then they had to deal with big constraints imposed by the European Commission on the budget. I agree that is unfair, but we cannot wait any longer. I think that the strategic analysis of the situation is of secondary importance, we had better think about means of financing our project on our own and to think about how to bring existing facilities together to do something similar to the Psy107."

The participants agreed to consider that suggestion, and they spent most of the meeting exploring the possibility of using the "B4" (a part of the hospital budget that can be used in flexible ways) to finance the pilot.

At the end of the meeting, however, the coordinator asked attendees to spend some time working t on the network agreement. The temporary head of the Wood Hospital said quite directly that he disagreed with the central role that was given to medical professionals: "We cannot underestimate primary care and mental health professionals for self-centred professionals trained by Universities!"

Following that remark, the participants started discussing who should or should not be included in the range of professionals empowered to call the guidance platform directly. The head of the PB Hospital stopped them after a while: "We have been discussing every words of

the charter to please everyone. Now, that text must be tested out and put into practice. The work of conceptualisation was necessary, but now we have to relate the concepts to the practices."

The head doctor added: "We will not succeed in convincing them (the jury) without concrete achievements."

The temporary head of the Wood Hospital introduced a new logic of action to the steering committee. The participants heard him carefully, because they knew that he was coming from the socialist pillar and that as such he had another view on the reform and the situation of the local project. In contrast to his consensual attitude during the previous meetings (December 2011), he expressed his disagreement with the central role that the local version of the guide gave to the medical profession. Thus, he told the participants, they would have to think of their project in another framework than that of Reform 107. He also made it clear that, thanks to their alliance with the Wood Hospital, they would have to rethink the local version of the guide. Finally, the last interjections of the head and head doctor of the first promoter hospital indicated that they had not lost hope of convincing the jury, although they decided to change their strategy.

14/03/2012

Steering Committee

N=12

This meeting was attended by the heads of the two promoter hospitals and the usual participants. It was the first meeting that was almost exclusively devoted to the structure of the network. Among the many issues raised by the participants, we will focus on the definition of the kinds of structures that should be involved in the network, the definition of the context in which the network took place, and that of the different working groups composing the network.

At the beginning of the meeting, the first promoter was so annoyed by the story of his project that he wanted to say nothing about it. Thus, he said, "Let's talk about the structuring of the network." He started the discussion by stressing the inscription, in the text of the network agreement, of the expression "every structure". He wondered if the coordinator meant all the care and social structures or only the mental health structures. In keeping with his view of the reform, the second promoter responded: "We must involve all the health structures, including primary care structures."

The participant agreed that the objectives must be defined in such a way as to enable a wide range of structures to become part of the network. Later, the participants asked if social insertion services were also concerned. A GP responded that, if they referred the definition of the WHO (which stated that health is a state of social, physical and psychological well-being) it was not necessary to specify that social services were involved! The head of the psychiatric PB Hospital agreed. Nevertheless, assuming that social rehabilitation was the primary concern of the federal authorities managing the reform, he would prefer to explicitly involve the social

structures. The head doctor supported that argument by reminding participants that the jury had criticised them, following their first application, for not including social services in the network.

The coordinator read the network agreement. When he arrived at the section on the context, the head of the psychiatric PB Hospital interrupted him to specify that he would prefer not to limit the network context to the policy guide. In his view, the local area and its rural character were as much part of the context as the guide. The participants did not disagree.

Following this, the coordinators started describing the working groups involved in the network. Several participants expressed concern that there were too many groups. The head of the PB Hospital agreed, before suggesting replacing the function committees with subject groups, created according to the needs of the networks. According to him, the concept of "function" involved a relational approach to the network's resources, resulting in a sense of identity that would lead, in practice, to the creation of new pillars in the system.

At the end of the previous meeting (02/2012), the suggestion of the second promoter to implement the project outside the federal framework was still floating. At the end of this meeting, the suggestion of the first promoter to replace the function committees by subject groups was now floating as well. Meanwhile, given the commitment of the first promoter to succeed in getting the explicit recognition of the jury, some strategic references to the guide had been made. They led the participants to enlarge the structural scope of the network to explicitly include social services. Thus, at this stage, thanks to budgetary uncertainty, the steering committee continued to enact the link between the local version and the initial inscription, while refusing to limit the first to the second. Moreover, it endorsed the "B4" and the subject groups as instrumental and conceptual solutions that might be substitute to that delicate link.

Internal Evaluation and Steering Committee

25/04/2012

N=15

This steering committee took place just after an evaluation meeting where the network coordinator presented the results of the internal evaluation of the therapeutic project: how many users had been cared for in that context; how many GPs participated in the therapeutic consultation; the main points learning achieved through the pilot; and so on. This presentation was an opportunity for the coordinator, the head doctors and GPs to describe the particular relationships they had developed to the addressing of personal problems in the course of that pilot.

The steering committee was not attended by the head of the Wood Hospital who temporarily stopped participating in the steering committee at this time because the internal reorganisation of the institution was accelerating.

The head of the PB Hospital first stated that he was disinclined to start without the authorisation of the jury. It was a question of honour: they had agreed to comply with the

requirements of that jury and it was therefore out of question to start without that agreement. The participants did not disagree.

The participants discussed the situation of the Wood Hospital for a while, and the network coordinator announced that the Federal Coordinator intended to visit the steering committee. Then, he specified that he was visiting all the projects, both those already working and those still waiting for the authorisation of the jury. The participants observed that, "If he wants to come, it is difficult to prevent him from coming!" The coordinator confirmed this. Following this, the meeting discussed a number of more or less serious matters, for instance: "It is industrial espionage! We must make a false meeting … if he really comes, we must know what we are going to tell him, and all of us must be there, to prove him that we are still mobilised by the project."

20/06/2012

Steering Committee

N=12

This steering committee had been preceded by two important events. First, following the last meeting, the members of the steering committee came to know that one of them was no longer committed to the project: the network coordinator had announced his early retirement. In fact, he had started questioning his involvement in the project following the first meeting with key actors from the Wood Hospital. From that point onward, he wondered whether he and his institution had not engaged too deeply and too quickly in the project (Interview with C2.4, 2011/12/14). At the beginning of 2012, the worsening relational and organisational situations served to reinforce his feeling that, in such conditions, he could not continue to support the project. He therefore decided to announce his early retirement as soon as possible, with a view to leaving sufficient time for a full handover to his successor.

Second, two days before the meeting, the Interministerial Conference (IMC) had finally decided to authorise local actors to implement the local version of the guide, as inscribed in the second proposal (plus addendum) presented above. Knowing that the IMC met on the 18th of June, the network coordinator, together with network coordinators from other projects also waiting for authorisation, had gone to Brussels to lobby the IMC. Thus, he was pleased that the head of his institution could tell the steering committee that they were allowed starting their project.

As usual, the head of the PB Hospital opened the meeting by giving the steering committee some information about the project mobilisation process. The local coordinator and the head doctor seemed to be surprised that he did not start by announcing the IMC decision.

The head came to that decision only a few minutes later, by telling the participants that the two promoter hospitals were allowed to freeze psychiatric beds as of July 2012, that the additional financing compensation relating to the medical function would be granted to the hospitals as of 2013 onward and, finally, that from the moment when the psychiatric beds were frozen they

would have six months to start working with the mobile teams. This had been verbally agreed by the IMC, but the decision had not yet been confirmed in writing.

The head doctor reacted: "So the project has been sanctioned by the Jury and we can start!" Following his intervention, the head continued: "What is essential is to thank all of you for still being here to ensure a good representation of the local care system and to show that there is enough motivation at the local level."

Following this, the participants discussed some practical details relating to the implementation of the mobile teams. Their discussion led them to discuss the risk taken by the hospital in developing mobile teams. The head reminded the group that obstacles met during the selection process had worsened those risks. The coordinator responded: "I want to boost the morale of the management! Because the policy decision is taken, and you know very well that it is always like that in the hospital system: the policy decision is taken first, then hospitals have to take significant risks, and finally the budget is released!" He also reminded participants that the mobile teams should start working very soon. Thus, they had to focus on the structuring of the network and developing the five functions. He asked the participants if they would agree to create a working group with the unique role of framing the network. The participants agreed and started a discussion about the five functions. They agreed that the priority was to develop functions 1, 3 and 5. For his part, the head of the PB Hospital commented that he would have preferred to work with subject groups, "Because the institutional life is carrying values and we are not here to take them apart." The coordinator highlighted that the FPS PH had said that there *was* no network outside the five functions

Finally, at the end of the meeting, a participant raised the fact that they needed to find a new coordinator. They agreed that the steering committee had to define what the network expected for its future coordinator.

During that meeting, the head of the PB Hospital looked like he was no longer motivated by the project. It seemed that, in a way similar to the network coordinator, his motivation had been significantly threatened by the selection process. This opened a period during which the local version of the guide itself became uncertain. Its questioning started on the occasion of the following meeting, during which the Federal Coordinator directly told local actors that the basic philosophy of their local version conflicted with that of the original guide.

19/12/2012

Steering Committee

N=19

This meeting was the first steering committee attended by the new coordinator, and the last attended by his predecessor. It was also attended by the Federal Coordinator.

In preparation for the meeting, the outgoing coordinator had circulated the drafted version of the network agreement to the members of the steering committee. He had appended a short letter (dated 30 October 2012) to the document, stating his commitment to reach an agreement on that document. He

wrote that they spent most of the steering committees wondering about the project's political situation. Now, they were about to start implementing the project and they needed that agreement: if they succeeded in signing it at the end of the next meeting, this move would give a positive signal to public authorities.

During the meeting, the new coordinator went through the document, article by article. She was continuously interrupted, either by the head and head doctor of the promoter hospitals or by the Federal Coordinator. Both sides used the document to support their conflicting conceptions of how to reorganise the Belgian system for addressing personal problems.

The new coordinator started by introducing herself briefly. Following this, she quickly moved on to discuss the network agreement.

The temporary head of the Wood Hospital remarked that Article 1 of the document stated that the network would develop integrated care around the reference doctor of the patient (either a GP or a specialist). He suggested that it was not necessary to specify that the reference doctor was either a GP or a specialist. The participants disagreed and started discussing the specific role of the GPs in the network for a while. The Federal Coordinator interjected to remind them that the reform was not exclusively devoted to people going to or leaving psychiatric hospital: "The objective of the reform is to organise care provision in such a way as to avoid specialised care. There has been much misunderstanding and appropriation of the object of the reform. Considering that you are going to start in January, it is worth reminding ourselves of what the objectives are."

Article 5 of the document related to the medical responsibility of psychiatrists. It raised many questions. However, the Federal Coordinator contended that many projects had already stressed the need for changing the legal framework for medical responsibility to make it suitable to the mobiles teams' working conditions. He reported that the FPS PH was currently considering the issue.

The next article concerned the structure of the network. The temporary head of the Wood Hospital suggested creating a non-profit association. The Federal Coordinator immediately said that this was completely out of the question! If the authorities had wanted to implement the reform through the intermediary of non-profit associations, they would have made the mental health care dialog platforms responsible for that.

"Non-profit associations," he said, "involve questions of power; they consist in creating and changing strategic alliance in relation to particular questions. We wanted to give the power back to services users and their relatives. …therefore, we do not want a committee to manage the network coordinator. The network coordinator must be at the top of the network. You can always disagree with that, but it is our position."

The head of the Peter Brothers Hospital strongly disapproved: "When an institution gives a particular mandate to a particular person, that institution wants that person to be accountable for that mandate! The word 'mandate' involves the obligation to bring something back."

The Federal Coordinator responded: "If you prefer that I leave, I will leave. But I want you to know that the FPS and the Federal Minister for Public Health want to work directly with the network coordinator. For us, she is the reference person. The hospitals are just go-betweens. If we had had other means to finance the reform than the hospital budgets, we would have preferred to use those alternative means. The coordinator had to act as a mediator; there is nobody above her, and nobody below her."

The head of the hospital emphasised: "Neither above nor below!"

The outgoing coordinator thanked the Federal Coordinator, before explaining to him that that document had resulted from the local story of the project. The Federal Coordinator understood what he meant and told them to keep their document and to adapt it along with changes in the ongoing story of their project.

The head of the PB Hospital and head doctor joined together to tell the Federal Coordinator that they agreed to conceive of that document as a work in process. Nevertheless, they wanted to agree a firm basis, acknowledging that, "Perhaps this is a protective attitude, but it is necessary."

In the course of this meeting, the Federal Coordinator questioned every aspect of the local version of the guide. First, the objectives of the reform were not to improve specialised care by improving their connections to primary care, but to avoid resorting to specialised care in the first place. Second, federal authorities were not seeking professionals' opinions about changes in their rights and obligations; they were making the changes on their behalf. Third, the power of decision had to leave the steering committee as soon as possible, to move towards services users and their relatives. That was the only objective with which the network coordinator had to comply. Fourth, institutions were not asked to think about how to better reorganise the Belgian system for addressing personal problem, but instead were to apply the federal version of that reorganisation. And, finally, local actors had not to concern themselves with elaborating new versions of change at local level, but simply had to put change into practice.

This meeting made it clear that, whatever they thought about the local/federal version of change in the system, local actors had to translate it into concrete practices. During the following steering committees, they decided to organise a kick-off day, where the network partners could collectively endorse the local version of the project and express their respective concerns in relation to its different dimensions.

That decision had been motivated not only by the federal authorisation to start the pilot, but also by the appointment of a new manager at the head of the Wood Hospital. She had previously worked at a big grouping of hospital in which the Wood Hospital had been incorporated and, interestingly, she had no particular idea of what Reform 107 or the local project should be. She was a manager trained in management. Accordingly, she was more concerned about developing a project contributing to the recovery of the institution than about the basic philosophy of the reform. That position appeared to provide a good starting point for developing an implicit alliance with the head of the Peter Brothers Hospital. In fact, it allowed the heads of the two institutions to endorse the working assumption that what was good for both institutions would be good for the REST network.

The new coordinator did not resist that working assumption. Indeed, by the end of February 2013, she announced her resignation to the members of the steering committee. She stated simply that she had not accurately evaluated the challenges involved in the project and that she felt unable to cope

with such challenges. At this point, the heads of the two institutions were the *de facto* project heads. Accordingly, they took leadership in organising the kick-off day. They set up a working group composed of members of the steering committee. That group quickly decided to devote the first half of the presentation of the local version of the guide and its development in the course of the past two years, and the second half to workshops focused on defining subject groups relevant to local needs. Implicit in this was the mark of the new working assumption. However, with a view to connect the enactment of the local and antagonistic version of the guide to the federal framework, they enrolled an actor involved in the federal training programme to manage the workshop. By endorsing that mandate, the federal trainer sanctioned the idea of replacing the committees of function with subject groups.

4.3. **The Third Sequence of Enactment: the Comeback of the Guide**

The third sequence of the local enactment of the guide was managed by a third coordinator. She started working few months after the kick-off. At that time, the local network had four main particularities. First, the power of decision was held by the alliance formed by the heads of the two promoter hospitals. Second, on a practical level, the network was emerging from and developing around the guidance platform. In this respect, from the moment they had the authorisation to start, the head doctor and a young nurse specialising in psychiatry and responsible for the new mobile teams had devoted much effort to the platform development (Interview with the coordinator of the guidance platform, 2012/06; activity report of the guidance platform, 2014/09). Thanks to their combined efforts, the project quickly achieved the mobile function (F2) in a way similar to other projects that started developing in 2011. Third, as we shall see, on the occasion of the next meeting, not only had the function committees not met for a long time, but the very concept of the function committee had been replaced by that of subject groups. Fourth, the Federal Coordinator had heard about the kick-off event and the decision to work with subject groups and, accordingly, would no longer associate himself with the project (Interview with the Federal Coordinator, 2014/02). Thus, in a few words, it appeared that the second sequence of enactment of the local version of the guide had set a context in which the local version of the project could develop without further reference to the initial version. This complete disconnection had been achieved by enacting the original connection in conflictual ways.

The new coordinator was a psychologist who had experience in human resource management. She came from the German-speaking part of the area, though she was now living and working in its French-speaking part (Interview with the third coordinator of the REST Network – C2.1, 2013/08).

She spent most of summer 2013 meeting with people who could help to develop her understanding of what was at issue in that project, and in the reform in general. She carefully listened to the versions of events told by the heads and head doctor of the promoter hospitals, the Federal Coordinator, the coordinators of other exploratory projects developing in neighbouring areas, and to our own story of the project's development (Interview/meeting with C2.1, 2013/08).

She then drew her own image of the project's situation from those accounts. That image presented the network as divided in three areas, or sub networks: that of the PB Hospital; that of the Wood Hospital; and that of the German-speaking community and the neighbouring French-speaking communities. She set this representation of the project in opposition to more usual representations describing it as divided between the areas of the two promoter hospitals. She was convinced that the main organisational and relational challenges involved in the project were to bring these three parts together.

She was aware that the implementation of the guide was simultaneously raising power and ideological issues at the local level, although she did not know the fine detail of those issues. Nevertheless, she had decided to fully embrace her role of coordinator, as defined in the guide: "I am responsible for implementing the guide at the local level, if they disagree with that, they would have to find someone else" (Interview with C2.1, 2013/08).

Finally, she knew that her mandate would start with a big challenge: that of responding to a call for projects launched by the NIHDI with the aim of financing new psycho-social rehabilitation structures on the territory of exploratory projects which lacked adequate resources to realise the third function. She was committed to involve all three parts of the project in the creation of that structure (Interview with C2.1, 2013/08).

The following section relates the different steps taken by the new coordinator to move from that conflicting situation to the presentation of the new structure of psychosocial rehabilitation to the Federal Coordinator, in September 2014. It starts by outlining initial debates raised by the position endorsed by the new coordinator. It then relates her successes: in reaching an agreement on the network agreement; in replacing the steering committee by a network committee enlarged to function representatives; in making that committee move from one place to another; and, finally, in responding to the NIHDI call for projects.

04/09/2013

Steering Committee

N=15

This steering committee was the first meeting managed by the new coordinator. The new coordinator and the heads of the PB and Wood Hospitals used the meeting to tell each other of the roles they intended to play in relation to the reform.

> The new coordinator welcomed everybody in his own language. She continued in French, telling the participants that she had met with the Federal Coordinator and other actors from the FPS PH, who required her to write a strategic plan, to include the development of organisational structures that were not or no longer existing (i.e. the function committees). She also mentioned the need to develop network instruments such as the individual care plan. In passing, she

specified that all these elements concerned the strategic level of the network; she was interested neither in political nor in clinical decisions.

Following this, she moved on to set out her vision of the network as divided between three areas or sub-networks. She stated that she was interested in the intersection.

Finally, she mentioned that, as a network coordinator, she wished to meet regularly with other local coordinators, to check whether the developments of the REST network correlated with the developments unfolding in other networks growing in the framework of the reform.

The head of the PB Hospital responded first. He said that he disagreed with the idea of working on the intersection, because it meant that the lowest common denominator would become to most important thing for the network. In his view, what was important was the diversity. He said: "If I move the focus from the intersection to the circumference, the network becomes an extension of myself; personally, I find this much more interesting. I prefer to see the network as an extension of our institution, through different kinds of partnerships, than as a reduction of our institution to specific functions."

The heads of the two promoter hospitals then joined together to remind participants that an important task had been carried out by the network partners during the kick-off meeting, before insisting on keeping the idea of working with subject groups rather than function committees. The head of the PB Hospital added that he felt that the public authorities were going beyond the limits of their jurisdiction by asking them to implement specific tools such as the individual care plan. He linked the individual care plan to the Minimum Psychiatric Summary by stressing that mental health institutions and professionals opposed the latter for ethical reasons. Finally, he raised the question of the relationships between local actors and public authorities, putting that: "We are not going to reject their demands, but we have to translate them in our own way. That is an administrative demand. If an academic authority tells us that a particular solution is better than another, we will more easily accept that solution; but, in front of a solution put forward by an administrative authority, our role is to lead them to them to think differently."

The coordinator responded last: "There is a framework defined by the FPS PH, and we have to comply with that framework."

The head of the PB Hospital responded: "It's a peculiarity of psychiatry to "recall the frame"."

During the meeting, the coordinator attempted to reconnect the REST project to the federal programme and other exploratory projects developing in that framework. Her conception of the network structures and procedures directly reflected the conception claimed by the Federal Coordinator: it brought him back into the meeting room. In turn, it also induced a strong reaction of the two promoters, who opposed that conception by restating their conception of the reform. The coordinator seemed disconcerted by those reactions and astonished by such opposition. She did not know about the story of the Minimum Psychiatric Summary; she ignored what had occurred during the kick off meeting, and she did not understand the conflict between proponents of the traditional coalition and those of the reformist network. As we shall see, the fact that she did not know about all of that enabled her, to a certain extent, to flout the resulting disagreements and oppositions.

| **25/09/2013** |
| **Steering Committee** |
| **N=18** |

The NIHDI launched a call for project a short time prior to this meeting. It intended to provide exploratory projects lacking the resources required to realise function 3 with the opportunity to create new psycho-social rehabilitation centres. Proposals had to be submitted in October 2010. Thus, this meeting was the last opportunity for the partners of the REST project to build a consensus and to inscribe it in the new care structure.

> The network coordinator started the meeting by urging the participants to reach a consensus. She warned them: if they did not reach an agreement, a decision would be taken by the network committee. In that framework, the different parts of the network would attempt to bring the project into their jurisdictions, and there would be a winner and at least two losers. Instead, she suggested them to work in a way to ensure that everybody got something from the project.

> The participants could not disagree with that proposal. Accordingly, they started wondering where to establish that new structure - either in the Green city, or the south or in German-speaking parts of the area? They spent the whole meeting considering different alternatives, by paying attention to the spread of the population over the area and questioning whether one city was more easily accessible than another.

> The meeting ended without an agreement having been reached. Instead the participants agreed to set up a working group, which would be in charge of determining a location and devising the psychosocial rehabilitation structure. Finally, the head doctor of the PB Hospital drew the attention of the participants to the specificity of psychiatric rehabilitation. Another participant confirmed that it involved particular techniques and principles, before of mentioning that the NIHDI would carefully check whether they had been taken into account in devising the project. The coordinator responded a bit nervously that those who knew about those principles and techniques were kindly invited to participate in the working group and that she would be pleased to learn about this aspect of care.

The meeting did not result in a consensus, as expected by the coordinator. However, it did set up a working group, which had the mandate to create a structure belonging to the network as a whole. The new coordinator, who was increasingly aware that some actors were using their professional culture as a resource against her managerial strategy, did not perceive it as a success. Following the meeting, the working group had to work hard and intensively to agree on a common proposal. That agreement was eventually inscribed in the proposal submitted to the NIHDI in October 2013.

| **15/01/2014** |
| **Steering Committee** |
| **N=18** |

The coordinator had prepared for this meeting in two ways. First, she drafted a new version of the network agreement. She was determined to go through this new version with the members of the steering committee and to write the final version before the next meeting. Second, she met with the heads of the two promoter hospitals just before the meeting, to propose to them the creation of a new network committee by enlarging the steering committee to include representatives from the committees of functions.

This agreement seemed acceptable to them. Thus, she was equally determined to lead the steering committee to set up a network committee, defined as an extension of itself to include the new groups of functions. In fact, the coordinator succeeded in giving up the idea of subject groups and restarted work with the previously defunct functions committees. She used these committees to support her strategy.

The meeting started with an explicit request made by the head of the PB Hospital to the coordinator to behave as the spokesperson of the project, not of the FPS PH: "public authorities put the coordinators between themselves and local care providers. Coordinators are in a very vulnerable position with regards to public authorities. And public authorities are using those coordinators of different forms and kinds to communicate any kinds of decisions to local care providers. I disagree with that attitude; they have to stop torturing coordinators, to assume their decisions and to communicate with us straightforwardly. I wish you to be the spokesperson of our project."

In response, she expressed her conviction that it was possible to move beyond those extreme positions. Finding the way of harmonising those positions was at the core of her role. She immediately enacted that role, by suggesting seeking for a middle way between rigidly applying the original guide and ignoring its existence: There is a document that has been sanctioned by the IMC, and that document cannot be completely reinvented! But, if we want to agree on our network agreement, we have to adapt that guide to our reality. Accordingly, I have drafted a new version of the network agreement by assembling elements from the guide with elements from previous drafts."

She then suggested relying on the same logic to gradually move from the steering committee to the network committee, defined as an extension of the steering committee to include representatives from the committees of function. That suggestion was followed by a period of silence from participants.

She quickly moved on to start work on the network agreement. She gave a copy of the five-page document to the 18 partners participating in the meeting. She started reading it, with a view to give them the opportunity to comment on the text. The main remarks made by the participants were the following:

P.1, §1

> Cette - 4ᵉ - réforme~~Celle-ci~~ est entrée en vigueur le 26 avril 2010 suite à l'approbation par la Conférence Interministérielle (C.I.M.) du guide intitulé « Vers de meilleurs soins en santé mentale par la réalisation de circuits et de réseaux de soins », qui définit les valeurs et axes de travail à mettre en place dans cette perspective de réforme.

The head of the PB Hospital put that Reform 107 was not "The Belgian Reform", but the *fourth* Belgian reform of mental health care. In the view of psychiatric hospitals, which underwent several reforms in just a few decades, the current reform did not seem so new. There were some new elements, but most of its content was already in the previous initiatives. According to him, if the current reform appeared as genuinely significant, it was because its proponents presented it as such, with a view to increase their political weight.

P.2, section 2 §1

> Les partenaires du projet souscrivent aux principes de soins, d'aide et d'accompagnement continus, sur mesure, accessibles à tous, et délivrés de préférence en milieu de vie, promus par la Réforme des soins en santé mentale en ~~Belgique~~Belgique, et en accord avec la philosophie de la Charte du réseau.

The head of a CMHS located in the German-speaking part of the area asked to add care accessibility to the list of the leading values of the reform agreed on by the local network partners.

P.2, section 3, §1

> Le partenaire s'engage à participer, dans l'esprit de la Réforme susvisée, à la constitution progressive d'un réseau d'opérateurs actifs, de manière directe ou indirecte, dans le champ de la santé mentale, en se reconnaissant comme opérateur dans au moins une des 5 fonctions suivantes (en référence au~~définies dans le~~ guide sus-cité) :
>
> REMARQUE : Les définitions vont être précisées dans les groupes fonction !

The head of the Wood Hospital suggested replacing the phrase "the five functions defined in the guide" with "the five functions; among others those defined in the guide". The coordinator preferred to keep a mention of the five functions defined in the guide, but she agreed to add some elements to those functions, according to the definition elaborated within the function committees. The participants agreed on that suggestion.

P.2, section 3, §2

> Fonction 1 : activités en matière de prévention, de promotion des soins en santé mentale, de détection précoce, de dépistage et d~~e pose~~'élaboration d'un diagnostic (première ligne)

The heads of the two psychiatric hospitals and the three CMHS partners of the network agreed to replace the notion of "early detection" with that of "reception of the demand of care", which was central to the missions of the CMHS. Both parties remarked that early detection and demand reception were wholly different matters.

P.2, section 3, §2

Fonction 4 : ~~unités intensives de~~ traitement résidentiel, dont projets d'unités intensives, aussi bien pour les problèmes psychiques aigus que chroniques, lorsqu'une hospitalisation s'avère ~~indispensable~~ indiquée

     The head of a CMHS suggested replacing the phrase "when hospitalization is unavoidable" with "when hospitalization is appropriate". The CMHS preferred the second expression, "Which refers to clinical criterions instead of political ones". The heads and head doctor of psychiatric hospitals agreed, before asking to replace "intensive residential treatment units" with "residential treatment units, among other intensive units". Indeed, in their view, it was impossible to transform all the treatment units into intensive units without having additional means to increase the clinical staffs.

P.3, section 4, §1

Dans le cadre de la Réforme, le terme « promoteurs » désigne les hôpitaux responsables de la mise en œuvre du projet 107 sur le territoire concerné ~~et du respect~~ dans l'esprit de la philosophie de la Réforme belge des soins de santé mentale.

     The head doctor of the PB Hospital did not agree to be responsible for the philosophy of the reform. The head of the hospital added: "It is too heavy to carry."

P.3, section 4, §4

est porte-parole du~~représente le~~ projet dans son ensemble et est associée à toute communication externe concernant le projet et ses composants.

     Some participants thought that the phrase "the coordinator represents the project" meant that the coordinator had power of decision. Thus, they asked to replace that phrase with "the coordinator is the spokesperson of the pilot".

30/01/2014

Function Committee 5

N=9

This meeting was attended by: psychologists from sheltered housing initiatives located in the German-speaking part of the area; representatives of social housing services located in the main city of the area; social workers responsible for family care services supplied by the Wood Hospital; and the manager of a sheltered housing initiative based in the extreme south of the area. The meeting proved that the coordinator had succeeded in interesting front-line professionals from the three sub-networks in the REST project.

The coordinator started the meeting by explaining to the participants that the Federal Coordinator was urging her to create an intermediate level in the project, between the steering committee and the committees of functions. Thus, they had not only to restart the work of definition initiated by the first coordinator, but to appoint function representatives to participate in the network committee. She specified that the first network committee would be organised in the building of a regional employment service situated in the biggest city of the area. In her view, symbolically, it was significant to organise the first network committee in that building, "because the reform is a global reform and I'm not sure that it is very clear for the members of the steering committee who are focused on mental health. I would also like to invite the Federal Coordinator to take part in a meeting of the network committee and to reframe the reform."

Following this, she gave the participants some new information about the reform in general. She first mentioned the requirement of the research teams to submit questionnaires to services users of mental health and psychiatric services involved in the network. She deplored the fact that researchers asked front-line professionals to do that work. Second, she described the "107 city" game; a kind of *Monopoly* which. had been created by project from the Brussels Region to help services users and their relatives to find their way in the reform. According to her, it was a very good way to better understand what was at stake in the reform. Third, she informed participants that the NIHDI had institutionalised the therapeutic consultation tested out in the framework of the therapeutic projects and that, from now on, that function would be performed by the multidisciplinary team of the guidance platform. The function could be activated by GPs, psychiatrists, social workers, psychologists, and service users' relatives. The participants were interested in this news. They asked if social workers also could call the platform to activate the mobile teams. The coordinator confirmed that this was the case.

Finally, she suggested initiating the building of function 5 by identifying the services involved in that function, "With a view to enable the partners to know each other and to understand their respective work. To be able to activate the network, we need to know the network." Accordingly, she asked the participants to prepare a document presenting their service. They would subsequently rely on those documents to reach a common definition for function and create "the I.D. card" of the function that they would give to the partners of the whole network. The participants agreed on the methodology. They were pleased to give concrete form to the project.

In the course of the meeting, the coordinator tried to interest front-line professionals in her strategy to improve the enactment of the guide inside the network committee. She asked them to help her in counterbalancing the power of the members of the steering committee. Following that strategic episode, she gave them key information about the project, which proved that the network was functioning and that they could use it.

19/03/2014

Network Committee

N=19

This meeting was the first network committee; that is, a committee composed of both the members of the steering committee and representatives from the committees of function. The network committee was not only an enlarged committee; it had become a peripatetic committee. In fact, from its first meeting in March 2014; the committee left the traditional meeting room of the PB Hospital to move from one place to another and across ecological and ideological lines.

As announced by the coordinator during the meeting of the function 5 committee, the first network committee took place in the building of a regional employment service situated in the biggest city of the area. That city was also the closest to the PB Hospital.

When they arrived in the meeting room (a big meeting room in a newly renovated historical building) the participants said that it made a change from the clinic; the sandwiches tasted much better.

The network coordinator first told the participants that the psycho-social rehabilitation centre was under construction. It was a product of the network as a whole, which had been created by network partners from the north and the south of the area, who represented the residential, community and rehabilitation ecologies.

Second, she introduced the coordinator of home care services, who was responsible for the administrative aspects of the therapeutic consultation. The latter informed participants that the NIHDI had decided to institutionalise the function of therapeutic consultation tested out through the therapeutic projects, and then explained how the new framework would be applied at the local level.

Third, the network coordinator introduced the representatives of the function committees. They succeeded one another to explain how their respective committees conceived of their work in relation to the network. Fourth, she distributed the final version of the network agreement to the participants.

Finally, she presented her strategic plan. She defined that plan by combining the committees of function with the subjects groups that had been defined on the occasion of the kick-off meeting. According to that representation, the network was composed of vertical pillars representing the functions, and each of those pillars had to consist of horizontal subjects including: continuity of care; management of crisis situations; care accessibility; and the activation procedure of the network.
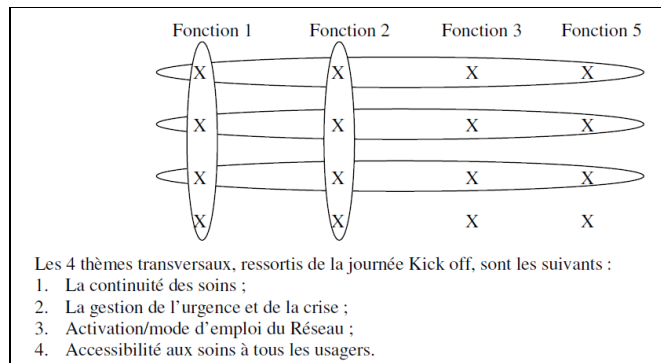
Figure 5 – REST Network: Strategic Plan

The meeting was incredibly consensual. The participants succeeded one another to present themselves and the role they had to play in the building of the network. Afterwards, by distributing the final version of the network agreement to the participants and by presenting them with a strategic plan assembling the federal and the local versions of how to build a local network, the coordinator put an end to longstanding debates about the respective values of those two versions.

30/09/2014

Network Committee

N=19

This was the third meeting of the network committee. The second network committee had taken place in a small city situated in the extreme south of the area. Except for the presentation of a new mobile team focusing on care circuits for inmates and working at the level of the province, nothing of particular interest had occurred during that meeting. The network coordinator had at this time been working for the project for around one year, and she took this opportunity to review the different challenges that the network partners had overcome, as well as future challenges falling to the network and function committees.

The third network committee, which is the last meeting related in our story of the REST Project, took place in a community mental health service located in the German-speaking part of the area. The head of the CMHS devoted some effort to put arrows along the route to the meeting room and to prepare the meeting space. The participants were welcomed by a great variety of coordinators standing in front of the door, including the Federal Coordinator, the Regional Coordinator, the two coordinators of the participation project and those of the care circuits for inmates. Their presence meant that, by reconnecting the local version to the federal version inscribed in the guide, the local coordinator succeeded in re-interesting the Federal Coordinator in the local network.

The local coordinator was inside the room, occupied in setting up her mobile projector, which she had bought when the network committee started moving from one place to another. The

participants remarked that, for the first time, they received a pen and a notebook. They also remarked that the quality of the sandwiches was unceasingly increasing. They thanked the head of the CMHS for welcoming them.

The local coordinator first asked the participants to introduce themselves to the Federal and Regional Coordinators. They started by stating their name, profession and the institution to which they belonged. The Federal Coordinator interjected to request that they mention the function to which they contributed instead of the institution to which they belonged. They started again.

The local coordinator then told the participants that the new Psycho-Social Rehabilitation Centre (PRC) of the network was due to start working after the following day, before introducing its manager. She was a young social worker who was significantly involved in the restructuring of the psychiatric Wood Hospital. She was just finishing a PhD in public health at the University of the Red city. She stated that she had always been interested in psycho-social rehabilitation and expressed her commitment to make the network a living entity through the PRC, which had emerged thanks to the work of the network partners. Finally, she explained that, alongside the daily management of the new structure, her priorities were to participate in the PRC training provided by the FPS PH and to take an active part in both the network committee and the committee of function 3.

Following that presentation, the Federal Coordinator congratulated the participants on their achievement. He told them that he was particularly pleased that each network had the opportunity to develop a PRC: this was important to the federal authorities.

After this, the representatives of the committees of function succeeded one another to explain their concrete achievements in implementing their functions and their future objectives. When describing the work of the mobile teams, the nurse managing the guidance platform mentioned that they were starting to think about the Individual Care Plan. The head doctor of the PB Hospital explained that, in the framework of function 4, they were trying to develop an accurate conception of psychiatric crisis and emergency, with a view not to transform social problems into psychiatric problems, and not to over-socialise psychiatry: "We would like to offer a good and well-balanced psychiatry."

In the course of that meeting, the participants succeeded in reconnecting the local project to the federal framework. The interventions of new actors, the young managers of the new PRC, the guidance platform and the representatives of the committees of functions, together proved that the social configuration was moving from a situation where interactions were dominated by the head and the head doctors of psychiatric hospitals, to a situation where new actors, embodying different knowledge and putting the functional model into practice, were responsible for part of the local network.

The presentation made by those actors showed the Federal Coordinator that they were enacting key aspects of his global conception (i.e. psychosocial rehabilitation, the individual care plan). In turn, the Federal Coordinator acknowledged the actions taken and the agreement reached by the actors of the local network.

Moreover, that reconnection did not entail further questioning of specific aspects of the local version of the guide, particularly the guidance platform and the network agreement. Thus, it seemed that, through the very tumultuous process related in this case study and after significant individual and collective efforts, the local system for addressing personal problems was ready to learn new games, consistent with local idiosyncrasies on the one hand, and with the global conception carried on by the Federal Coordinator on the other.

5.   CONCLUSION

In this conclusion, we will first look at changes that arose from successive sequences of enactment of the guide in the local system. Second, we will stress what the structural and social configuration of the system meant in terms of collective action that occurred in relation to the REST project. Third, we will raise the question of the role of inscribed and embodied knowledge in collective action, as observed in the framework of the local enactment of the policy guide.

5.1. **Changes in the Local System for Addressing Personal Problems**

The story of the REST project started with an initial shift in the structural landscape of the local system: the transformation of the old house of the Peter brothers into the guidance platform. That move demonstrated that the local system had arrived at a turning point in the reconversion process started several decades before. However, by centring the network on the PB Hospital, the guidance platform gave concrete expression to the local order prevailing at the start of the project. That local order was characterised by the significant power exerted by the head and head doctor of the PB Hospital on the REST project. It had not been contested by the first coordinator, who tended to step aside in deference to that strong alliance. The positions endorsed by that alliance were also routinely reinforced by the initial project partners, who came from a pre-existing local coalition directing the change process in a way consistent with institutional and professional interests.

By enacting the guide again and again, through successive attempts to write a local project satisfying public authorities and to interest local actors, key actors of the PB Hospital became increasingly aware of what the guide meant in the context of the change process. Accordingly, they increasingly expressed their dissent on the model suggested by the public authorities. They inscribed that dissent in their local proposal, for instance by insisting that the network committee and coordinator must be accountable to the steering committee. They also voiced that dissent on the occasion of several meetings. With the passing of time and following repeated failures of the PB to convince the public authorities to authorise the project's commencement, the disagreement turned into an open conflict between local actors and federal authorities, respectively advocating the logics of action specific to the traditional coalition and the reformist network. That conflict concerned the main dimensions of the policy programme, including the role played by different kinds of actors in the reform, the nature of their relationships, and the kinds of knowledge they referred to; with

administrative knowledge and political skills embodied by the members of the jury on the one hand, and academic and medical knowledge embodied by key actors of the REST Network on the other.

In the meantime, by leading local actors to consider the gap between their perception of the reform and the model advocated by federal authorities, that conflict made local actors increasingly aware of the meaning of the new policy programme and the uncertainty of the context confronting them. As a result, they started moving at an accelerated pace across ecological boundaries and ideological lines to create unthinkable alliances and to mobilise multiple supports likely to help them in obtaining the necessary federal authorisation. In that respect, it might be argued that, supported by an especially hard selection process (well-equipped in the terms of Law (1986)), the guide succeeded in stimulating new connections at the local level, resulting in enlarging the pre-existing coalition to include new actors with different knowledge. New actors with different knowledge meant, in turn, increased possibilities to enact the guide in a way more faithful to its global philosophy. The meetings of the committees of function, information meetings with key actors of the Wood Hospital, and the steering committees attended by the temporary head of the Wood Hospital, indicated the existence of such possibilities.

However, by maintaining a separation between the committees of function and the steering committees, key actors of the REST project succeeded, during this initial period, in preventing knowledge claimed by front-line professionals from directly questioning the definition of the project. Furthermore, when obliged to ally with the Wood Hospital, they enacted that alliance in a way that helped them to protect the division of work inscribed in their project. More precisely, by jointly enacting the REST project, the head of the PB Hospital and the new head of the Wood Hospital gradually came to recognise their common interest, which grew in the form of enacted knowledge, drawing from their respective perception of their context of action. This common interest, therefore, was not necessarily consistent with the guide.

At the moment when the alliance had almost succeeded in transforming the model inscribed in the guide (by replacing the committees of function by subject groups), the third coordinator entered the scene and straightforwardly brought the guide back into the meeting room (Callon, 1986). The coordinator first enacted her role as a faithful spokesperson, or an "intermediary" (Latour, 2005, p. 55), of the policy guide. By speaking and behaving on the behalf of the federal authorities, the coordinator directly questioned the leading role played by the growing alliance, thus obliging its members to make their conception of the reform very explicit. Accordingly, throughout the early meetings of the third sequence, members of the alliance clarified what they expected from the coordinator; that is, to act on the behalf of local actors by further developing the local project with an awareness of the many efforts they had made to bring it into existence. The coordinator reacted by assuring local actors that she was committed to reaching an agreement with them regarding the conditions under which they might be able to cooperate in the framework of the REST project. She set, however, two conditions to be met before continuing negotiating their cooperation: they had to

reach an agreement on the creation of the rehabilitation centre asked for by the public authorities; and they had to set up the network committee. She presented those two conditions as a minimal link to the federal context, which must be established before further defining the local network.

By being obliged to reach an agreement regarding the rehabilitation centre (the creation of which necessarily involved actors from different parts of the area and the community ecology), she forced negotiations involving, for the first time, the entire spectrum of actors participating in the project. Conversely, by empowering front-line professionals and enrolling them in the network committee, she succeeded in transcending the separation between the management of psychiatric and mental health institution (sharing a traditional conception of personal problems) and front-line professionals (advocating multiple kinds of relationships to personal problems). To succeed in these two projects, the coordinator made concessions to the initial alliance, for instance by proposing to create the network committee by enlarging the steering committee to include front-line professionals. In so doing, she proved to local actors her willingness to take their concerns seriously, provided that they similarly considered some requirements likely to reinforce the connection between the local and federal contexts. The last meeting related in our story of the REST illustrated that such connection was re-established, in a manner both satisfactory to federal authorities and respectful to the local trajectory of the change process.

On the whole, throughout the devising and implementation of the REST project, the decision-making power progressively moved from the top of the PB Hospital to an alliance including the PB and the Wood Hospital, and from the steering to the network committee. The creation of new structures and groups of actors (particularly the guidance platform, the network committee and the rehabilitation centre) were the most obvious means through which those moves in the local order became institutionalised (i.e. inscribed in the Belgian system for addressing personal problems). The movement of the network committee, from one place to another and across ecological and ideological lines, also proved that the REST project had begun to belong to the network as a whole. The improvement of the meeting places and materials also provided the Network with an increased internal consistency.

5.2. The Meaning of the Ecological and Social Configuration of the System for Collective Action

The traditional coalition obviously impacted on the development trajectory of the REST project. The presence of actors linked to the traditional coalition appeared very clearly through the use of particular strategies, the expression of particular values, and repeated references to particular documents, knowledge and knowledge producers associated with that coalition.

First, key actors of the REST project enacted protective games and a reconversion strategy at several points in the process. They found concrete expression in the vision of the local project

inscribed in the proposal and through speeches of key actors in the REST project. As previously mentioned, after having presented the local version of the guide, the proposal document put forward protective definitions of the respective roles: of the promoter hospital (as knowledge broker); of the steering committee (as manager of the network); and of the medical profession including GPs and psychiatrists (as the respective gatekeepers of the residential and community worlds). Moreover, the reconversion strategy had been expressed several times by key actors, especially the first network coordinator who assumed, for instance, that the PB Hospital was, "concerned about care for mental health problems, not about social difficulties in general [and used] the 107 to improve the functioning of the hospital, but not to demolish the hospital."(See the meeting at the Wood Hospital, 12/11/2011) For his part, the head of the institution stated: "I prefer to see the network as an extension of our institution, through different kinds of partnerships, than as a reduction of our institution to specific functions." (See the Steering Committee, 04/09/2013)

Second, both the local version of the guide and key actors of the project continuously enacted the values of the traditional coalition, including: the importance of institutional self-determination; professional autonomy; patients' freedom of choice; quality of specialised care; continuity of care; and the richness of local diversity.

Third, both the actors and documents involved in the REST project referred to knowledge resources and producers specific to the traditional coalition, including: the balanced-care model; NACH concepts and advisory notes; professional federations; and the mental health care model they learned about by visiting Lausanne.

On the whole, the importance of the traditional coalition at the local level entailed multiple instances of inscribed and embodied knowledge which led local actors to make sense of the guide in a way that was not consistent with the vision of systemic reorganisation inscribed in the guide. Thus, repeated requests made by the public authorities to local actors for enlarging the network to multiple ecologies and actors embodying different kinds of knowledge can be viewed as attempts to exert some control on the context in which the guide was enacted locally. In fact, although very few proponents of the reformist network were involved in the REST project, they proved to be faithful and skilful spokespersons of the guide. This was particularly true of the temporary head of the Wood Hospital, who explicitly and firmly embodied the pragmatic reasoning specific to that network against professional and strategic thinking jointly held by the head and head doctor of the PB Hospital.

Regarding the existence of multiple and overlapping ecologies in the system, the story of the REST project showed their ambiguous status in relation to collective action. If we assume that ecologies represent particular relationships to the addressing of personal problems developed by particular actors in the course of past individual and collective experiences, we must not only recognise their multiplicity but also their ability to give particular direction to collective action. Actors of the REST project (including the heads of different institutions, the coordinator and front-line professionals) saw great worth in the specific relationships to the addressing of personal problems that

they had previously and successfully enacted. Accordingly, they were not only committed to defending those relationships against attempts to transform them, but also to impose them as useful ways to relate to personal problems in the framework of the reform. Repeated expressions of the need to incorporate work procedures developed through the therapeutic projects and psychiatric home care into the REST project illustrate that point. It is worth remarking, however, that depending on the situation in which they were referred to, these relationships either enhanced or impaired the ability of actors to cope with the problems they were collectively facing, i.e. that of implementing the functional model locally.

Furthermore, the involvement of multiple micro- (for instance, the Psychiatric Home Care teams) and macro-ecologies (for instance, the community ecology, the "profession of medicine", local political powers, the European Commission, the Public Health IMC, and so on) in the mobilisation process supporting the development of the REST Network, emphasised that change in the system cannot be understood as an organisational issue only. Instead, it was an inter-organisational, interprofessional, multi-levels and multi-sites process, of which the understanding was improved by endorsing a linked ecologies approach to collective action (see, for instance, the "Interlude" and the Steering Committee, 09/11/2011).

5.3. The Role of Embodied Knowledge in Collective Action

Actors need embodied knowledge to make sense of particular inscriptions and thus to engage in collective action taking place in relation to those inscriptions. The story of the REST project illustrates that when local actors did not embody knowledge helpful in understanding the practical implications implicit in a document; they felt uncertain and refused to enact it properly. In that respect, the first network coordinator was aware of being more confident in the framework of the therapeutic projects than in that of Reform 107, thanks to his knowledge of the making up of the associated federal framework. The head doctor of the Wood Hospital also explicitly stated that he would refuse to enact the reform fully while he felt unable to understand the "intelligence" of that reform.

In turn, in order to deal with uncertainty characterising the context in which the REST project took place, local actors initially made sense of the policy guide by relying on knowledge they embodied through past individual or collective experiences. This resulted in multiple and particular understandings of the reform: by relying on knowledge embodied through his membership of the Federation for Hospital Institutions, the head of the PB Hospital conceived of the reform as a project framed by professional federations; in the view of the first local coordinator, it was a project devised by the NACH and slightly adapted for budgetary reasons; and for the temporary head of the Wood Hospital (who had worked as a delegate of socialist ministers of public health for about three decades) it was a project painstakingly developed by the reformist network. Those understandings gave rise to specific enactments of their respective role in relation to the reform. For instance, the first network coordinator thought of his role as consisting in facilitating relationships among self-determining

institutions, and he performed his role accordingly. For his part, the head of the PB Hospital thought that, as head of a professional institution, his role was to put the model proposed by public authority to the test of empirical reality and to adapt it to fit in with local and professional contingencies. Similar logics applied to the behaviour of other actions.

However, by enacting the guide again and again - in different settings and in relation to multiple actors - key actors of the REST project became increasingly knowledgeable about the "intelligence" of the guide. They decided of how to behave in the framework of the reform accordingly, either by slightly modifying their strategy (as in the case of the head of the PB Hospital), or by deciding the retreat from collective action (as the first coordinator did).

Thus, the story of the REST project illustrates that although embodied knowledge appeared necessary to make sense of particular inscriptions and proved a very strong influence in directing collective action, it might also have been regularly adapted to fit in with enacted knowledge produced through successive sequences of actions/interactions.

5.4. The Role of Inscribed Knowledge in Collective Action

Inscribed knowledge (including the policy guide, its local version and a series of other documents) played an important role in the REST project. However, that role was anything but a straightforward influence on the course of the collective action.

First, the story of the REST project showed that actors inscribed knowledge to fix the meaning they gave to collective action. Documents and other kinds of material supports appeared particularly helpful in framing collective action insofar as it unfolded at the junction between multiple organisations. Documents helped in stabilising new work procedures and relationships prevailing in situations shared by multiple organisations, i.e. situations in relation to which multiple ecologies were interdependent. Documents then become formal means to support collective action, just as the formal structure supports collective action in organisations.

Second, actors involved in writing documents elaborated the meaning inscribed in it by assembling pieces of inscribed knowledge with knowledge embodied through involvement in professional projects and experiences to which they devoted many efforts. Accordingly, actors who produced inscribed knowledge were very attached to the resulting documents. In turn, questioning those documents (i.e. by refusing to recognise their value in relation to the addressing of personal problems) meant questioning the right of those actors to keep their position in the system.

Third, and consequently, documents circulating in the framework of the REST project were not neutral. On the contrary, they involved particular conceptions of how to reorganise the system for addressing personal problems, which were expressed through particular definitions of work organisation and procedures. Thus, they had an impact on collective action in the local system. That impact became explicit when documents started circulating to be enacted in different settings. For instance, the practical impact of the protective strategy involved in the local version of the guide

became clear when it was enacted by the local coordinator in the framework of the function committees.

Enactments were thus necessary for the conception of the reform inscribed in the local version of the guide to come into being. As previously mentioned, enactments also enabled the conception of the reform inscribed in the guide - including the contradictions it held - to become meaningful at the local level. In turn, enactments of the guide made local actors responsible for dealing with those contradictions, which federal authorities feigned to ignore provided that they succeeded in starting their reform. The difficulties met by the first coordinator in performing his job showed that such implicit transfer of responsibility caused stressful situations and questionable working conditions (Pichault & Schoenaers, 2012).

Fourth, the story of the REST project showed that, in order to keep circulating and to succeed in orienting collective action in a way consistent with the objective of those who inscribed knowledge in documents, those documents needed a spokesperson. The story of the REST project gave us the opportunity to observe the actions of different kinds of spokespersons. At the beginning, the first coordinator behaved as the spokesperson of a particular vision of the guide, strongly influenced by NACH concepts and the institutional strategy of the PB Hospital. Therefore, through the first sequence of the enactment of the guide, we observed that the original policy guide was virtually ignored by local actors. Then, when the REST project had been authorised to start, we observed the intervention of the Federal Coordinator who straightforwardly enacted the vision of the reform inscribed in the guide, thus challenging local conceptions and questioning the role and the position of local actors in the system for addressing personal problems. In so doing, the Federal Coordinator caused changes in local strategies, which eventually caused significant divergence between the local project f and the original guide. In the third part of the story, the new coordinator gradually adapted her view of her role as spokesperson for the guide by relying on her growing knowledge of the concrete functioning of the REST project. Accordingly, she moved from a position of faithful intermediary (Latour, 2005) to a role of strategic relay (Friedberg, 1997, p. 58), making the most of her arising knowledge of both the local order and the context outlined by the guide to ensure that the project kept working.

Fifth, and finally, the story of the REST project provided us with many opportunities to observe the synthesis of inscribed knowledge. It emphasised the painstaking, meaningful and time consuming work involved in the collective creation of documents. It also allowed us to observe that every expression inscribed in a document involved far more enacted knowledge than that eventually made visible to the reader. It follows that documents alone cannot regulate collective action. Documents can be used to support communication, but they need to be followed by face-to-face interactions through which their meaning is made explicit to those supposed to enact it.

Chapter VI – **AN IN-BETWEEN VERSION OF THE GUIDE**

SUMMARY

The FUL originated from two projects that were requested to merge by the public authorities. Initially, one project had been devised by an alliance of institutions aligned with the Catholic pillar, and the other by an alliance of public institutions. They had divided the territory of the Province of Red in two parts, by distinguishing between the centre and the periphery.

In the view of the public authorities, the two projects entailed interesting conceptions of the reform, appropriate to the part of the territory on which they intended to focus. Both projects also had their own sources of political support in federal administrations and government. But the division of the provincial territory along ideological lines did not fit with the spirit of the reform. Thus, public authorities authorised the project to start under the primary condition that the two alliances merge their project into a single initiative.

Following this, the writing of the FUL project involved aligning two contrasting conceptions of the reform, the different needs of the centre and the periphery, and two sets of structural and human resources that had developed separately over several decades. The time for realising such a tricky exercise was very short, but the leaders of the two projects were almost guaranteed to be authorised to start if they were successful in merging their projects.

Accordingly, immediately after having submitted the merged version, they started a large-scale interessement process, inviting about a hundred front-line professionals to attend a big meeting where the coordinator of the project presented both the federal care model and how the FUL project intended to implement it locally. Front-line professionals were invited to tell the coordinator whether they were interested in participating in committees of function intended to refine each care function, and to specify which care function(s) they were interested in.

The creation of those committees of function was slightly delayed by disagreements between the leaders of the project and the public authorities on the identity of the coordinator and the location where he planned to meet with the committees of function. The public authorities were convinced, in fact, that refining the model under the leadership of that particular person in that particular place meant exposing the process to disruptive interventions caused by various pillars' interests. Local actors responded to these federal apprehensions by drawing imaginative solutions ensuring that, even in that place and with that person, the FUL would be free to follow its own trajectory.

Following this, the FUL project started to develop through the work of the committees of function. Depending on the care function on which they were focusing, the size and the composition of those committees varied greatly. In every case, however, operationalising the function meant at first reaching an agreement on a new definition of that function, with reference to particular local needs and different kinds of knowledge and concerns expressed by the participants. Then, on the basis of those emergent definitions, they were able to start thinking about the creation of new work procedures and organisational structure. The key role played by front-line professionals in that process indicated new opportunities for shifting the foundation of the local care system from psychiatric hospitals to community settings.

INTRODUCTION

The FUL project developed in the same province than the REST project, in the immediate surroundings of the main city of that province, the Red city. The FUL project concerned a population of about 785 500 people living in the city centre and suburban and semi-rural areas. The total territory of the project averaged 1800 square meters; that is, a smaller territory than the REST project with a population almost three times higher. Big urban areas included in the territory of the project were post-industrial areas facing many socio-economic challenges. Those challenges supported the development of a very dense network of social and psycho-social services. Thus, the project's local area included not only big psychiatrist hospitals but many mental health facilities, psychiatric rehabilitation centres and social services.

The two main psychiatric hospitals of the area are a private hospital situated in the immediate surroundings of the city centre and a public hospital situated at the city centre. Following the federal call for projects, those two hospitals decided to apply to develop their respective exploratory projects. Such an endeavour to develop two different projects in the same area was not consistent with the global philosophy of the reform, which consisted in using every existing resource in a given area to provide people with personal problems with responses adequate to their needs. However, each project was supported by key actors involved in the follow-up of the reform at the federal level. Thus, the jury advised the IMC to authorise both projects to start provided that their promoters merged their two proposals into a single project. In response to that request, the promoter hospitals joined together to write new proposal, which outlined the FUL project.

This case study relates the story of the FUL project, from the moment the head of two hospitals decided to participate in the reform to the point at which the FUL had been enacted through successive function committee meetings. It first outlines the context in which the FUL project developed. That context includes the two contrasted institutional environments which gave rise to the two initial projects, as well as inscribed and embodied knowledge circulating in those environments. The story highlights how that knowledge supported contrasting understandings of the guide, including a professional understanding and a pragmatic perception. Second, the case study focuses on the document outlining the FUL project. By identifying the particular conceptions, objectives, and organisational principles inscribed in that document, the case study shows that it was devised by juxtaposing parts of the two initial projects, rather than translating them into a shared project. Third, it relates the initial enactments of the FUL project by the managers of the partner organisations. It emphasises that those enactments concerned the conditions under which local actors and public health authorities agreed to develop concrete collaborations in the framework of the reform, which had not been properly addressed during the merging of the two initial projects. Fourth, it suggests in-depth analyses of the enactment of the FUL project by front-line professionals. It relates successive meetings during which multiple actors attempted to move from abstract definitions inscribed in the policy guide

to operational definitions of the five functions. It particularly stresses that the meeting processes and resulting definitions varied significantly according to the kinds of embodied and inscribed knowledge brought to the table by front-line professionals. Particular groups of actors with particular knowledge of personal problems also gave rise to contrasting local orders, which progressively gave shape to the FUL network. Finally, in keeping with the reflection proposed at the end of the story of the REST project, this case study ends by summarising ongoing changes in the local care system, before highlighting key points of analytical learning regarding the influence of the traditional coalition and reformist network on the one hand, and the role of embodied and inscribed knowledge into collective action on the other.

1.   SETTING THE CONTEXT

The FUL project started with two separate projects: the PUPH project, which was supported by public services and institutions close to the socialist pillar; and the PRIPH project, which was supported by private services and institutions connected to the Catholic pillar.

At the first stage of the selection process, on 20th December 2010, the IMC decided that those two local alliances would be allowed to take part in the reform provided that they merge their proposals into one single project. That project had to be jointly promoted by the public (PUPH) and private (PRIPH) psychiatric hospitals at the heart of the initial proposals. Thus, the FUL project resulted from a local assemblage between two contrasting views of the reform and two particular institutional strategies, involving different kinds of inscribed and embodied knowledge. The following sections present the conditions, including different kinds of inscribed and embodied knowledge, which led to the development of the two initial projects.

1.1. A Professional Understanding of the Guide

Two main elements pertain to the understanding of the PRIPH vision of the reform: the professional project of the head doctor of the PRIPH and an institutional arrangement made between the head of the PRIPH and the head of a private general hospital just before the reform. A third element which impacted on the PRIPH project was the particular relationship to personal problems embodied by the Club (a private non-profit association holding CMHS and ISH).

1.1.1. *The Position of the Psychiatric Hospital's Head Doctor in Relation to the Reform*

The PRIPH was an old institution. It had been set up by religious congregations in 1928. Its development reflected the main historical changes in the system for addressing personal problems. Its main steps being the following: by 1965, the hospital had received authorisation from Minister for Public Health for 230 psychiatric beds; at the beginning of the 1970s, the professionalisation of

paramedical staff started increasing at an accelerated pace with the engagement of nurses, social workers, and educational therapists; then, in the early 1990s, the hospital opened a day hospital and a psychiatric nursing homes, the latter being developed in partnership with a community mental health service and a university day hospital.

Alongside those professional and structural developments, a particularity of the PRIPH was its close relationship with the University of the Red City. That connection took shape through the intermediary of its successive head doctors, most of whom were also professors of psychiatry at faculty of medicine of the University of the Red City.

The professional trajectory of the head doctor who wrote the PRIPH version of the guide was embedded in that local tradition. The importance of his professional project to the PRIPH version of the guide was emphasised in the initial proposal, through the detailed account of his professional trajectory suggested in the section devoted to the presentation of the promoter hospital.

When asked about his career, the head doctor insisted that psychiatry was a real vocation for him: "I have always known that I wanted to be psychiatrist, I decided to learn psychiatry at secondary school, and I am a psychiatrist" (Interview with the head doctor of the PRIPH – P3, 11/2011). He also claimed a deep knowledge of his professional and institutional environment. In fact, after having studied medicine at the University of the Red City, he had been trained as psychiatrist in the PRIPH, before of becoming a psychiatrist in that institution and head doctor in 1999.

His appointment as head doctor followed a conflict between the previous head doctor and the head of the institution. He thought that the head choose him to exert that function thanks to his medical project, which involved "a will to improve the organisation of mental health care in general, and to better our tool, our institution" (Interview with P3, 11/2011). Thus, from 1999 onwards, he devoted less time to clinical practice to focus on structural aspects: "I was a clinician psychiatrist, now I'm structural as well" (Interview with P3, 11/2011). That shift led him to create an association of head doctors of French-speaking psychiatric hospitals and to participate in reflection groups that took place in the framework of the Platform of the Red province, of which he was the then the president. As mentioned when relating the story of the REST project, the dream of the head doctor was to develop an exploratory project in connection to the platform:

> "As in the case of the therapeutic projects, I was dreaming about transforming the platform in a structure focusing on the coordination of care in the local area. The coordinator of the platform would take the role of care network coordinator, by giving the opportunity to every member to tell how they defined themselves, to identify gaps in local care provision and to stimulate partners the create the lacking instruments, and to use existing resources in more efficient ways." (Interview with P3, 11/2011)

His interest in the reorganisation of the system also motivated the head doctor to participate in reflection conducted by the NIHDI to prepare the reform. At that time, that reflection focused on the means by which the medical function would be financed in the framework of Reform 107:

"At the beginning of the reform, during discussions that unfolded at the NIHDI, we had calculated that the budget required to finance the medical function needed to develop the new mobile teams to be 225 000 Euros. That amount represented the cost of freezing 30 psychiatric beds with an occupation rate of about 80 percent, as it is the case everywhere in Belgium. Now, they decided to allocate 225 000 Euros for the medical function to every project, whatever the number of beds they had frozen … Thus, the demands made by the jury to the different candidates are unbalanced and, above all, they are not stimulating the closing of a large number of beds." (Idem)

Moreover, during the same period, the head doctor took the lead in the writing of a position paper by the association of head doctors of French-speaking psychiatric hospitals:

"The head doctors of the Walloon and Brussels psychiatric hospitals are aware of the need for reforming their institutions. However, in relation to that reform process that is already ongoing, we want to stress the unavoidable utility of our structures. The possible use of Article 107 and the ongoing debates in relation to the Birmingham model came to boost our reflexion, and we thought that the time had come to share our conclusions[28]."

The position defined in that document was very consistent with the conversion strategy specific to the traditional coalition. As explained by the head doctor of the PRIPH:

"Our first intent was to defend our psychiatric beds. Then, we thought that we must instead stress the idea that psychiatric hospitals must give up their protective function to focus on care, especially by overinvesting in acute treatments; and to increase its openness, among other through the development of a consultation function." (Interview with P3, 11/2011)

Alongside the reflection that took place at the NIHDI, the role played by the head doctor in writing that document resolutely influenced his conception of the reform. As showed by the following quotation, that conception was also consistent with that underlying the REST project: it stressed the added value of using Article 11 of the hospital law (concerning the concept of care networks and circuits) and the shift in the focus of the reform from the reconversion of resources belonging to the residential ecology to the reorganisation of care networks on the basis of the principles of psychiatric rehabilitation.

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[28] Position paper of the association of head doctors of French-speaking psychiatric hospitals on the function of psychiatric hospitals in relation to the reform of care circuits, September 2010.

"I'm convinced of the need for reforming psychiatry … I agree with the idea of the five functions and I think that the idea of care circuits and networks also provides concrete opportunities for improving the continuity and efficacy of psychiatric care." (Interview with P3, 11/2011)

"At its origin, the objective of the reform consisted of transforming psychiatric hospitals to bring them closer to hospital models developed in other countries. But now, very little attention is paid to the fourth function [residential treatment intensive units], and we have no means for developing the fifth function [alternative housing facilities] which is essential to decrease the number of psychiatric beds. Instead, significant efforts are devoted to the third function … I know that the Federal Coordinator has a lot of skills in psychiatric rehabilitation … I also have the impression that, ideologically, all of that draws from the assumption that psychiatric patients must find new role in the society, it is a beautiful ideal but it barely concerns ten percent of psychiatric patients!" (Interview with P3, 11/2011)

"If we had continued working in the framework of Articles 11 and 97, the hospital would have to gradually decrease hospitalisation to do something else, but now, the spirit of the reform is totally different." (Idem)

That knowledge of what the change process was and how it changed over the preceding years significantly impacted on the conception of the reform put forward by the head doctor. In turn, it partly determined the kind of knowledge enacted by service representatives appointed by PRIPH to participate in the committees of function, especially the psychiatrist managing the PRIPH mobile teams and involved in committee of function 2. As we shall see, not only did the psychiatrist rely on a conception of the reform as reorganising the hospital by developing mobile teams, but he lacked adequate resources to determine how to organise the work of the mobile teams.

1.1.2. *Local Contingencies and Institutional Strategy*

A short time prior to the beginning of Reform 107, the head of the PRIPH came to know that a large grouping of private general hospitals had decided to build a big institution on a disused site very close to the PRIPH. The arrival of that hospital in its immediate environment meant too much competition for an institution of the size of the PRIPH. Thus, the head of the PRIPH asked the head doctor to make a proposal to bring the psychiatric wards of the general hospital and his institution, or part of the associated facilities, together. The proposal made by the head doctor included three possibilities. The most challenging possibility consisted of devising an exploratory project which would be jointly promoted by the two institutions. That solution was consistent with the project of the head doctor. This helped to compensate for the refusal of the REST project to associate with the PRIPH. In that respect, it allowed the replacing of one partner, and associated resources, by another

partner with resources of other kinds. Additionally, the head of the general hospital and the head doctor of its psychiatric wards were willing to freeze a large number of beds and, above all, to develop the acute mobile teams.

> "I was very young when I became head doctor, and I became head doctor only to avoid another psychiatrist being appointed to that function. In other words, when I started, psychiatry was undergoing a deep crisis in this hospital. I tried to improve the functioning of the psychiatric wards and it worked! The number of beds started increasing to reach to 75 T-beds, which is rare for general hospitals. Then those T-beds had been changed in acute beds." (Focus group with the member of the PRIPH acute team, intervention of the head doctor of the general hospital psychiatric ward, 03/2012)

The head doctor of the PRIPH was interested in giving the responsibility for the development of the acute mobile team to the head doctor of the general hospital's psychiatric wards. Indeed, most members of the PRIPH medical and paramedical staffs were rather opposed to the idea of leaving their wards to work in mobile teams, especially the acute team. The PRIPH head doctor was aware that psychiatrists in his medical staff found it hard to alter their conception of their work. Concerning paramedical staff, the head doctor thought they feared moving from very stable and secure settings to mobile teams where both the content and the organisation of work remained unknown to them. Thus, he preferred managing the development of the chronic teams, which were a bit less challenging than the acute team.

For his part, the head doctor of the psychiatric ward of the general hospital and the members of his team were also, to a certain extent, worried about their new conditions of work. However, given the decision of the hospital management to participate in the project, the head doctor agreed to conduct the development of the acute team, and members of the paramedical staff accustomed to working with the doctor decided to follow him in that new experience. Moreover, most of the members of the new teams were interested in testing the new work conditions and enthusiastic about the composition of the team. Accordingly, as we shall see through the short story of the meetings of function committee 2, that acute team started working with very flexible procedures, which were gradually adapted as they learned how to provide psychiatric care in the patients' living environment. Indeed, most members of the team, including a charge nurse, two psychiatric nurses, one community-health nurse and two psychologists, had much more experience in working in psychiatric wards than in community settings (Focus group with the eight members of the PRIPH acute mobile team, 03/2012).

1.1.3. *The Club: from Partner to Challenger*

The Club is a private association holding various kinds of psychiatric rehabilitation and community facilities, including CMHS and ISH. These facilities are located in the community and managed by a pluridisciplinary team supervised by a head doctor. Their primary objective is to avoid care fragmentation and to work close to the patients' living environment and in connection with social partners.

The head doctor of the club had been trained as a psychiatrist after having worked as GP in a variety of workplaces, including family planning and V.I.H reference centres. As a psychiatrist, she worked both in residential and community services before deciding to work part-time as psychoanalyst in private practice and part-time as head doctor of the Club. She was interested in any reflection concerning the reorganisation of psychiatric care. She and the head of the Club were convinced that the therapeutic outcomes of residential treatments were too weak in relation to their cost. The head doctor also insisted that, in her view, psychiatrists had a social mandate. This did not necessarily consist of participating in the creation of psychiatric and mental health policies, but rather in directing one's clinical practice so as to address intricate psychosocial situations met by people with personal problems.

Insofar as they thought that Reform 107 might improve the ability of local care providers to deal with such situations by bettering the coordination of their interventions, the head and head doctor of the Club had accepted the invitation of the PRIPH head doctor to become a partner of his project. The head doctor specified, however, that she did not wish to become a partner of the PRIPH rather than the PUPH. The Club was involved in the PRIPH project simply because the head doctor of the PRIPH had invited it to become a partner. In contrast, the PUPH had decided to start working with its special partners, before enlarging the network to partners with which they were less used to working. Consequently, the head doctor was rather pleased that the PRIPH and the PUPH had been obliged to merged (Interview with the head doctor of the Club – P7, 11/2011). In this way, the Club immediately had the opportunity to collaborate with the care structures involved in the PRIPH and PUPH networks.

Regarding her conception of the objectives of the exploratory project, the head doctor insisted that the care structures must be able to coordinate themselves in a way suitable to particular needs of particular people at a particular time. She also stressed that, according to her, the notion of continuity did not only mean continuity of care but also involved the continuity of the relationship between mental health professionals and people with personal problems; even if the preservation of that relationship forced professionals to accept unexpected decisions made by the patient. In that respect, she was a bit worried about the stress exerted by the reform on the idea of rehabilitation. She thought that social insertion was not an end in itself: "We must pay a great attention not to mix up reinsertion and normalisation." (Interview with P7, 12/2011)

Meanwhile, the head doctor also expected that the reform might lead to a reform of the financing of psychiatric and mental health care. Indeed, she was opposed to the concentration of budgetary resources and decision making power in structures belonging to the residential ecology. With regard to that issue, she made clear that she and the head of the club had no intention of taking part in the meetings of the function committees to learn about what promoter hospitals wanted them to do:

> "I'm convinced that the interest of such project lies in confronting conflicting positions with one another, and I think that every partner had to be encouraged to make explicit the content as well as the limits of its works. Our first intent must be to succeed in making our work culture and logic of action very explicit; but I am aware that is a challenging objective." (Interview with P7, 12/2011)

The position of the Club in relation to the reform contrasted with traditional and reformist conceptions claimed by most members of the PRIPH and PUPH alliances. As we shall see through our short stories of the function committees meetings, the particular relationship to personal problems claimed by the representatives of the Club borrowed notions from professional visions of the reform, such as the stress put on care continuity and coordination, while giving those concepts slightly different meanings. That relationship also borrowed key elements from reformist approaches to personal problems, such as the emphasis placed on community care. Nevertheless, the club also questioned some aspects of the community model, especially the idea of social reinsertion. Consequently, service representatives of the Club generally took the role of challenger, alternatively questioning arguments put forward by service representatives coming from different ecologies and the meaning of the collective process in which they were all participating.

1.2. A Pragmatic Understanding of the Guide

The second project initially submitted to public authorities, the PUPH project, had been devised by public psychiatric, mental health and psychosocial rehabilitation services and institutions. The writing of that local version of the guide was a collective endeavour during which knowledge of alternative approaches to personal problems had been enacted and assembled with one another, before of being inscribed in the application documents.

The first actor involved in the creation of the PUPH proposal was a large public psychiatric hospital. This hospital held different kinds of knowledge: both knowledge inscribed in its structural resources and knowledge embodied by human resources. The following presentation of key actors and the organisational strategy of the PUPH will show that those different kinds of knowledge were fairly consistent with the global approach outlined in the guide.

1.2.1. *Pragmatic Thinking and Institutional Strategy*

The public hospital grew out from institutions specialising in psychiatry and care for the elderly, which were managed by local social services until 1993[29]. In 1993, these institutions joined together to create two associations shared by several communes. The two associations were finally incorporated into a single inter-communal association in 2008. This association was composed of three sectors, including a large mental health sector (sector A) involving the following resources: one psychiatric hospital spilt between two sites representing 474 A- and T-beds, about 50 beds for adolescents and two mobile teams called "Speed" and "Orchestra"; two psychiatric nursing homes (48 beds), three CMHS, fifteen sheltered housing initiatives corresponding to 77 beds, three welcome centres for people with drug addiction (10 beds) and one stress reduction clinic.

The PUPH was managed by a women trained as social nurse. She started working there at the beginning of her career, when the psychiatric hospital was managed by local social services. She became charge nurse of psychiatric wards before successfully passing the exams required to occupy management functions. Throughout her 35 year career in the institution, she had always been interested in alternative approaches to personal problems, and she took the necessary steps to set institutional conditions stimulating the development of new practices. Thus, she gladly agreed to play a leading role in the transformation of the psychiatric hospitals (Interview with the head of the PUPH – D4, 11/2011).

The head doctor of the PUPH also supported change in the organisation of psychiatric care. Although for different reasons, he shared the conviction of the head doctor of the PRIPH that Belgian psychiatrists could do much better with the means they had at their disposal. He thought that he was prepared for the reform thanks to his professional trajectory. In fact, after having studied medicine in Belgium, he moved away to do his psychiatric training in England and the United-States:

"I experienced deinstitutionalisation in England and the United-States. In the United-States, the number of psychiatric beds had decreased by half during the period between the fifties and the eighties; and in England, I took part in the closing of a big psychiatric institution. Following this I became aware that it was much more difficult to help people to reintegrate the society by using residential treatments: if you want to help people to return to the community, you have to move outside psychiatric institutions to work with those people within community settings." (Interview with the head doctor of the PUPH – P8, 02/2012)

According to the head doctor, those experiences explained his enthusiasm in relation to the reform, but also that he found it a bit timid:

"We have been waiting a very long time for this reform. Now, it seems that there are opportunities to start with it and people appear to be mobilised by the policy project. But it

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[29] The presentation of the PRIPH drew from the 2008 annual report of the inter-communal association.

would have been easier if policy makers had taken more radical decision. It did not happen; therefore we have to manage to do something with the means put at our disposal." (Idem)

The head doctor thought that the change process could have been more straightforward. He first argued that professionals currently knew that it was possible to work differently and acknowledged the need for reorganising the system. Accordingly, he wondered why they had to spend several years testing out new models before really reorganising the system. Second, he deplored the policy decision to finance the reform through the intermediary of psychiatric hospitals. He stressed that, since psychiatric hospitals and psychiatric beds were unevenly distributed among different geographical areas, some areas were lacking the necessary resources to develop alternative facilities required by the implementing of the functional model. Some local care systems were particularly lacking psychiatric rehabilitation services required to develop function 3 and, more generally, means were lacking to sharply intensify hospital treatments and to create alternative housing facilities.

The head of the hospital agreed with the head doctor on this final point. In spite of her commitment to transform psychiatric hospitals, she was worried about the situation of people unable to reintegrate into the community and the lack of housing structures adequate to their needs. In that respect, both of them thought that the transformation of big institutions should not mean losing their *know-how*. That knowledge should rather be transferred to other kinds of structures which should gradually increase in number, particularly in areas where community services were weakly developed. Thus, although they recognised that specialised care necessarily changed over time and that residential care did not seem to be the most adequate means of addressing personal problems, the head and head doctors of the PUPH assumed that personal problems required specialised care. As the head doctor put it: "My hope for the reform is that we have found a balance between residential and community care. There is no room for ideological debates about the need for specialised care: specialised care has changed over time and from one society to another, but the need for specialised care exists." (Interview with P8, 02/2012)

By the same token, both the head and the head doctor insisted that they conceived of the reform as primarily focused on the reorganisation of care. They agreed that personal problems involved psycho-social aspects, but they were firmly opposed to the intervention of the new mobile teams to respond to social problems.

The discourse of the head and head doctor was the public discourse of "professionals" (Freidson, 1988) considering the institutional and political aspects of the system for addressing personal problems. That discourse was informed by a deep knowledge of past shifts in the local care system on the one hand, and by knowledge of deinstitutionalisation process that had taken place in other countries on the other. It was consistent with the global philosophy inscribed in the guide, although it qualified some aspects of the functional model, especially the focus put on rehabilitation and primary care.

1.2.2. *The Reformist Allies of the PUPH*

The PUPH project involved two special partners of the institution: the Association and the psychiatric ward of a public general hospital which worked in close connection to the emergency services. Those partnerships were helpful to the PUPH endeavour.

First, the Association meant a direct connection to the Federal Coordinator. The Association was a very big intercommunal association holding more than ninety social, psychosocial, psychiatric rehabilitation and health care services situated in the territory of the FUL project. The Federal Coordinator had spent most of his career working in that Association. As emphasised when relating the creation of the guide, he drew his knowledge of "how to build a local care network" from his experience in organising the service network involved in that Association.

Second, few years before, the Association and the PUPH had created a psychiatric mobile team called "Speed", which was jointly managed by mental health professionals coming from the two organisations. In the view of the PUPH and the Association, Speed pioneered the mobile teams that were to be developed in the framework of the reform: it involved a pluridisciplinary team bringing treatments to patients in their living environment and helping them to set up a social context able to support their recovery from personal problems. Moreover, the members of the PUPH and the Association involved in Speed had the opportunity to present their team to the Federal Minister for Public Health. Accordingly, the head of the PUPH was convinced that the jury would recognise the quality of the PUPH project:

"We knew that our project was a good project. At the local level, we pioneered the spirit of the reform and we have strong partnerships with the *X* [Association]. Thus, given that we had always been working in a way consistent with the model developed by the Association, and that the coordinator of the Association became Federal Coordinator, we were convinced that the jury would appreciate our project." (Interview with D4, 12/2011)

Third, given the purpose of the reform to implement the functional model, the big network of services held by the Association was also very helpful. As stressed by a member of the Association, except for residential resources, its network entailed every kind of resources needed for developing the functional model:

"In the committee of function 1, there would be representatives of our CMHS; in the function 2 committee, there would be members of the Association who had been involved in "Speed" for a few years; in the function 3, there would be representatives of our rehabilitation and reinsertion services; the function 4 is exclusively devoted to hospitals so there would be no involvement; and in the function 5, there would be representatives of our sheltered housing initiatives." (Interview with the assistant manager of the association, 02/2012)

Fourth, the partnership with a psychiatric ward working in close connection with the emergency services of a public general meant capturing knowledge relevant to the creation of the mobile teams, especially the acute team. The head doctor of the psychiatric ward was a proponent of a radical shift in the organisation of the system for addressing personal problems: "In my view, Belgian psychiatry is a rotten thing, exceedingly centred on psychiatric hospitals, with far more psychiatric beds. I'm really into alternative psychiatry. Even if I work in an institution, I'm convinced that we are responsible for the chronic psychiatric problems." (Interview with the head doctor of the psychiatric ward of a general hospital – P5, 12/2011)

Thus, the head doctor was committed to participate in the change process. Moreover, he held two kinds of knowledge relevant to the development of the mobile teams. First, he had practice-based knowledge of psychiatric emergencies. That knowledge was particularly helpful to the PUPH. In fact, although the charge nurse responsible for the Speed team knew about psychiatric care in the patients' living environment, she did not know about the particular function of an acute mobile team and the management of crisis situation. Thus, she, the head and the head doctor of the PUPH were very interested in the proposal of the head doctor of the psychiatric ward to connect the new teams to his service. For his part, the head doctor of the psychiatric ward thought that the connection of the acute teams to emergency services represented an interesting means to help patients who did not absolutely need psychiatric hospitalisation to return home when leaving emergency beds. Given his anger towards psychiatric hospitals, the head doctor was very interested in that solution. Second, the psychiatric ward worked in partnership with the Association a great deal. Psychologists working in this ward were trained to preform therapeutic consultation and networking according to the model developed by the Association. As emphasised by the head doctors, such knowledge was all the more precious since it could not be acquired in school.

> "I have always delegated much work to psychologists, because there are too many patients in emergency services to work alone, because psychologists have their specificity, and because it allows working in a much more democratic system; the psychologist had his point of view, the psychiatrist has his own … Following university courses, psychologists and nurses are not prepared to networking. … they must know about psychopathologies, they must know how to behave in front of crisis situations, they must know about consultation, they must know the network, how to get in contact with the network, how to communicate with partners in the network…"(Interview with P5, 12/2011).

Thus, not only the head doctor but his team embodied pieces of knowledge lacking to the PUPH coalition to be able to completely realise the functional model inscribed in the guide.

1.3. **The Local Coordinator: a Culture of Institutional Consensus**

The local coordinator had been trained as clinical psychologist. He had various kinds of professional experience. As psychologist, he first worked in psychiatric hospital, prisons, CMHS, and private practice. He then applied to become coordinator of the MHCDP. He was interested in that role as he considered that clinical practice cannot exist outside a particular administrative framework.

As coordinator of the platform, he had participated in the therapeutic projects and the horizontal consultation. In that framework, he had been entrusted with a role of intermediary actor, working to bridge the gap between public authorities and the coordinators responsible for cross-project discussion. He deplored the way in which that pilot experience unfolded. He thought that the experts in charge of the scientific evaluation had made no effort to collaborate with local actors, but he was also convinced that the mandate provided to intermediary actors in charge of managing the pilots at the local level was not enough clear. In his view, the public authorities did not provide them with the means and information likely to help them to manage the process.

Concerning the reform itself, the coordinator was convinced that the Federal Coordinator had had a determining influence on the model inscribed in the guide:

> "You ask me about my view of the reform? Well, I would say that the reform has a very clear view of its purpose, and that I have to conform to that view. Thus, according to me, the best way to discuss the vision of the reform is to speak about the person it came from: Mr *X* [the Federal Coordinator]" (Interview with the network coordinator of the FUL project, 10/2011).

According to the local coordinator, the way in which the coordination function had been defined was consistent with the intent of the public authorities to promote a particular view of how to reorganise the system for addressing personal problems. He particularly wondered about the insistence on leadership skills. He thought that leadership was a subjective quality, a personal characteristic, and something that belonged to the worlds of management and policy making. He assumed that leadership skills were necessary to prevent psychiatric hospitals from controlling the local implementation of the reform. However, he stressed a difference between the ability of the local coordinator to manage the local implementation of the functional model in such a way as to avoid excessive strategic appropriation, and his willingness to straightforwardly apply the model inscribed in the guide to the local system: "Then, it is political orthodoxy and I think that it is largely inappropriate to the field of mental health." (Idem)

In that respect, he thought that public authorities were attempting to bring their vision of how to reorganise the system into local care system through the intermediary of the network coordinators, and by coaching and training them to adhere to that vision. According to him, in so doing, the public authorities were going beyond their competencies in relation to the system for addressing personal problems: "Public authorities are responsible for organising the means and resources available to the

system, but it is not their role to define precise techniques and approaches that clinicians must use in doing their job." (Interview with the network coordinator of the FUL project, 10/2011)

In contrast, regarding the means conceived of by public authorities to implement Reform 107 (i.e. the exploratory projects); the coordinator had the impression that it made room for the creativity of local actors. He stressed that the framework must remain flexible: "If the federal framework defined precise aspects of the concrete working of exploratory projects, it would be deadly to the reform as a whole" (Idem). He insisted that the reform entailed an important shift in professional cultures, and that such a transformation of longstanding tradition could not be decided unilaterally. Moreover, in relation to that shift in professional cultures, he specified that, in his view, the system for addressing personal problems must be allowed to decide on its own limits: "It is not contradictory with the global approach, it simply means that we mental health services have to decided ourselves what is included and what is not included in our jurisdiction." (Interview with the network coordinator of the FUL project, 10/2011)

He therefore considered that his role in relation to the reform consisted in helping institutions and services involved in the project to reach consensus on new work procedures: "It is to try to reach a consensus through consultation; a well-structured consultation of course" (Idem). He was also convinced that his knowledge of the local care system and his experiences in dealing with consultation between local actors would be very helpful in performing that function.

2.   FROM GLOBAL INSCRIPTION TO LOCAL ASSEMBLAGE

In this section, we will briefly outline the content of the document detailing the FUL project. However, in contrast with the first and second case studies, we will not detail every aspect of that document. Indeed, the objective of that documents was chiefly to secure the authorisation of the jury to start the project. Therefore, we will rather focus on the technique of collage used by the promoters of the FUL project to succeed in jointly writing a new proposal, outlining their merged exploratory project. We will attend to the practical consequences of that collage when relating the enactment of the project by front-line professionals, especially in the framework of committee of function 2.

The proposal for *The Constitution of a Care Network in the Area of the Red* City [30] is a 52 page document, plus appendixes, headed with the logo of the reform. The title targeted the membership of the project partners to a particular region. Following the merger, that regional membership was indeed the main aspect of the identity of the project. The subtitle specified that the project had resulted from two projects initially submitted by two different alliances of care providers which had been required "to unify their respective networks" by the IMC.

The first page of the main document introduced the different kinds of actors who played a role in the FUL project. The first category was composed of the promoters, including one private

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[30] May 2011, *Project of constitution of a care network in the area of the red city.*

psychiatric and general hospital and one public psychiatric hospital; the second was composed of special partners including two public general hospitals and two private non-profit associations, the "Association" and the "Club", which ran different kinds of psychosocial, community and psychiatric rehabilitation services. The third category involved many kinds of structures listed in the document's appendix. Those which took an active part in the building of the local project, appointing service representatives to participate in committees of function, were the following: prevention services; GP's associations; health care centres; psychiatric emergency services reception centres; community mental health services; psychiatric rehabilitation centres; day hospitals; psychiatric home care services; services specialised in drug addiction; and psychiatric and general hospitals.

2.1. **Using "Collage"**

The writing of the merged project consisted in pasting the PRIPH and PUPH projects together. The following figure illustrates this point: the highlighted parts are pieces of the PRIPH project and the other are pieces of the PUPH project. Those pieces had simply been put together into a single document while trying to maintain a relative consistency. That consistency, however, was more formal than substantial. It was limited to the subjects dealt with in the different sections of the documents. For instance, in the section of the document presented in the following figure, the promoters set out their "vision of the project". It started with the vision of the PRIPH project, which stressed the shift from a care model based on care supply to a model based on an inter-organisational network. The emphasis put on the inter-organisation networks was consistent with the model devised by the NACH in the early 2000s. Later in the document, another piece of the PRIPH project included a reference to the 2002 IMC joint-declaration, thus making it clear that the PRIPH project involved a conception of the reform deriving from documents that preceded the guide. In contrast, pieces of the PUPH project referred to the values advocated by the WHO. It also mentioned the existence of a professional culture of networking, shared and developed by the partners of the project. Thus, the section of the document devoted to the vision of the project juxtaposed two contrasting visions, the first making networking the objective of the change process, and the other conceiving of networking as a cultural prerequisite likely to help the partners to move closer to the principles put forward by the WHO.
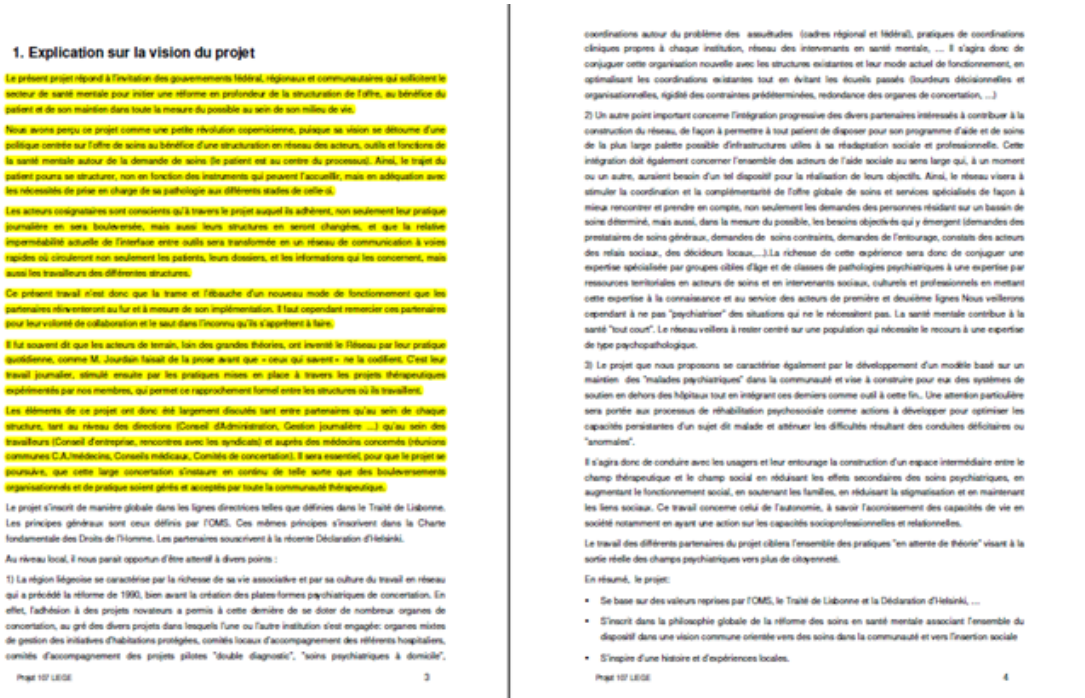
Figure 6 – Writing the Proposal for the FUL Project

The following sections were devoted to the objectives and the organisational principles of the FUL project. They were organised according to the same pattern. The section focusing on the objectives of the project provided another interesting instance of the juxtaposition of the two initial projects. The initial PUPH project distinguished between three kinds of objectives: objectives at the level of service users; objectives at the level of mental health professionals; and objectives at the level of the network. In a way very consistent with the procedures set out in the policy guide, operational definition and assessment criteria had been associated to every kind of objective indicated by the authors of the PUPH project. The PRIPH project instead focused on organisational objectives, considered at the level of the network. The combination of the PUPH and the PRIPH project gave rise to a section setting out the three kinds of objectives borrowed from the PUPH project, which was immediately followed by another section devoted to the "organisational principles" of the networks, which corresponded to the objectives of the initial PRIPH project.

The next sections were far more practical. They focused on the realisation of the five functions at the local level. Each section started with a short definition of the care function, which borrowed either from the PUPH or to the PRIPH project according to their respective specialisation. For instance, the documents set out a very long and detailed version of function 4 (intensive residential treatment) which reflected the attention paid to the transformation of the role of the hospital by the head doctor at the origin of the PRIPH project. In contrast, the long and detailed definition of the work of the chronic mobile teams derived from the PUPH project, which relied on the experience of the

"Speed" mobile team. In a way similar to the previous sections, the definition of the five functions involved two contrasting understandings of the reform, which had been juxtaposed into a single document. Those definitions were followed by lists of partners, including those involved in the PRIPH and the PUPH networks, who were likely to contribute to the realisation of each function.

2.2. Specifying the Terms of the Collaboration with the Public Authorities

Only the section devoted to the mobile teams entailed explicit references to the merger Four mobiles teams were presented throughout that section: one chronic and one mobile team which would be managed by the PUPH; and one chronic and one mobile team which would be managed by the PRIPH. The promoters explained that, given the different conditions of work applying the clinical staffs of their public and private institution; it was unthinkable to ask them to form cross-institutional teams. Meanwhile, considering that spitting the mobile teams meant splitting medical supervision, they requested the public authorities to allocate them with a doubled budget for the medical function. In the view of the local actors, that was a vital condition under which they could comply with the demand of the public authorities to merge the two projects.

2.3. A Political Document

The document presenting the FUL project was a collage composed of elements of the two original projects and intended to respond to the demand expressed by the public authorities. It was primarily a political document, through which local actors demonstrated to the public authorities that they agreed on merging their initial projects into a single project expanding to the territory of the Red city. This document also stated the conditions under which that merged project might be realised (i.e. provided that the federal authorities allowed them to develop four mobile teams).

As we shall see in the following sections, those conditions would cause further disagreements between local actors and the public authorities. Those disagreements significantly delayed the beginning of the project (i.e. its enactments by front-line professionals).Furthermore, the resolution of those disagreements, concerning the conditions under which local and federal actors agreed to collaborate in the framework of the reform, did not enable the resolution of underlying ideological conflicts implicit in the document. In that respect, it must be remarked that, just as in the case of the REST project, professional projects which developed in response to the call for projects proved to be very resistant to attempts by public authorities to reframe them in a way consistent with objectives specific to Reform 107. Consequently, the document that gave rise to the FUL project can be seen as circulating the oppositions implicit in the FUL project, transferring the responsibility for resolving them from the heads of local institutions to front-line professionals.

3. INITIAL ENACTMENTS OF THE LOCAL ASSEMBLAGE: THE RESURGENCE OF CONFLICTING WORLDVIEWS

The period between the IMC's authorisation for the project to start (in June 2011) and the point it actually started (by the end of January 2012) involved three events in the course of which conflicting views of the reform, and the local documents in which both were inscribed, were simultaneously enacted. The first event, the general meeting, involved local actors, including managers and front-line professionals. The two other meetings respectively involved local actors and the jury, and local actors and researchers conducting the scientific evaluation of the reform under the control of the federal public health authorities.

19/08/2011	General meeting
25/10/2011	Meeting between local actors and public health authorities (FPS PH)
17/01/2012	Meeting between local actors and researchers in charge of the scientific evaluation of the reform

By enacting the merged version of the project through interactions with the public health authorities, local actors became increasingly aware of the scope and objectives of the reform. Until then, they had perceived the reform in different ways, depending on the knowledge they embodied thanks to their professional trajectory and through working in a particular institutional environment. Thus, sequences of interactions between local actors and public health authorities provided the former with a more accurate knowledge of what was inscribed in the guide. In turn, local actors attempted to tell public health authorities, directly or through the intermediary of researchers in charge of the scientific evaluation of Reform 107, what their request to merge the two initial projects meant to them.

3.1. The General Meeting: a Big Event for an Unusual Alliance

The first general meeting of the project took place in August 2011. The participants were local actors, including the head and head doctors of the hospitals promoting the FUL project, the coordinator of the mental health care dialogue platform of the Red province who intended to became network coordinator (he already acted as spokesperson for the FUL project at this point), and about eighty front-line professionals representing social services and different kinds of mental health and psychiatric services and institutions situated in the territory of the project. The intent of the meeting was: 1) to present the reform in general; 2) to present the local project that emerged in response to the federal call for projects; 3) to ask the participants if they would be interested in participating in a committee of function; 4) and to specify in which function(s) they were interested.

> The head of the PUPH first welcomed the participants. The coordinator of the Red Platform followed her to set out the policy programme and the local project, designed to support the development of the FUL Network. He started by mentioning that he would probably become the coordinator of the FUL Network, before specifying the context,

including past pilot projects in mental health, the 2002 IMC joint agreement and the use of Article 107 to finance the reform.

He mentioned that, at the origin, there were two projects which had decided to merge into the FUL project. Given that decision, the FUL project had the particularity of working with two acute and two chronic mobile teams, what represented about 32 full-time workers. The local project was the only one that would develop four mobile teams at once.

Following this, the coordinator focused on the organisation chart of the project. As advocated by the guide, it included five function committees composed of front-line professionals and a network committee. The coordinator also mentioned the existence of a steering committee composed of the promoters of the projects. He explained that the five committees of function were responsible for the operational definition of the five functions, while the network committee had to connect those definitions and the associated procedures with one another. The steering committee would then sanction the decision taken by function and network committees.

When he gave these explanations to the participants, the coordinator emphasised several times that "the content of the project had to be built up", that it would be done "step by step", and that the local project was "not a ready-made project", which would be contradictory to the global philosophy of the reform. He finally told the participants that they could take one of the forms lying on the table at the entrance of the room to specify in which committee of function they were interested, before stating that the first committees of function might take place in September 2011.

During this meeting, the coordinator attempted to interest participants in the local project. To do so, he reiterated the discourse held by the Federal Minister for Public Health on the occasion of the national information event. The main aspect of that discourse was the stress put on the possibility for local actors to create the content of the reform. Except for the four mobile teams, he did not stress any particularity of the project; neither did he refer to the local inscription defining the project. Thus, through that presentation, not only did the coordinator fail to mention the conflicting projects from which the FUL project resulted, but he presented it as a local project consistent with the model suggested by the guide.

3.2. **When Meeting with the Jury Turned into a Power Struggle**

By October 2011, the project had still not started. This delay resulted from a disagreement between the promoters of the project, the local coordinator and the jury. That disagreement turned into an open conflict on the occasion of a meeting that took place in Brussels, on 25th October 2011. That conflict has two aspects, as outlined below.

3.2.1. *Financing the Medical Function Twice*

In the document outlining the merged version of their projects, local actors told public authorities that they refused to merge their mobile teams. They requested double funding for the medical function, arguing that mental health professionals working in private hospitals had different

working conditions than those working in public hospitals. Therefore, their trade unions would inevitably disagree on their becoming part of the same teams.

That request put the jury in a difficult position in relation to the promoters of the REST project, who had been asked to wait again and again, amongst other for budgetary reasons! Moreover, knowing that the promoters of the FUL project had asked for a double financing, those of the REST project had told the members of the jury that agreeing to that request would definitely undermined their credibility as leaders of a federal reform supposed to improve the quality and effectiveness of mental health care all over the country. They had also raised that issue on the occasion of a meeting at the Red Platform, thus questioning the role traditionally played by the platform as an intermediary between *all* its members and the public authorities. In response, the head doctor of the PRIPH, who was then presiding over the platform, had agreed that the platform send a letter to the Federal Minister for Public Health to support the REST project.

In that context, in spite of the authorisation given to local actors on the basis of the document in which they inscribed their intention to ask for double funding for the medical function, the public health authorities delayed their decision. Meanwhile, local actors refused to organise the function of coordination which was, according to the public authorities, a condition for starting with the local project. That local strategy was obviously impeding the agenda of the reform. As expressed by the network coordinator: "Exploratory projects selected by the IMC are developing all over the country. Meanwhile, here in [the Red City], nothing happens!" (Interview with the network coordinator, 2011/11)

3.2.2. *The Tricky Issue of the Coordination Function*

During the meeting of the 25th October 2011, local actors and public authorities did not manage to reach an agreement on the issue of the financing. Instead, the conflict got worse. In fact, the public authorities opposed to the decision of local actors to appoint the coordinator of the platform as network coordinator. Indeed, in the view of the Federal Coordinator, the philosophy of the platform was too different from that of the reform for the coordinator to be able to shift form the first to the second:

> "The coordinator of the platform has the mission of organising institutional consultation at local level. Here we are speaking of a different kind of consultation. It must not be limited to the members of the platform. It must rather include all the members of the local network … The second mission of the coordinator of the platform is to represent local actors to community, regional and federal authorities. In that respect, the role of the network coordinator is totally different! It means working with us to coordinate local actors!" (Interview with the Federal Coordinator, 2012/01)

For his part, as we have previously mentioned, the coordinator of the platform was convinced that his knowledge of the local care system and his experience in managing consultation between local mental health services and institutions would help him to cope with the development of the FUL Network. Moreover, he was convinced that his connection to the platform caused a problem to the extent that, as an organisational structure, the platform involved logics of action conflicting with the global philosophy of the reform. For the reminder, the platforms were the first output of Busquin reform started in 1989 (see chapter 3). Our analysis of that reform highlighted that the associated policy programme had been negotiated by representatives of the residential ecology in a way that fit with its global strategy in relation to change. Furthermore, the Walloon platforms were for the most part presided over by the head or head doctor of private psychiatric hospitals, and their active members were chiefly services and institutions connected to the residential ecology. Therefore, the Federal Coordinator was determined to avoid his reform falling under the jurisdiction of the platform.

Finally, that conflict had been resolved through an agreement establishing that the coordinator of the platform was authorised to take the role of network coordinator, provided that activities relating to the network were organised in meeting rooms different from those in which the activities of the platform took place. Local actors thus set up new meeting rooms and offices on the ground-floor of the building of the platform.

3.3. **Meeting with the Scientific Research Teams: Speaking Different Languages**

The participants in this meeting were: three researchers from scientific research teams responsible for the evaluation of the reform; heads and head doctors of psychiatric hospitals promoting the project; head doctors of the psychiatric wards of the general hospital; and head doctors and assistant managers from CMHS. That group of local actors represented the two alliances at the origin of the merged project.

> At the beginning of the meeting, researchers asked local actors how the project took shape and how they had delineated the territory of the local network. The network coordinator explained that the project had resulted from the merging of two projects, each of which concerned a particular territory, and that the territory of the project had been defined by combining those two territories.

> Following his response, the researches asked why they had decided to merge. The participants seemed to be surprised by that question. The coordinator responded that it was not a decision but an obligation! It was a condition imposed by the jury and sanctioned by the IMC. Moreover, as he and other participants became aware that the researchers did not know the story of their project, they started telling that story in a way that was faithful to its particular developments. They said that "historical partnerships existed in the area". On the one hand, there were longstanding collaborations between the PUPH, the Association and the psychiatric ward of a public general hospital. On the other hand, collaborations existed between the PRIPH and the Club, and they decided to ally with the psychiatric ward of a

general hospital. Thus, following the call for projects those two alliances conceived two different projects. The first one was limited to the city centre and proposed to freeze 30 T-beds; the second one expanded to the periphery, and proposed to freeze 30 T-beds and 15 A-beds. Now, given the request of the jury to merge those two projects into a single one, the project involved 75 A- and T-beds, and expanded to a large territory including both the centre and the periphery, with a population of about 750000.

Following this narrative, through which the FUL project started to exist, the participants took the opportunity to tell researches who they were. Accordingly, most of them outlined their own relationship to personal problems, by emphasising aspects of that relationship which were particularly consistent with the objectives of the reform and, conversely, aspects of the reform which were particularly appropriate to local needs.

> For instance, the head and head doctor of the PUPH explained that they had always been interested in developing community facilities and that they had already taken several steps in that direction. They added that the reform was an occasion to move one step further towards the community, without having to finance it from their own budget.

> For his part, the assistant manager of a CHMS part of the Association told the story of that organisation. The main points of that story were the following: from its origins, the association had been tightly related to local powers; its initial focus was on social help and general medicine; the density of its networks of social and care structures increased over time; those structures were able to cope with psychosocial distress and to detect heavy psychiatric cases; and, finally, every structure of the network was working with the individual care plan.

> Following this, the head doctor spoke again to specify that the PUPH was a big institution located close to a city centre. It included 500 psychiatric beds, with a length of stay averaging 50-60 days for some 2500 admissions per year. In that context, the need for specialising and intensifying psychiatric treatment was obvious. However, he thought that, "We have to be careful not to lose the know-how of big institutions."

The participants connected their relationships to personal problems to the framework of the reform and, in some cases, they specified what the reform meant to them. In so doing, they also positioned themselves in relation to the reform. The manager of the CMHS expressed his complete adhesion to the global philosophy of the reform by emphasising that his organisation had been enacting its key principles for years. In contrast, the head and head doctor of the PUPH expressed their agreement with the care model underlying the reform, but they also meant to protect the knowledge they embodied by practicing residential treatments in urban contexts and by testing out new practices.

Afterward, the participants stressed the positive effects that each of them associated with the merging the two projects, as well as the challenges it raised for the project as a whole.

> For instance, the head doctor of the Club stressed that the two projects had positive aspects; the territory defined by the PRIPH project included the whole population using services supplied by the Club, and the PUPH project included the objective of moving from a medical to a global approach to addressing personal problems. For his part, the manager of the

CMHS of the Association highlighted that, thanks to the merger, every association part of the network of the Association would become part of the FUL network. In fact, the small territory that had initially been defined by the promoters of the PUPH project excluded some resources of the Association from that network.

The head doctor of the PUHP then moved on to address the collective challenges caused by the merger. He told the researchers that the project would have to deal with several divisions at once. First, there were the pillars: the logic of pillars was not appropriate to networking: "If we want to provide patients with the most adequate responses to their specific needs, we have to seek for the most appropriate resources where they are." Second, there was the well-known division between residential and community services. Third, various objectives coexisted within the projects, especially managerial objectives and objectives related to the improvement of patients' quality of life, and they were not necessarily consistent with one another.

In response to that explanation, researchers concluded that there was strong competition inside the project. The head doctor of the Club and the PUPH joined together to qualify that statement: it was not a question of competition, rather, there were "ideological difference relating to the way in which mental health is perceived by each of us." The head of the PUPH went on to further clarify that point: "Some of us consider mental illness as resulting from social dysfunction; the others consider it as a real illness." The head of the Club added: "But working groups settled in the framework of the projects are specifically intended to help us going beyond such differences." The head doctor of the PUPH concluded: "There are strong professional identities involved in the project and, with a view to improve our complementarity, we have first to clarify our identity." The researchers answered with a nod, before asking: "And did you have implement management techniques?"

That question constituted a turning point in the meeting. Until that point, the head doctor of the PRIPH had remained very careful, listening to the different visions of the project expressed by his partners. In a way similar to his partners, he used the question to express his own view of the project. In contrast to previous interventions, however, he shifted the focus from the services and institutions involved in the project to the political context in which that project took shape.

To the question *did you have implement management techniques,* the coordinator barely responded: "No, not really." The head doctor of the PRIPH then put that, "Now, we have a coordinator. It is important because it will improve our ability to get a global view of the network, supporting the development of adequate management techniques."

Moreover, he stressed the very short time that the head of the PUPH and himself had had to incorporate the two projects into a single document. In his view, that justified the need to adapt the project inscribed in that document over time, alongside the fact that the document "…was shaped in a particular way because it had a particular function (to respond to the requirement to merge the PRIPH and PUPH projects); which was not to be the bible of the network. By now we have to agree on a network convention which, hopefully, will involve management techniques."

Through that intervention, the head doctor reminded the participants that if the project had not yet reached the stage where management techniques might be implemented, it was because the public

authorities had opposed the appointment of the coordinator of the platform to the function of network coordinator, thus delaying the creation of that function. In passing, he stipulated that he conceived of the application document as a political document, embodying a political merger, which needed to be adapted to fit with concrete practices.

> The researchers took from that interjection that the project had not yet implemented management techniques, and they moved to the next question: *do you intend to define operational objectives?* The network coordinator answered that it would depend on the function; he assumed that some function committees would find it useful, while other would prefer working on the basis of global objectives.

> The researchers took note of this response without asking for details. Instead, they asked again how the territory of the project had been defined. The participants abandoned their idea of explaining them that the territory of the project resulted from a pragmatic assemblage caused by a political decision. Instead they suggested a new and a slightly ironical assemblage involving criteria that would seem more objective to the researchers. Accordingly, they stated that the territory had been defined by taking into account the strong cultural identity of the Red Province, the territory of the related mental health care dialog platform and the care areas determined by the Walloon Region.

This meeting appeared as more helpful in leading the partners of the FUL Network to enact collective knowledge of their system of action, than in making scientific researchers knowledgeable of the way in which the FUL project had been defined. In this respect, it can be seen as setting (instead of the document inscribing a political conception of the FUL project) the conditions in which further enactments by front-line professionals took place. Moreover, individual conceptions of Reform 107 enacted through that meeting were conceptions that significantly marked the institutional environment of front-line professionals who participated in the function committees as service representatives. By determining, in part, how those actors made sense of the reform and how they understood the discussions that unfolded during the function committee meetings, those conceptions came to be inscribed in the operational definition resulting from the functions committees' meetings. As we shall see through the following stories, the specific ways in which those conceptions had been assembled with one another to form local and operational versions of the five functions depended, however, on the particular local orders that start to develop along with the meetings of the five committees.

4.   THE ENACTMENT OF THE FUL PROJECT BY SERVICE REPRESENTATIVES

By January 2012, the merged version of the guide started to be enacted in collective settings, particularly meetings of the five committees of function. In contrast to the REST project, most enactments of the FUL project occurred in function committees composed of front-line professionals.

This section relates the development of the committees of function by conceiving this as a social process through which new groups and possibly local orders were gradually built up. The first section presents the five committees set up by the coordinator following the general meeting. It emphasises

that the size and composition of the committees varied significantly according to the functions, before detailing the mandate of the five committees of function, as conceived by the network coordinator. Regarding that mandate, it distinguishes between the explicit mandate set out by the coordinator and his conception of the mandate implicit in the process.

Second, it focuses on the interactions that occurred during the first meetings of two committees with very different characteristics; the committees of function 3 and 4. By relying on instances of those interactions, it shows that through different attempts to define areas of work in which all of them were interested, service representatives on those committees gradually created a body of enacted knowledge relating to their respective/collective roles in the reform. It also stresses the role played by particular actors, holding particular resources, in stimulating the emergence of such enacted knowledge.

Third, by drawing on the assumption that different meeting processes give rise to particular local orders, it provides more detailed stories of the meeting processes involved in two other committees with contrasting properties; the committees of function 1 and 2. By considering successive sequences of interactions that took place in the framework of their respective meetings, it highlight contrasting social processes; the first one being a somewhat consensual process directed toward the development of communication instruments shared by its members; and the second one being far more conflictual and entirely devoted to the progressive building of an agreement on the conditions under which its members might cooperate, in spite of conflicting logics of action.

4.1. From General Meeting to Function Committees

The first public enactment of the FUL project, on the occasion of the general meeting that took place in January 2011, was directed toward interesting front-line professionals in participating in function committees. Following that meeting, many structures had decided to participate in one or more of the committees of function. Accordingly, they appointed service representatives to participate in the meetings of those committees. Meanwhile, the network coordinator had constituted the five committees by collating the candidatures he received following the general meeting, before fixing the date of the first meeting of each committee. He also planned to create the network committee as soon as possible, by asking the members of the function committees who were interested in participating in the network committee to apply to stand as function representatives.

4.1.1. Five Committees with Different Properties

The five committees of function set up by the coordinator were distinguished by their size and their composition. In fact, they involved service representatives coming from different ecologies and belonging to different alliances. Among those service representatives, some were directly concerned with the development of the functions, while others were more interested in the development of new services that might improve their ability to deal with their own work (for instance, the representatives

of social services sitting on the committee of function 4 focusing on intensifying residential treatments). Every committee also included experiential experts who had been trained by service user groups on the occasion of the therapeutic projects and the horizontal consultation.

The first committee (prevention, promotion, early detection and initial diagnosis) was a big group of about thirty actors from different ecologies. It involved front-line professionals appointed as function representatives by several community mental health services, local social services, health centres, and day hospitals.

The second committee (mobile teams for acute and chronic mental health problems) was also a big group of about twenty-five actors. Among those actors, we must distinguish between those who were directly concerned with the development of the mobile teams (that is, psychiatrists, charge nurses and social workers part of the mobile teams) and actors interested in the way the new mobile teams would translated their mandate, including service representatives of local social services, CMHS, health centres, and general practitioners.

The third committee (psycho-social rehabilitation, socio-professional insertion) was again a big group of thirty actors. It was the most heterogeneous groups of the five committees. In contrast to the second committee, however, that heterogeneity did not reflect the interests of different partners in the emergence in new entities in the system for addressing personal problems, but rather the scope of the jurisdiction delineated by the function. The members of that committee had been appointed as service representatives by community mental health services, psycho-social rehabilitation services, sheltered housing initiatives, local social services, employment services, health centres, social housing and social emergency services.

The fourth committee was the smallest group. Given its focus on intensive residential treatment, it consequently involved about ten members coming from the residential ecology, including psychiatric hospitals, psychiatric wards of general hospitals, and psychiatric services providing specialised care to specific target groups.

The fifth committee was an average-size group of about 15 service representatives. It was also a rather homogeneous committee whose most members, except for the representatives of local social services, came from sheltered housing initiatives and psychiatric nursing homes.

4.1.2. *The Mandate of the Five Committees: Moving from Abstract Definition/Particular Project to Operational Definition/Global Project*

As set out by the network coordinator at the beginning of the process, the explicit mandate of the committees of function had four aspects: 1) moving from abstract definitions inscribed in the guide to operational definitions agreed on by service representatives; 2) ensuring that each function developed in connection to the other functions and the network as a whole; 3) agreeing on the network convention; and 4) examining and responding to different kinds of requests and proposals made by the

public authorities to local actors. That definition was consistent with the conception of the creation of local networks inscribed by the public authorities in the guide.

However, the coordinator also engaged in the process with the conviction that the realisation of that mandate must be processual. He thought that the life-course of the five committees of function would imply a consultation process involving a time for sharing knowledge and experiences embodied by the committees members, and a time for agreeing on common objectives and procedures; that is, "for translating particular observations into standardised and general rules" (Interview with the network coordinator of the FUL project, 18/01/2011). In that respect, he conceived of his role as consisting in helping "people to agree on abstract projects and to reach global agreement on how to structure the network without predetermining the way in which individual practitioners should cope with concrete situations …" (Idem). This conception of the process implicit in the committees meeting reflected his experience as coordinator of the platform. In practice, this led the coordinator to make room for the expression, by every service representative, of his/her particular expectations in relation to the reform.

Meanwhile, if we mix the explicit mandate set out by the coordinator with his conception of the process implicit in the associated meetings, we can postulate that the *concrete mandate* of the five committees consisted in moving from situation *A* defined by 1) the existence of abstract definitions of the five functions inscribed in a policy document and 2) the presence of a series of front-line professionals with particular projects); to situation *B* defined by 1) the emergence of enacted and perhaps inscribed knowledge of the meaning of the five functions at the local level and 2) the arising of global projects, specific to the FUL Network).

The following analyses of sequences of interactions brought about by the realisation of that concrete mandate intend to highlight the characteristics of the social process through which service representatives, together with the network coordinator, moved from situation *A* to situation *B*. By focusing only on the first aspect of the function committees' explicit mandate, those analyses set aside the issues of the network committee, the network convention and the relationships with policy makers. There are three main reasons for this, as outlined below.

First, given the schedule of our research and that of the FUL project, we had the opportunity to attend only one meeting of the network committee. Moreover, service representatives involved in the five committees did not pay much attention to the appointment of function representatives. Thus, we had little data regarding the relationships between the committees of function and the network committee. This does not mean, however, that we ignored the different actors and conceptions of personal problems involved in that committee. In fact, the network committee was composed of the promoters of the project (whose conceptions are set out in the previous sections of this chapter) and of representatives of the committees of function, who participated in the interactions related in the following sections.

Second, regarding the issue of the network convention, it is worth mentioning that, in contrast with the actors involved in the steering committee of the REST project, front-line professionals participating in the FUL project's committees of function did not care about that document. Accordingly, in the course of the meeting process, the network convention had been cited only by the coordinator, to tell the participants that he would send them the document, with the intention of discussing its content on the occasion of the next meetings. However, the document was never discussed throughout the six first meetings of the five committees. One explanation for the weak interest of service representatives in the network convention is that it mentioned only big ideas, very similar to those inscribed in the guide. Thus, as stressed by a services representative: "If we disagreed on such ideas we would not have come!" (Observations, CF4, M2 2012/02) A second explanation is that service representatives had continuously been focusing on the definition of "their" function, thus avoiding thinking of the network as a whole. Concerning that issue, it is worth noting that some service representatives noticed the tendency of some of their colleagues to focus on "their function" at the exclusion of the four other functions, or on "their mobile team" at the exclusion of the three other mobile teams. In the following instance, a service representative reminded another of the philosophy inscribed in the functional model:

"Those are functions, not groups! The network must be able to realise the five functions; we must not "belong to" a function, we had rather to activate functions, and we can activate several functions at once. Similar tricky issues are rising in the different committees of function; we cannot start passing the buck to each other." (Observations, CF3, M2, 2012/03)

Third, the issue of the relationships between the function committees and public authorities (the third aspect of the mandate of the committees) was not discussed much in the course of the meetings. Through the sequences of interactions related in the following sections, we will mention some instances in which the coordinator or other participants mentioned actions taken by (and inscribed knowledge provided by) the public authorities. Most of time, however, the coordinator was alone in enacting that relationship, by informing service representatives of requests or proposals made by the public authorities. At the beginning of the process, the main request stated by the public authorities was to define the needs for training expressed by members of the function committees. Later in the process those requests concerned the particular tasks to be fulfilled in relation to the scientific research, the integration of the coordinators of new care circuits for inmate in committees of function, and the development of increased partnerships with services networks specialised in drug addictions. Except for defining training needs, which had been dealt with by the representatives of the mobile teams outside the framework of the committee of function 2, these issues did not cause particular reactions. Actually, thanks in his experience in previous pilots, the coordinator appeared more worried than service representatives about the requirements of the public authorities, particularly in relation to scientific research:

"The SPF PH will organise a meeting to inform us about data collection and monitoring systems developed in relation to the scientific evaluation. I'm going to attend that meeting and I'm determined to stress possible risks that they would not have thought through. Given my experience of this kind of situation in the framework of the therapeutic projects, I really do not want us to repeat the same mistakes." (Observation, Committee of Function (CF) 1, Meeting (M) 3, 2012/04)

4.2. **From Abstract to Operational Definitions**

Deciding on the operational definitions of the five functions meant producing local versions of the abstract definitions inscribed in the guide. Local versions must be adapted to local particularities. As stated by the coordinator, they must "specify what we bring into that function, what that function means to us" (Observations, CF1, M3, 2012/04). The meeting processes related below illustrate initial attempts made by service representatives participating in the committees of function 3 and 4 to move from their particular situation to global objectives.

24/01/2012	Committee of function 4 – 1st meeting – 10 service representatives
02/02/2012	Committee of function 3 – 1st meeting – 27 service representatives
27/02/2012	Committee of function 4 – 2nd meeting – 9 service representatives
07/03/2012	Committee of function 3 – 2nd meeting – 25 service representatives
16/04/2012	Committee of function 4 – 4th meeting – 9 service representatives

As previously mentioned, the committees 3 and 4 had very different properties; the first one involving a very large and heterogeneous group of actors, and the second one involving a small and very homogeneous group. Those committees had also different roles to play in relation to the reform. The committee of function 3 was the masterpiece and the most innovative aspect of the policy programme; it reflected the commitment of the Federal Coordinator to promote psychiatric rehabilitation. By contrast, the committee 4 was exclusively devoted to the transformation of psychiatric hospitals.

4.2.1. *Seeking the Meaning of Intensive Psychiatric Treatment*

The coordinator tended to start meetings by reminding service representatives of the particular challenges involved in their function and its position in the global model. Moreover, being confronted with small and homogeneous groups, he suggested that service representatives should directly focus on the core of their function; that is, intensive residential treatment units: "Public authorities allocated no additional means to this function. Thus, we can conceive of our work as an internal reflection intended to inform the creation of something more intensive … First of all; we have to wonder about the meaning of intensive residential treatment…"(Observations, CF4, M1, 01/2012).

Following this, service representatives followed one another to express what intensive residential treatment meant to them, according to their actual work conditions and past professional experiences. We have numbered their interventions to be able to refer to precise interactions in the following analysis.

[1] The charge nurse managing specialised psychiatric services first recounted: "Our service grew out from a pilot project that implied very high standards. We are about 17 full-time workers for 20 patients. Thus, from our viewpoint, the intensity is everywhere, in the diversity, the specialisation, the rapidity, and the mobility of the responses brought to patients." (Observations, CF4, M1, 01/2012).

[2] The head doctor of the psychiatric wards of a general hospital responded: "We have not enough means to provide patients with intensive treatment, but we are constantly dealing with acute problems." (Idem)

[3] In response, representatives of social services stated that they regularly worked in partnership with the psychiatric ward of a general hospital. They thought that their partners had an interesting conception of intensive treatments: "Patients are hospitalised for one week during which staff made the appraisal of somatic and psychiatric symptoms. They work with a case manager who organised the network and set up the care plan; thus the hospital care about what is going on after the hospitalisation. The hospitalisation itself is conceived as a short transition." (Idem)

[4] The coordinator suggested: "If we define intensity in relation to the rapidity of the intervention, some services involved in function 4 might supply non-specialised care for crisis situations." (Idem)

[5] A charge nurse working in a psychiatric hospital disagreed: "In my view, intensive treatments do not mean rapid response! Intensity relates to the importance and specialisation of clinical staff." (Idem)

[6] The head doctor of the psychiatric ward of a general hospital responded: "Ok, but if you define intensity in relation to the importance of clinical staffs, I had better to go back home!" (Idem)

[7] A little later, she added: "We might agree or not with this reform, but it is perhaps an opportunity to formalise our ways of working, to improve our conditions of work and, in that respect, what we need is to improve our knowledge of the admission procedures used by each of us." (Idem)

[8] Later in the discussion, the head doctor of a psychiatric hospital stated: "If we look at the definition suggested in the guide, we see that function 4 is only about cure. Thus, I wonder what we have to do with our T-beds [care]. I think that we should reintroduce the idea of care in our definition." The coordinator responded: "I agree, but I think that it is a purposeful omission"; and the head doctor: "I know, but we can work in a strategic perspective, and then we have to raise that question." (Observations, CF4, M2, 02/2012).

[9] Then, the head doctor insisted: "I would like to incorporate "the care", "the cure" and "the secure" into the definition".

Four observations can be derived from those interactions. First, according to their situations of work, including particular standards [1], structural conditions [3-6] and partnerships [2], service

representatives were able to conceive of intensive treatment more or less extensively/restrictively. In that respect, the involvement of service representatives in organisations associated with pilot projects or part of big networks of services and institutions appeared to be a resource, which helped them to think of intensive treatment rather extensively [1] or imaginatively [3].

Second, depending on their institutional environment and their position in the system, service representatives associated the task of refining function 4 to political [8] and managerial [7] strategies.

Third, by sharing their different conceptions of (the task of defining) intensive residential treatment, service representatives started outlining the role they intended to play in their committee. In the case just mentioned, we can distinguish innovative [1-3], pragmatic [2-7], and strategic [8] roles.

Fourth, successive sequences of interactions brought about enacted knowledge. Although conceptions of intensive care enacted by service representatives borrowed from their current conditions of work and past professional experiences, their collective definition of intensive care gradually emerged from successive interactions. Thus, the following draft definition of the means used and the role performed by intensive residential treatment units seems to be inseparable from those interactions: "The means is permanency (secure), the roles are: pluridisciplinary appraisal of the patient's situation; continuity of care and individual trajectories; and stabilisation of symptomatology." (Observations, CF4, M4, 04/2012).

4.2.2. *Enacting a Different Relationship to Rehabilitation*

As usual, the coordinator introduced the first meeting by reminding service representatives of the particular challenges involved in their function. In this case, that endeavour led him to connect the meeting process initiated at the local level to the policy programme conceived of by the public authorities. Moreover, when confronted with very large and heterogeneous groups such as committees 1 and 3, he suggested that the participants should distinguish different work areas corresponding to their needs (as local care providers) in relation to the reform.

> "There were so many of us who participated in our first meeting. It evidences that our network has many resources to bring into function 3. … This committee is the most heterogeneous group. It is because function 3does not only relate to rehabilitation services; it concerns many needs of the patient, such as social inclusion. No later than yesterday, the Federal Coordinator reminded us that function 3 was essential to the new model; it must allow us to build a link between the wide range of services that might help people in recovering…"(Observations, CF3, M1, 02/2012)

> "The public authorities planned to allocate additional means to care structures involved in function 3, to allow them to engage job coaches. That initiative takes place in the framework of the reform. Thus, it is an interesting resource for this group…" (Idem)

> "But we are a very big group; I think that we must try defining particular areas of work as a basis for our reflection. Then: which areas of work for this function? which are your expectations in relation to this function?" (Idem)

By asking services representative to express their needs in relation to the function, the coordinator intended to highlight general areas of work from which he, together with service representatives, might derive global and specific objectives to be incorporated into the local definition of the function. However, as illustrated by the interactions related below, the move from particular relationships to personal problems to global areas of work proved particularly challenging.

[1] At the very beginning of the meeting, an experiential expert suggested to service representatives that a duty for this group might consist in finding a way to provide service users with information, and with a representation enabling them to understand the network.

The coordinator took note.

[2] Following this, the representative of the Club stated that sheltered housing initiatives were interested in improving their relationships with non-specialised housing and home care services to ensure that the work on the social link initiated in the sheltered housing initiatives was continued in the patient's living environment.

[3] The representative of social housing services responded: "We are managing a great number of social housing units; however it is hard to get in contact with the psychiatric system. We are just about to set up a liaison function, so, it is time…" (Observations, CF3, M1, 02/2012).

[4] The coordinator summarised their points by stating that non-specialised workers needed training. A service representative working in social services said that she was not sure that non-specialised workers need training. In her view, specialised training might increase their fear of not being able to cope with certain situations. Representative of home care services agreed. They said that, instead of training, they needed increased possibilities for rapid contact with services able to help them in their action.

[5] Later in the meeting the coordinator remarked that, although many psycho-social rehabilitation centres (PRC) were involved in the project, they were not present everywhere in the territory. The representative of a PRC part of the Association network responded that it was not a good idea to think in terms of territory, he was not interested in "*sectors à la française*" (Idem).

[6] The representative of the Club also warned the participants: "We must pay great attention not to move from continuity of care to care order. It is challenging for mental health professionals to continuously wonder if they are not proposing easily accessible solutions instead of solutions fitting with the patient's individual trajectory. Perhaps we might think about that." (Idem)

[7] The representative of employment services then started talking. He spoke for a while, telling the participants that, due to changes in the requirements that unemployed people had to meet, his organisation's front-line staff were increasingly confronting with people with personal problems. Accordingly, it was very important for them to take part in that committee, because it provided opportunities to find ways of improving the relationships between their services and mental health services, to be recognised as a legitimate partner in debate relating to personal problems, and to share information about was what going on in both fields of employment and mental health. In passing, he reminded the participants that a social worker member of his services had participated in a therapeutic project: "At the beginning, her presence raised many issues concerning medical confidentiality and so on; she continued however to participate in

therapeutic consultation and, at the end of the pilot experience, everybody found that her presence had a therapeutic value." (Idem)

[8] Following his interjection, the coordinator suggested summarising their main areas of work: housing, professional training, information, etc. The representative of the Club interrupted him: "We cannot think only in terms of socio-professional rehabilitation, we have to think about socio-cultural solutions as well!" (Idem).

[9]A psychiatrist responsible for a PRC responded that the intent was not for everybody to do the same thing: "If we want to find an interest in meeting with each other, we must keep our identities, our specialisation in care, training, culture, and so on." (Idem)

[10] The coordinator concluded with the summary of the areas of work: "…housing, socio-professional insertion, services consultations and coordination, training, accessibility, information…" (Idem)

[11] A service representative then remarked that: "…consultation and coordination instruments had already been thought of in the framework of therapeutic project, and it had developed far beyond we had been able to imagine." (Idem)

Based on this short narrative, it is possible to distinguish between two categories of actors: those who held a particular position in the system for addressing personal problems, and those at the edge of or external to the system. Actors belonging to the first category [1-2-5-6-8-9-11] were concerned about defending their particular relationship to personal problems. Throughout the meeting, the representatives of sheltered housing initiatives and PRC expressed professional knowledge and personal convictions they developed through thinking about the local organisation of networks of services and institutions (among other the Club and the Associations) [5], by practicing particular approaches to personal problems inscribed in their structures [2], or in pilot projects in which they played an active role [10]. Thus, not only did front-line professionals care about expressing (or defending) their relationships to personal problems but, in a way similar to the heads and head doctors of psychiatric and mental health services and institutions, they conceived of their role in relation to the reform in the light of knowledge embodied throughout their individual trajectory. In that respect, it appeared that the representative of the Club intended to question conceptions enacted by the participants, with a view to remind them that they had to work in the interest of the patient [6-8]. That role was consistent with her approach to the reform, as reported in the first section of this chapter.

For their part, actors external to or at the edge of the system enacted their exclusion from the jurisdiction of personal problems. They did so by stressing that they expected service representatives to provide them with the means to understand the organisation of the system for addressing personal problems [1], and to get in contact with actors involved in that system [3-4-7]. Sometimes, they also explicitly acknowledged their intent to become part of the system [7]. In return for the increased accountability/opening they asked for, they proposed making structural [3] or human resources [7] available to the network as a whole.

Such proposals for strategic agreements –negotiated exchange of behaviour (Friedberg, 1997)– were presented as attempts to improve partnerships beneficial to people with personal problems [7]. For instance, the demand of the employment services for increased partnerships with mental health services can be understood as an attempt either to improve the ability of unemployed people with personal problems to return to employment, or to get rid of people who increase unemployment figures by moving those people from the employment to public health insurance system. The effort devoted by the representative of employment services to carefully explain the reasons why he participated in the committee proved that he was totally aware that his presence might provoke opposition.

These two categories of actors played an active role in shaping a provisory definition of the roles each of them had to play in the committee. This division of work [9] as well as provisory versions of the areas of work focused on by the committee [10].

During the following meetings, service representatives discussed those areas of work again and again, seeking for means to move from those issues reflecting particular concerns towards a general objective. In so doing, they attempted to find what was common to those different areas of work, before suggesting shifting their focus to developing work instruments that materialised that common interest. For instance:

> "The only thing that our services have in common is the patient. Thus, we might think of a communication tool that follows the patient, such as an individual care plan" (Observations, CF3, M2, 03/2012).

> Later in the meeting, after having heard the successive interventions of his colleagues, another service representative remarked: "I think that what we are doing here is something like a mapping of the network; why not explicitly decide to focus on that task? Then, we might use the map of the network to find a better route between our services." (Idem)

> In response, yet another service representative stated that he would prefer to think of the definition of the function by relying on the definition inscribed in the guide, and finally they joined together to tell the coordinator they wanted to change their methodology. They wanted "to write things down" and "to use the withe board". The coordinator agreed to work in that way, by "…starting with the global objective to specify areas of needs in relation to that objective."(Idem)

The interactions that occurred in the course of the second meeting were all directed toward finding a means to move from particular projects to a global objective, shared by the members of the committee. The participants finally agreed on using the whiteboard to write down a global objective, by drawing inspiration from the guide, before identifying specific objectives, representing different ways of interpreting the global objective in the light of concrete needs and resources existing in the local system.

The following short stories of the committees of function 1 and 2 show that from this point onwards the coordinator applied that methodology in other committees whose members were also

struggling with their concrete mandate; that is, all five committees of function. Thus, that change of methodology represented a turning point in the trajectory followed by the five committees.

The following two stories deepen the observations drawn from the interactions related above. The story of committee of function 1 shows how the members of that committee used their particular resources to give shape to their interactions, before suggesting a detailed account of the synthesis of the local version of their function.

In contrast, the story of the committee of function 2 highlights the difficulties met by service representatives in attempting to agree on the role that the four mobile teams had to play in relation to personal problems. In an attempt to understand those difficulties, the story will first highlight that some actors who had to manage the development of the mobile teams did not know what they were supposed to do with these new devices. They also ignored the role they had to play in those teams. Accordingly, they used the meetings of the committees of function to improve their knowledge of their role in relation to the reform. Following this, it will show that another reason explaining those difficulties was that key actors of the committee embodied two conflicting conceptions of the reform, respectively deriving from the PRIPH and PUPH projects. Given that the head of those hospitals had neither made explicit nor reconciled the conflict between two different conceptions of the reform involved in the merged project, members of the committee had first to express those conflicting conceptions, before being able to agree on a common vision of the function.

4.3. The Committee of Function 1

The first meeting of the function committee was attended by 30 actors from the community ecology, primary care, home care and social services. We attended five meetings of this committee. The number of participants was generally high, except for the last meeting, in June 2012, when attendance dropped to 12.

24/01/2012	Committee of function 1 – 1st meeting – 30 service representatives
05/03/2012	Committee of function 1 – 2nd meeting – 27 service representatives
17/04/2012	Committee of function 1 – 3rd meeting – 25 service representatives
29/05/2012	Committee of function 1 – 4th meeting – 20 service representatives
19/06/2012	Committee of function 1 – 6th meeting – 12 service representatives

In the course of the meeting process, service representatives and the coordinator devoted much of their attention to two subjects: the definition of the general and operational objectives of the committee; and the development of communication tools. The three first meetings chiefly consisted in discussions through which the participants introduced themselves and gradually gave shape to their common interest.

4.3.1. *Creating a Local Order Relevant to Function 1*

The first meeting was almost entirely devoted to the expression, by every participant, of the way in which the service (s)he represented might (or might not) contribute to the realisation of function 1, for instance:

> [1]The representative of a CMHS (linked to the Association): "Except for prevention, the missions associated to function 1 fit in with the Decree defining the CMHS; early detection, diagnosis, and individualised follow-ups in partnerships with the network are included in our legal mandate." (Observations, CF1, M1, 01/2012)

> [2] The representative of another CMHS (linked to the PUPH): "The concept of prevention has several meanings. I think that it is not really involved in our missions; I prefer speaking about effective accessibility. We are integrated in the social fabric, thus it is possible for us to get in contact with people who need help in expressing their mental health care needs. Financial accessibility is effective as well. I think that accessibility might be an area of work." (Idem)

> [3] The representative of health centre: "Health centres have a global understanding of patients; we might help patients to make the decision of going to CMHS." (Idem)

> [4] The representative of local social services: "We might contribute to early detection. Our services are situated in the different areas of the city and we attract members of the public who are not necessarily integrated in the care system." (Idem)

> [5] The representative of home care services: "Our workers are based in the living environment and they know about the daily life of people they care for. They can contribute to detection, but not to diagnosis. Moreover, they do not know the mental health system. Thus, they have to be informed about what exists, and then they might get in touch with you." (Idem)

Services representatives specified their possible contribution to the realisation of function 1 by relating the large area of work defined in the guide to different aspects of their situation of work, including: the Walloon Decree defining the CMHS [1]; the position of the CMHS in the social fabric [2]; defining features of their approach (i.e. global understanding) [3]; characteristics of their public [4]; and involvement of home care workers in the patients' living environment [4-5]. In passing, some of them also specified the conditions under which such contributions might be realised [5].

Along with their successive interventions, the set of resources available to the function and specific challenges the committee had to deal with were progressively identified. The role of each participant in responding to those challenges and managing those resources also gradually took shape. As illustrated below, the CMHS positioned themselves as key actors, i.e. those holding specialised knowledge particularly relevant to the realisation of function 1. At the end of the meeting, the representatives of two CMHS (respectively linked to the Association and the Club) confirmed that they would take the leadership of the development of function 1, provided that the committee set conditions under which they might perform that role without decreasing the quality of services supplied by their organisations:

The representative of a CMHS linked to the Association explained that they were committed to take an active part in the realisation of the first function: "…but we have to find means of reaching that objective and to set up adequate work procedures. Because there are two problems for the CMHS: we spend a lot of time trying to deal with increasingly intricate situations with psychosocial aspects, and we are increasingly asked for networking and to organise therapeutic consultations, and that takes a lot of time as well." (Observations, CF1, M1, 01/2012)

The representative of the CMHS linked to the Club added: "We have to ensure that function 1 will be implemented in a way that makes it possible for us to keep working correctly, because if we are able to see patients barely three time a year, that's nonsense." (Idem)

The coordinator confirmed that CMHS had a central role to play in the reform. He specified that instruments such as the individual care plan were particularly consistent with the global philosophy of the reform:

Following an interjection by the representative of a CMHS linked to the Association, who explained that instruments such as the individual care plan were central to the work performed by his organisation, the coordinator stated that: "The Federal Coordinator is particularly interested in that kind of instrument; we, the local network coordinators, will have a training session on that subject next week."

And later: "There is no particular budget allocated to the CMHS but, by creating the liaison function following the beginning of the 107, and by incorporating it in the Decree, public authorities sanctioned the importance of this function." (Observations, CF1, M1, 01/2012).

Interactions that occurred during the second meeting of the committee continued to give shape to an agreement on the specific division of work between members of the committee. That agreement first involved the recognition of the CMHS as holding specialised knowledge relevant to the realisation of function 1, and particular tools enabling the use of that knowledge in the framework of an enlarged network of services (including social and home care services). Second, it relied on the assumption that, provided that their involvement in the local network meant concrete opportunities for assistance in dealing with the personal problems they were confronted with; social and home care services would take an active part in expanding the network from community services to the patients' living environment. Third, that agreement meant acknowledging that the coordinator needed knowledge held by representatives of CMHS to be able to realise function 1 in a way consistent with the model inscribed in the guide. In fact, thanks to their involvement in the networks developed by the Association, representatives of the CMHS had inscribed the individual care plan and practiced-based knowledge of ways of working very consistent with the functional model. Fourth, given the assumption that each of them was confronted with increased difficulties in coping with their usual work, and that they did not agree to forgo forgive professional practices based on psycho-social approaches to personal problems, representatives of other CMHS agreed to join the CMHS connected to the Association in leading the local development of function 1.

That agreement on the conditions under which the members of the committee were interested in developing function 1 together found concrete expression in their decision to focus on the development of a communication tool shared by the members of the local network.

That common interest continued to take shape during the third meeting, through the collective elaboration of a local version of function one.

4.3.2. *Creating the Local Version of Function 1*

At the beginning of the third meeting, the coordinator suggested refining function one through an interactive exercise. After having reminded participants of the definition inscribed in the guide (see below), he moved from the table to the whiteboard and said, "You give me some ideas and then we'll make a phrase by putting those ideas together …" (Observations, CF1, M3, 04/2012).

> **The first function: activities on prevention and promotion of mental health care, early detection, screening and diagnostic activities**
> The first function is relating to basic tasks, all preferably in the home environment of the client. With a focus on prevention, reception of demands, early detection and early intervention, diagnosis and indication, … If necessary, therapeutic long-term continuity should be assured. Involvement of the primary care (specifically GP's) in developing this function is also important.

Services representatives succeeded one another to specify different ideas and concepts that must figure in the definitions of function 1, "such as 'understood by the members of the committee of function 1 of the FUL project'" (Idem). The following account relates their successive interventions and the way in which they were assembled to create the local definition of function 1, in the course of the third meeting of the committee of function 1, which took place in April 2012.

[1]: "Accessibility."

[2]: "I think that we could distinguish between active and passive accessibility."

[3]: "Promotion."

[4]: "WHO's definition?"

[5]: "Care accessibility?"

[6]: "The idea of care is too restrictive, why not psychopathology? It is more inclusive that 'care'."

[7]: The coordinator asked: "Do you think that function 1 had to be connected to primary care?"

[8]: "That is our objective; we are all coming from primary care!"

[9]: The coordinator agreed. However, he thought it was meaningful to specify it in the definition: "We can keep the idea but we will most probably have to reformulate it."

[10]: "The idea of networking must be included in the definition."

[11]: "Then the idea of consultation must also be expressed somewhere."

[12]: "We must clarify the idea of consultation, because consultation is like coordination: those concepts have different meanings."

[13]: "We must emphasise the idea of pluridisciplinary work."

[14]: "Inter-sectorial work as well."

[15]: "I disagree, with the term inter-sectorial we include justice as well. It will raise discussion in relation to medical confidentiality, ethics, and so on. We must specify inter-sectorial in the fields of help and care."

[16]: "I think that the idea of 'shared values' could help us going forward."

[17]: "Would not it be better to start by presenting us to each other (?); to improve our knowledge of each other, or particularities, our limits…"

[18]: The coordinator responded: "It would be time-consuming."

[19]: "Our knowledge will run through our interactions, it pervades gradually…It is very interesting, it is progressive but constant."

[20]: "Don't we have to stipulate something in relation to the outcomes? For instance: the interests of the patient?"

Following that intervention, the coordinator recapitulated the ideas expressed by the participants. He assembled those ideas as follow: 1) active accessibility; 2) WHO's definition; 3) primary care (close to the living environment); 4) networking; 5) help and care; 6) pluridisciplinary; and 7) the interests of the person. He proposed drawing on those expressions to define the general objective: "Partners of the function one have the mission…"

[21]: "It is different to say to 'we have the mission of' than 'we committed ourselves to'…"

[22]: The coordinator rephrased: "Partners of function one devote themselves to the organising of help and care networks."

[23]: "Are we really going to 'create', or rather to 'reorganize', or simply to 'improve' or 'optimise' the network (?); because the network already exists."

[24]: "It would be better to start the phrase with the idea of accessibility. It is the starting point."

[25]: The coordinator suggested: "Partners of function one devote themselves to optimise the help and care network to facilitate access to community resources."

[26]: "Those resources must also be appropriate to the needs of the person."

[27]: "Why not reverse the two parts of the phrase to put the objective first and then the means used to reach that objective: 'partners of function one committed themselves to facilitate the access to community resources appropriate to the persons' needs, by optimising the help and care network'…"

The participants discussed that last suggestion for some time. Some of them thought that they could do more than simply facilitating the access; instead the access might be improved or increased. Other stressed that the idea of increasing involved measuring. Moreover, they remarked that they must be aware of their concrete possibilities for action. Accordingly, they finally acknowledged that the idea of facilitating was the most appropriate.

The coordinator concluded that they had reached an agreement on the general objective. He urged service representatives to move on to define the operational objectives.

[28]: He told them: "Thanks to previous meetings and discussions, we already know one of the expected outputs: to have a communication tool shared by the partners of function 1." He put that the corresponding objective might be: "To formalise communication with service users."

[29]: "Are we talking about communicating with or about services users? And are we focusing on services users themselves or their situation as a whole"?

[30]: "We must distinguish between communication and consultation."

[31]: "Why not to mention our communication strategy? Strategy involves both tools and methods, and so on."

[32] The coordinator took note of those three remarks and suggested: "…'Objective 1: to formalise communication around (and with) the situation we meet; output: a tool and a strategy of communication shared by the partners of function one.'…"

[33] Then, a service representative reminded the group that: "There was a common will to communicate about the network towards the network."

[34] The coordinator responded: "This is the dimension of promotion which is in the guide."

[35] A services representative specified: "It is very important. I remember that, after the first meeting, the representative of an association asked me how to get in contact with the network. I did not know what to answer because our network had no entrance, it turns round on itself."

[36]: The coordinator responded to him: "You are raising the issue of the network gatekeeper. You know that it is a highly touchy issue in Belgium."

[37] Based on this, the coordinator suggested defining objective 3 as promoting the network and diffusing information about the network. Regarding the output, he thought that they might reasonably expect to develop a website. He mentioned that a website was an effective integration strategy for the networks partners as well. He referred to a Canadian expert who spoke at a conference organised by the FPS PH. She had explained that it was very important to enhance the integration of the network partners through, for instance, a website or common training. A participant confirmed that training was a good way of meeting each other and to know oneself. Thus, they agreed that the fourth objective was "the promotion of the links between the partners of function 1", and the associated output: "integration tools including training, immersion, conferences".

[38] A service representative then remarked that they had not yet explored the issue of early detection. Another said that the issue of detection must be connected to activation procedures. The coordinator agreed with him; he proposed the following definition: "operational objective 5: connection between early detection and intervention; associated output: referral criteria and procedures."

[39] Most service representatives disagreed. In their view, the notion of criteria was conflicting with that of detection: "By defining criteria, we limit the number and kinds of situation that we are able to see!" Moreover, they noticed that the requirement for diagnosing the situation was not involved in their objectives. The coordinator took their remarks into account. He transformed the output: "Identification of the person's needs and referral procedures."

The new methodology borrowed from learning the coordinator had gained by leading meetings of committee of function 3 (see the previous short story). The members of committee 1 willingly participated in the collective definition exercise. Except for one service representative (who thought

that they needed to know each other before they could learn what they might do together), the members of the committee thought that they could learn about each other by defining what they would to do together [17-19].

The interactions related above showed that, by discussing the operational definition of their function, the participants enacted knowledge that largely exceeded what the final version of that definition made explicit to its audience. The narration of those interactions is helpful in highlighting: 1) the scope of the common definition exercise; 2) how the members of committee 1 proceeded to gradually build the operational definition of their function; and 3) the role of the network coordinator in brokering between the local order emerging from the meetings of the committee, and its environment (including other committees of function, the network committee and the policy programme in which all of them were involved).

a)   Defining the Jurisdiction of Function 1

Knowledge enacted during this meeting concerned the primary aspects of a professional jurisdiction, as defined by Abbott (1988). That knowledge first concerned the tasks to which the members of the committee committed themselves [for instance, 1; 3; 21-23].

Second, it concerned the definition of the scope of function 1. Services representatives started defining it by including/excluding particular actors according to the way they addressed personal problems [7-9; 14-15]. It followed that only those who had a care or help relationship to personal problems were included in the function 1 jurisdiction [25].

Third, they positioned themselves in relation to their environment. They did this by considering what that environment (including the pre-existence of formal and informal services networks) meant to their concrete possibilities for action [23; 25]. By deciding to limit themselves to facilitating access to the network, they incorporated part of the environment into their definition, thus preventing the corresponding actors from questioning their right to perform the tasks to which they committed themselves.

Fourth, they positioned themselves in relation to dominant ideologies, relating key concepts such as primary care, promotion or early detection to factual knowledge (e.g. "Most of us are from primary care" [8]), to concrete needs expressed by members of the committee [35], and to strategic concerns involved in using one word instead of another [39].

b)   The Sources of Enacted Knowledge

The members of the committee of function 1 achieved a definition of their jurisdiction by producing and reproducing enacted knowledge, most of which had been inscribed in the operational definition. The interactions related above allow us to distinguish between three main sources of enacted knowledge.

First, service representatives brought professional and personal convictions into the defining process. These convictions concerned the meaning of particular concepts involved in the definition of function 1, or the meaning of the reform as a whole [1; 3-6]. Service representatives holding those convictions started enacting them at the beginning of the process, and gradually refined their formulation in the course of successive meetings. For instance, the idea of activation had been expressed at the very beginning of the first meeting, by a representative of CMHS who wanted to tell the participants what early detection meant to her. That idea had been enacted again at the beginning of the third meeting [1], before of being specified through the expression "active accessibility" [2], and then inscribed in the local version of function 1[27], replacing the concept of early detection inscribed in the guide.

Second, service representatives enacted knowledge embodied by participating in past initiatives. That knowledge became visible through references to particular conceptual assemblage designed to frame past shifts in the system. In the case related above, service representatives enacted the association of "networking"; "consultation"; "coordination"; "pluridisciplinary work"; and "inter-sectorial work" [10-14], stabilised through the therapeutic project (see NACH advisory documents and Therapeutic Projects, chapter 3). Service representatives also enacted practice-based knowledge of jurisdictional conflicts following from past enactments of such assemblages [15]. In this case, learning achieved through participating in the therapeutic projects led them to exclude particular fields of activity from their jurisdiction [15].

Third, service representatives and the coordinator [28, 33] enacted knowledge they embodied in the course of previous meetings. That knowledge had been specified and qualified through repeated enactments, before being inscribed in the operational definition finally endorsed by the committee [29-32].

c)   The Network Coordinator: Brokering between an Emerging Local Order and the Wider System

In the course of that meeting, the coordinator performed a brokering role between the local order emerging in relation to the committee and its environment, including other committees of function, the network committee and the policy programme as a whole. The growing local orders was characterised by the leading role played by representatives of CMHS, especially those connected to the Association, and the collective endorsement of a pragmatic logic of action. Accordingly, the members of the committee 1 were willing to make decisions very consistent with the global philosophy of the reform [for instance, 8; 35; 39]. Knowing the ideological debates entailed by particular concepts, the coordinator encouraged them to shape their decisions in a way that would be acceptable to the members of the network committee [9; 36], which was responsible for sanctioning work procedures suggested by the committees of function. In so doing, the coordinator relied on his knowledge of the

local care system as well as knowledge embodied by participating in conferences held in the framework of the training programme set up by the public health authorities [37].

4.3.3. *Conclusion: from Local Order to Local Knowledge of Function 1*

By relying on observations of five two-hours meetings held in the framework of the committee of function 1, we argued that the corresponding meeting process started to give shape to a particular local order which in turn informed the synthesis of a specific version of function 1. We have highlighted that inscribed and embodied knowledge held by the members of the committee was essential in explaining enacted knowledge of their common interest. For example, in the course of the first meeting related in this section, the members of the committee 1 identified particular needs associated with the function and specific means likely to improve their ability to respond to those needs. They did so by drawing on practice-based knowledge expressed by representatives of social and home care services on the one hand, and inscribed knowledge held by representatives of the CMHS on the other.

Then, based on observations of the interactions that occurred during the third meeting, we argued that the way in which service representatives gradually gave shape to their common interest, through the synthesis of their operational definition, was also informed by knowledge of past shifts and current debates unfolding in the system. Together with the coordinator brokering between the committee and its environment, the members of the committee 1 built up an operational definition able to circulate in the FUL network.

On the basis of these conclusions, we would like to formulate the following remarks. To a certain extent, inscribed and embodied knowledge held by the participants determined their ability to make sense of a particular inscription; in this case, the guide. However, such effects of disposition were not sufficient to understand the results of the collective action that arose in the framework of committee 1. In fact, as we have seen by looking at the third meeting of the committee, disposition effects had been mediated through the participants' perception of their position in the local system for addressing personal problems and the system of action developing in relation to the reform. In that respect, is worth noting that the coordinator played a strategic role by making particular knowledge of their environment available to the participants. Thus, both *disposition* and *position* effects helped in conceiving the way in which the members of the committee 1 enacted the guide. The perception of their joint influence on the defining process had be enabled by direct observation of *situations* collective action taking place in the course of meeting processes.

This means: 1) that change in the balance of power in the local system for addressing personal problems, such as supported by the developments of new local orders, cannot be separated from the definition of the problems local actors were dealing with; and (2) that precise sequences of interactions, standing for particular moments of collective action, cannot be thought of outside the global change process of which they were part, and to which they gave, in turn, particular orientations.

Thus, the combination of processual/strategic approaches stressing the importance of interests/meaning to collective action appear relevant to the understanding of what was unfolding in committees of function 1, 3 and 4 of the FUL project.

4.4. The Committee of Function 2: Seeking the Local Definition of Acute and Chronic Mobile Teams

The story of the committee of function 2 is based on observations of six two-hour meetings that took place during the period between January 2012 and January 2013.

23/01/2012	Committee of function 2 – 1st meeting – 26 service representatives
10/02/2012	Committee of function 2 – 2nd meeting – 25 service representatives
02/03/2012	Committee of function 2 – 3rd meeting – 23 service representatives
23/03/2012	Committee of function 2 – 4th meeting – 20 service representatives
23/04/2012	Committee of function 2 – 5th meeting – 21 service representatives
01/15/2013	Committee of function 2 – 10th meeting – 16 service representatives

The committee of function 2 was a big group composed of about 20 actors from the residential, rehabilitation and community ecologies. These actors were mental health professionals; mostly psychiatrists, social and psychiatric nurses, GPs and psychologists. They represented the two alliances involved in the FUL project. The meetings of that committee were also attended by representatives of primary care structures, local social services, and experiential experts trained by service user groups on the occasion of the participation project (see chapter 3).

The size and the composition of this committee showed that local actors - both those directly involved in the development of mobile teams (for instance psychiatrists and social nurses) and those viewing mobile teams as a means to improve their ability to cope with their job - were interested in the function 2. However, given that these actors were meeting for the first time, they did not know their respective positions in relation to the mobile teams and the reform in general. Furthermore, to the extent that three out of four mobile teams had not yet started working, the participants knew almost nothing about the function they were supposed to define. Accordingly, members of the committee 2 spent most of their time sharing about their conception of personal problems and the role mobile teams should play in helping people with personal problems.

4.4.1. *Attempts to Defined a Shared Jurisdiction*

At the beginning of the first meeting, the coordinator told participants that their mandate was to agree on an operational definition of function 2, including the activation procedures used by the four teams, the content of their work, their target groups and their composition. By reflecting on those dimensions of their work, the representatives of the four mobile teams expressed their conception of the role that mobile teams should play in the system and how it should be carried out. Accordingly, we will

conceive of their interactions as different attempts to agree on a common jurisdiction (Abbott, 1988), in spite of the many differences relating to work cultures.

In response to the request made by the coordinator, the charge nurse of the acute and chronic mobile teams connected to the PUPH alliance explained that the creation of the two teams was ongoing.

> Regarding the chronic team, she mentioned that the existing "Speed" team must be transformed to fit with the objectives of the FUL project. That transformation implied increasing the number of patients followed by the teams, and to make its services available to patients referred by institutions external to the PUPH alliance. In turn, it entailed engaging new workers, to train them on how to work with the members of Speed, and to train the Speed team as a whole on how to deal with a bigger network. Training included immersion in partner services and institutions.

> Regarding the acute team, she reported that they had started meeting with their colleagues from the general hospital to think about the development of acute teams in connection to emergency services. In this way, they intended to avoid patients who would better recover in the community than in residential setting being transferred directly from the emergency services to psychiatric wards or hospitals. The acute team should then accompany the return of the patient to his/her living environment and focus on improving his/her care networks (Observations, CF2, M1, 2012/01).

Through her intervention, the charge nurse made it clear that she had a strategic plan for the development of the two teams. It involved methods inscribed in the guide (immersion) and the development of concrete collaborations with new partners. However, she also stressed that she was still facing many uncertainties. She explained to the participants that she would prefer to learn how to cope with those uncertainties with the members of her current team before having to agree on common procedures with those managing the other mobile teams. As she put it later in the process: " as a team, we have to work at our cohesion and our partnerships first when we will start to work, when our first patients will be included, then the time will come to meet with our colleagues from the two other teams." (Observations, CF2, M3, 03/2012).

The head doctor responsible for the acute teams connected to the PRIPH alliance followed the charge nurse to explain his involvement. He first stated that his team had started working on 1st January. The participants did not know that one of the four teams had already started to work.

> The head doctor apologised for that. He explained that his team was ready to start from the moment the FUL project got the recognition of the IMC, and that thirty beds had immediately been frozen. He did not want to lose either the mobilising effect of the constitution of the new team or the resources released by freezing the beds.

> Following those explanations, he gave some details about the admission procedures used by the team. He specified that, in contrast to the other acute teams, he did not want to develop his team in connection to the emergency service of the general hospital. The 17 patients who were followed by the team at that moment had been referred for its intervention by GPs,

psychiatrists working in community services, emergency services and services users' relatives. Thus, referral by a medical doctor was not a necessary condition for activating his mobile team.

The intervention of the head doctor indicated that he was thinking of the development of his team very pragmatically. He had started to work by relying on general criteria but without knowing much about the functioning of mobiles teams. Accordingly, he and his team were drawing their knowledge of community practices from their daily experiences: "Many kinds of people are requesting the intervention of our team and, to be honest, we know better when we refuse to intervene than when we agree to send our mobile team at the domicile of the patient. (Observations, CF2, M2, 02/2012)

Following that intervention, the psychiatrist responsible for the chronic team connected to the PRIPH also wanted to tell the participants what was going on in his institution.

He recounted that, similarly to the charge nurse managing the PUPH teams, he was currently engaged in reflecting about the role of his team and recruiting mental health professionals to become part of the team. However, in contrast to the charge nurse, he did not know about psychiatric home care and nobody in his organisational environment had knowledge of community practices. Thus, he explained the difficulties he met in trying to set up the new team. Moreover, he stressed that medical and paramedical staff in his institution were rather opposed to the project.

He also spent a long time explaining how he conceived of his role, as a psychiatrist, in the new mobile team. According to him, it was necessary to distinguish between the referent psychiatrist and the psychiatrist-coordinator: he agreed to play the role of psychiatrist-coordinator in relation to his team, but he insisted that patients who would be followed by his teams must have a referent psychiatrist. He evoked other organisational aspects, before concluding that he would be very interested to know about the experience of the "Speed" team.

The psychiatrist told the other members of the committee that some aspects of his institutional environment were hindering the development of his team, but also that he did not know exactly how to organise that team, or the role he had to play in it. His successive interjections, throughout the six observed meetings, corroborated that first impression. When reflecting on his role, he continuously enacted the conception put forward by the head doctor of his institution: "As a psychiatrist, I cannot be the psychiatrist of every patient, I would be the psychiatrist who makes the inclusion; then we will seek for the referent psychiatrist." (Observations, CF2, M2, 02/2012). He also refined his conception by positioning himself in relation to the conception put forward by the public authorities: "They view the teams as therapeutic teams, I'm not. I am trained as psychoanalyst; for me, the link is essential to therapy, and mobile teams cannot make up for that link, they had not the necessary means for that." (Observations, CF2, M3, 03/2012).

In the course of the first meeting, service representatives thus related their respective experiences in developing the new mobile teams. In so doing, they outlined the role they would play throughout the whole process: the charge nurse of the PUPH presented herself as cautiously

assembling existing knowledge and resources in a way suitable to Reform 107; the head doctor managing the PRIPH acute teams presented himself as an experimenter, thinking of the development of his team on the basis of concrete experiences and practical knowledge collated by the team's members; and the psychiatrist in charge of the PRIPH chronic teams presented himself as a professional, seeking a new identity by confronting conceptions circulating in his institutional environment with stories told by the other members of the committee 2 and conceptions stated by public authorities.

Meanwhile, the participants did not find any way to move beyond their particular experiences to a global project, as expected by the coordinator. The head doctor responsible for the PRIPH acute team thus suggested an alternative methodology. His intervention brought about contentious situations which, in turn, justified the mediating intervention of the service representatives coming from the PUPH alliances.

> The head doctor of the PRIPH acute team reminded that he knew better when his team refused to intervene than when it agreed to move to the patient's domicile, before suggesting to define their common jurisdiction based on the limits of their interventions. Thus, he started enumerating the few criteria on the basis of which demands for mobile intervention were refused. In doing so, he mentioned that the team refused demands from patients hospitalised in psychiatric wards.

> Experiential experts reacted to that statement: they thought it would be interesting for hospitalised patients that mobile teams help them to express their needs, including that of putting an end to their hospitalisation.

> Following that intervention, participants succeeded one another to express their particular expectations in relation to mobile teams. After a while, noticing that describing what mobile teams were not doing was no more helpful than outlining what they were doing, a participant suggested reflecting in more abstract terms, by questioning why and for whom the mobile teams should exist.

> The psychiatrist in charge of the PRIPH chronic teams immediately responded: "Mobile teams are intended to patients with a psychiatric diagnosis!" That statement brought about a strong protest from services users: "Psychiatrists are not alone in deciding who psychiatric patient are!" (Observations, CF2, M2, 02/2012). The discussion between the psychiatrist and services users then raised a series of questions that diverted the attention of the participants away from their objectives.

> The service representative of the Association put an end to their discussion. He stated that they had to consider what they were going to do. He reminded that the Speed project had been testing out working with mobile teams for a while: "…and the job of that team simply consisted of an individual follow-up with a light medical treatment and great attention paid to (re)building of adequate living conditions, including participation in collective activities, a link with a GPs and referent psychiatrists, professional training, and so on." (Observations, CF2, M2, 02/2012)

> The representative of the Club also told others participants that she disagreed with how things had happened. She said that she wanted to know if they were participating in a common project where the participants were willing to change their respective ways of working to improve the consistency of the local care system, or if the partners were rather defining their work procedures independently from each other. In the second case, the only interest of the

function committee meetings consisted in sharing information; she was not interested in getting information on what some of them were doing, she was interested in building something new, a common project.

The psychiatrist responsible for the PRIPH chronic teams responded: "But what is new with the reform is the development of mobile teams." The representative of the Association disagreed: "The reform goes far beyond the development of mobile teams! The reform is about a totally different approach to patients, a different organisation of the entire system." (Observations, CF2, M2, 02/2012)

The pattern of this meeting was similar to that of the first meeting: it started with participants attempting to define a common jurisdiction, to end with the expression of particular conceptions of the objectives of the reform. It proved once again the coexistence of multiple understandings of the policy guide. Meanwhile, the services representatives continued to frame their respective role in the committee, thus giving shape to their future interactions.

First, interactions between the psychiatrist responsible for the PRIPH chronic team and experiential experts raised contentious issues and power struggles which had been enacted over the whole meeting process.

Second, through his intervention, the representative of the Association positioned himself as spokesperson for Reform 107, before suggesting that the charge nurse responsible for the PUPH mobile team might help him in performing this function. He reminded service representatives that they were not expected to recount what they thought about the reform but to concentrate on how to realise function2 at the local level. In passing, he also specified that he and the charge nurse of the PUPH mobile teams had a concrete experience of psychiatric care in the patient's living environment. As we shall see, both of them regularly used that knowledge to act as broker between the model inscribed in the guide and the conceptions expressed by the participants.

Third, the representative of the Club positioned herself as challenger. She told the participants that, despite having concrete opportunities to participate in the building of mobile teams conducted by the residential ecology, she was not interested in participating in the committee 2 meetings. Her statement caused the psychiatrist in charge of the PRIPH chronic team to outlines his understanding of the objective of the reform. That understanding reflected the conception put forward by the head doctor of the PRIPH and the main thrust of the traditional coalition. This was directly contested by the representative of the Association who straightforwardly enacted the view of the reform held by the Federal Coordinator.

4.4.2. *Seeking a New Methodology*

The third meeting started with the representative of the Club. She told the participants that she disagreed with their methodology:

> "During the last meeting, by stating what you refused to do, you excluded a series of service user groups from your jurisdiction; you started with people undergoing residential treatment, and you continued with people with drug addiction, of course!" (Observations, CF2, M3, 03/2012)

> She stressed that the only possible outcome of such a reflection was to exclude particular service user groups, especially those most often excluded from the jurisdiction of all the existing services. It seemed to her that the objective of the reform was not to make one more service available to people currently using existing services. Accordingly, she suggested focusing on how to help those people with "bad" personal problems.

> The psychiatrist responsible for the PRIPH mobile teams disagreed; he insisted that exclusion criteria had to be specified. He mentioned instances where the follow-up of people with drug addiction by a mobile team seemed inappropriate to him. Afterwards, the participants succeeded one another to recount different situations in which they "would be interested in finding somewhere to care for people outside the psychiatric system" (Observations, CF2, M3, 03/2012).Their discussions raised the question of which kinds of people were allowed to ask for the mobile teams' intervention. In that respect, the service representatives had different opinions.

> The psychiatrist responsible for the PRIPH chronic team first affirmed that, "You should not talk of a 'patient', and thus ask for a mobile team's intervention; if a medical doctor did not say that he was a patient!"(Idem)

> Experiential experts strongly disagreed: "Services users' relatives are as well placed as medical doctors to know whether or not their relative is undergoing psychiatric problems"(Idem). The representative of the Club qualified that position: "We can always try to ask you for an intervention." (Idem); the representative of health care centre specified: "From my point of view, we can even insist!" (Idem)

> The doctor responded: "Everybody cannot do everything!" In response, the experiential expert asserted that, "In other countries, there are different means to lead someone to acknowledge his illness" (Idem). That position appeared to be unacceptable to the head doctor in charge of the PRIPH acute team: "Our Belgian society is neither concentrated on law and order nor a Swiss and Protestant society, there are limits to our right to interfere in private life" (Idem).

> The coordinator concluded: "What is at stake here is the inclusion procedure!" (Idem) The other members of the committee seemed to be surprised by that conclusion. One of them put that, in any case, they would have to work a bit differently; he suggested working on the basis of concrete cases. The service representatives agreed with him. Another remarked that abstract thinking involved professional culture: "…and that professional culture is an old culture. In contrast, concrete thinking allows us to change professional culture."(Observations, CF2, M3, 03/2012)

> He added, "We are trying to think about implementing a community model by relying on the logic of action of psychiatric hospitals" (Idem). The charge nurse of the PUPH mobile teams kept going: "Those debates are unavoidable. Two big poles of the psychiatric system are meeting one another, and those poles have very different conceptions of what psychiatry is. I

would like to ease our discussions because I have worked in the patients' living environment as much as in psychiatric hospitals." (Idem) The representative of the Association joined her to explain to participants that, during the last few decades, things had changed significantly and that, even though much remained to be done, residential psychiatry made considerable efforts to open to the community. The coordinator concluded again: "There are misunderstandings between the two poles and it is necessary to air those misunderstandings, but it is also necessary to be able to go beyond such discussions!" (Idem)

The interactions that unfolded during the third meeting reinforced the local order that had been growing along with the first two meetings of the committee 2. The corresponding division of work order was as follows.

First, the representative of the Club adopted an attitude of challenger, questioning both dominant conceptions enacted by the participants and the very existence of a merged project. That attitude was consistent with the role played by other representatives of the Club attending the meetings of committees 1 and 4 (see above). It reflected the strategy of the Club in relation to the reform (see section 1 of this chapter). Second, representatives of the health centres generally joined representative of the Club in challenging conceptions enacted by actors holding a dominant position in the system for addressing personal problems. In fact, as proponents of community care, they took part in the committees of function with the explicit intent of stimulating a radical shift in the balance of power prevailing in the system. That shift entailed rebalancing the resources available to the system between primary and specialised care services.

Third, experiential experts questioned traditional conceptions of the division of work prevailing in the system for addressing personal problems. Their contributions were intended to ask mobile teams for specific interventions, or to contest conceptions of the role of the mobile teams expressed by other participants. Given their longstanding concern about the development of mobile teams (see the proposals for a future reform resulting for the Participation Project, chapter 3); they were determined to prevent the leaders of the new teams from defining their jurisdiction without taking their needs into account. However, their expectations conflicted with established definitions of the division of work in the system, including the traditional doctor-patient relationships.

Fourth, representatives of psychiatric and general hospitals linked to the PRIPH coalition were (to varying degrees) defending traditional conceptions of their work. The psychiatrist responsible for the chronic team adopted a very defensive position. That position reflected the many uncertainties he faced in his institutional environment, and the difficulties he met in attempting to conceive of his role in relation to the new mobile teams. In contrast, the head doctor responsible for the acute teams was willing to learn about his new role, as manager of a psychiatric mobile team, through concrete experiences. However, he was determined to maintain control over the activation procedure of his teams.

Fifth, the representatives of the PUPH mobile teams used practice-based knowledge of ways of working consistent with the functional model to encourage other members of the committee to move in that direction. They also made ideological conflicts explicit, thus adopting a reflexive standpoint. That attitude reflected the position of the head doctor of the PUPH hospital. It is worth noting, in fact, that the head doctor had told the scientific research teams that, thanks to the merger, conflicting professional identities were involved in the FUL project (see the second section of this chapter). On that occasion, he had specified that these conflicting logics of action would represent a big challenge for the committees of function.

Sixth, the representatives of the Association regularly enacted their knowledge of the model inscribed in the guide. That knowledge concerned both the role of mobile teams in the system for addressing personal problems and the role of the committee in relation to the reform.

Seventh, the coordinator was struggling with resurgent professional and ideological conflicts. His different attempts to moderate those conflicts were, however, systematically contested by challengers who expected him to stimulate a more radical shift in the balance of power.

Finally, although the members of the committee of function 2 did not agree on a common objective, they formed a system of interdependent actors whose respective role took shape along with successive sequences of interactions. In other words, their interactions brought about enacted knowledge of their respective identities which, in turn, informed their conception of the role they had to play in the committee, with a view to make it move in the desired direction. By repeatedly enacting their respective roles, they caused more conflicts than consensus. However, as illustrated through the presentation of the following meeting, those conflicts enabled slight changes in the balance of power characterising the committee.

4.4.3. *Raising the Local Version of Function 2*

The coordinator introduced the following meeting by announcing a change in their methodology. It seemed that the time for sharing experiences and expressing particular intentions was over. The task was now to define a global project. This entailed bringing the guide back in the meeting room:

> "It has been said (by public authorities and members of other committees of function) that a relevant methodology for the function committees might consist in defining operational objectives to be reached during the exploratory phase. The idea is to define a general objective in relation to the general definition of the function and the identity of the FUL project, before determining five operational objectives and the associated outputs. Operational objectives should force us thinking pragmatically about the operationalisation of the functional model. A good starting point is obviously the definition proposed in the guide." (Observations, CF2, M5, 04/2012)

Thus, the coordinator reminded participants of the definition of function 2 inscribed in the guide:

> **The second function: ambulatory teams offering intensive treatment for both acute and chronic mental health problems**
> The second function relates to the treatment teams in the home environment. On the one hand these are the teams for people in a sub-acute or acute condition. On the other hand these teams focus to work with people with chronic psychiatric problems.
>
> This is about the creation of a mobile service, immediately and intensively intervening in crisis situations. The intensity and duration of an intervention by such a service will be adjusted for patients with a chronic problem. In this way such a mobile service is an alternative to hospitalization.

The committee started working on that basis.

A service representative initially disagreed with the concept of mobile teams as an alternative to hospitalisation. He wanted a positive definition: "The idea is not to say where we do not work but where we are working." (Observations, CF2, M5, 04/2012). Regarding the place where they were working, many service representatives preferred substituting "care in the living environment" for "home care".

One of them wanted to stress the added value of what they were doing: "We proposed care and therapeutic follow-up in the living environment; we never did that before, it is the first time that we're going outside the hospital to be confronted with the patients' living environment - at least as far as I'm concerned." (Idem)

Another remarked that their work was not just to provide a follow-up: they must help the person to find social roles. The coordinator thus suggested adding the idea of autonomy to the definition. The psychiatrists managing the PRIPH mobile teams disagreed: "I am not a re-integrator of patients; that is not my job." (Observations, CF2, M5, 04/2012)

Accordingly, the participants discussed this for a while, seeking to distinguish between patients' quality of life and autonomy. They also focused on the idea of home versus living environment. They wanted to be very careful in defining the scope of their intervention. In fact, they were aware that, by so doing, they were excluding particular sections of the public from their jurisdiction.

The coordinator listened to them before proposing to define the objective of function 2 as: "Organising pluridisciplinary mobile teams on the territory of the project, with a view to encourage the provision of cares and therapeutic follow-ups in the living environment, in partnership with all network resources, with the prospect of autonomy." (Observations, CF2, M5, 04/2012)

The participants did not oppose that definition. However, they discussed its different dimensions again and again. The coordinator interrupted them: "The issues that you are raising are real issues to which the network must attempt to bring solutions. However, those issues are not objectives specific to function 2! What we want to know is: what might be expected from the mobile teams?!" (Idem) Although they reformulated the question a bit, service representatives agreed that every member of that committee must know what he might expect from the other.

The coordinator recapitulated: "Operational objective 1: analysis of the needs and the services supplied by function 2. Output: qualitative and quantitative description of met and unmet needs… Operational objective 2: adaptation of the functioning of the mobile teams. Objective 3: connection of the mobiles teams to the other resources of the network. Output: communication tool shared by the partners…" and so on.

He concluded: "The meeting is coming to its end, and the output associated with operational objective 3 is still missing." A service representative suggested: "Continuous assessment of work procedures?" The coordinator took note of that suggestion and told the participants: "Let it sit with us until next time." (Observations, CF2, M5, 04/2012)

The fifth meeting of the committee gave rise to the first version of the local definition of function 2. That local version drew some elements from the definition inscribed in the guide. Those elements had initially been qualified in a way that fit with the ideas of the committee's members. Other elements had then been introduced, for instance the idea of autonomy, before being combined with initial elements in a way that respected the contrasting perceptions expressed by members of the committee. For instance, the idea of autonomy became "the prospect of autonomy". In that respect, it is worth noting that the coordinator took an active part in the defining process by proposing assemblages recapitulating different kinds of arguments put forward by the participants, and by urging them to focus on defining their common objectives. However, many elements included in the guides' definition (for instance the kind of situations dealt with by mobile teams, the distinction between acute and chronic teams, and their respective publics) were not evoked in that initial definition. In fact, as we have seen through our story of the first five meetings, the participants did not succeed in reaching an agreement on those aspects.

4.4.4. *New Resources Available to the Committee of Function 2*

By attending the tenth meeting of the committee, held in January 2013, we had the opportunity to observe that the committee was still exploring the limits of the mobile teams' interventions. At that time, however, members of the committee started acquiring new resources that might help them to think of their work a bit differently.

As illustrated by the quotations below, the coordinator introduced that meeting by telling service representatives that new kinds of knowledge were becoming available in their immediate environment. He also attempted to interest them in those new kinds of knowledge, including practice-based knowledge that members of the four teams were acquiring through immersion training and knowledge of psychiatric rehabilitation models embodied by the coordinator. Then, by inviting participants to tell him if they were interested in visiting Lausanne, he attempted to enrol them in that collective learning process. Given the difficulties they met in building the local version of function two, the participants immediately expressed their interest in learning about alternative ways of working.

Two members of each of the two chronic mobile teams were undergoing practical training in Lausanne. That training was organised by federal public health authorities. It consisted in taking part in the daily work of the Lausanne teams.

The coordinator also stressed that the four teams of the FUL project were organising crossed immersion. He added that that practice should be enlarged to include other kinds of services involved in each of the functions: "immersion is the best way to understand what partners are experiencing in their work environment" (Observations, CF2, M10, 01/2013).

The members of the committee were very interested in this information; they asked what exactly the members of the mobile teams had learned from their training in Lausanne. The coordinator ensured that feedback would be presented in the network and functions committees. He also told the participants that he had attended a training session on psychiatric rehabilitation conducted by a well-known Professor form the University of Boston. This took place at the FPS PH, and gave him the opportunity to learn about a very interesting concept of "housing-first" which had been imported from New-York to the Netherlands. Accordingly, he suggested the participant travelling to Utrecht to learn more about that model. That model seemed very interesting to them to the extent that it involved a more flexible version of the model underlying the sheltered housing initiatives.

4.4.5. *Conclusion: from Political Decision to Concrete Collaboration*

The synthesis of the local version of the five care functions defined in the guide was not separable from the negotiation of the local order relevant to each function. Reaching an agreement on objectives shared by the members of the committees of function thus entailed, in some cases, challenging the balance of power prevailing in the local system. The extent to which the different committees had been struggling with that challenge depended on their on the relative (in-) consistency of the multiple logics of action claimed by the members. Meanwhile, their relative ability to think of the change process associated to their function depended on the extent to which their members held knowledge relevant to the realisation of the concerned function.

The committee of function 2 entailed conflicting logics of action, involving deeply opposing ways of thinking about the reorganisation of the system for addressing personal problems. The members of the committee inherited that opposition from the trajectory of the FUL project in which they were participating. In fact, conflicting views enacted in the course of the meeting process related above directly reflected the origin of the FUL project: two different projects respectively involving traditional and reformist conceptions of how to reorganise the Belgian system for addressing personal problems. The document which gave concrete expression to the merging of the two projects did not resolve the opposition existing between those two visions. As stated by the head of the PRIPH in the course of the meeting with the scientific research teams; that document was a political document responding to a political requirement to merge.

In addition, the document transferred the responsibility for resolving ideological issues from institutional actors at the origin of the two initial projects to front-line professionals asked to consider the local definition of function 2. Accordingly, members of the function 2 committee had first to enact

the conflict implicit in the document. Then, as the power struggles involved in their discussions started to become more explicit, they became increasingly able to focus on defining what they were going to do with the four mobile teams of the FUL project.

In that respect, however, members of the committee of function had very unequal resources. Actors associated with the PUPH coalition had not only embodied and inscribed knowledge of the care model inscribed in the guide but practice-based knowledge of working in mobile teams. In contrast, actors associated to the PRIPH coalition knew neither about the functional model nor about professional practices specific to the mobile teams. Moreover, depending on the characteristics of their institutional environment, the acute and chronic PRIPH mobile teams, respectively connected to a general and a psychiatric hospital, were more or less willing to test out new conditions of work. The psychiatrist managing the chronic team in particular faced the opposition of those who were supposed to act with him as a team. Accordingly (whether intentionally or not), he used the meeting of the committee to express the difficulties he was facing, and to think about the role he might play in his teams.

Thus, not only did the committee of function 2 have to deal with ideological issues implicit in the FUL project, but it was also faced with the heterogeneity of practices and knowledge involved in the same institutional categories resulting, ultimately, from the disorganised development of the system along ideological lines and through uncoordinated policy initiatives. The section defining the context in which the FUL project developed showed, in fact, that the two psychiatric hospitals situated in the same city involved very different ideologies and service networks.

The committee of function 2 had yet to address a third challenge: the need of front-line professionals to be involved in a particular relationship to personal problems, before being able to consider how to relate to other actors in the system. In that respect, the story of committee of function 2 showed that, even PUPH actors (who knew about mobile teams in general) needed to know about the particular development of their new team before reflecting on their articulation to the PRIPH teams.

Accordingly, based on our analyses of six meetings of committee 2, we argue that the concrete mandate of the meeting process related to committee 2 entailed the three following aspects: 1) that the four teams came to know about professional practices and relationships involved in the mobile teams; 2) that practice-based knowledge led members of the teams to acknowledge that the functional model implied, (a) a different division of work between professional systems and their target groups, (b) a new sharing of responsibilities and resources between primary and specialised care, and (c) a new sharing of resources between the three ecologies involved in the Belgian system for addressing personal problems; and 3) that each individual team, and the mobiles teams as a whole, became aware of their jurisdiction and its position in the system for addressing personal problems.

5. CONCLUSION

This conclusion first summarises how the reform stimulated change in the local care system. Following this, it stresses how the structural and social configuration of the system influenced the course of the FUL project, before raising the question of the role of inscribed and embodied knowledge in collective action taking place in relation to the FUL project.

5.1. Changes in the Local System for Addressing Personal Problems

The local system for addressing personal problems had traditionally been divided between two systems which had developed along ideological lines. By requesting the two corresponding coalitions of actors to jointly promote the FUL project, Reform 107induced an important shift in the system. It forced the emergence of a new project incorporating the whole range of resources available locally. However, as we have seen through the first enactments, leaders of the two coalitions attempted to protect their autonomy in conducting the development of the mobile teams. Consequently, the creation of a common project, including multiple care structures with different knowledge of personal problems, had not been followed by an agreement on a common approach to the local change process, shared by the two initial coalitions.

In the meantime, attempts by the leaders of those coalitions to set conditions helping them to protect, to a certain extent, their professional and institutional jurisdictions, caused strong disagreements with the federal authorities. Those disagreements were gradually resolved through the first sequences of enactment of the FUL project. In a way similar to key actors of the REST project, key actors of the FUL project became increasingly aware of the scope of the reform by confronting their conception of the guide to that enacted by the federal authorities. They had succeeded in convincing the federal authorities to finance the four mobile teams and authorise the coordinator of the Red platform to manage the development of the local network. However, they also came to understand that if they wanted to maintain the trust of the federal authorities, they must take care not to underestimate certain aspects of the reform, including the development of the entire network, the stress put on the function of rehabilitation, and the empowerment of front-line professional members of the committees of function. Moreover, through the meeting with the researchers, key actors of the two coalitions had the opportunity to jointly enact their knowledge of what was at stake in the implementation of the FUL project. That meeting led them to assume that the local system involved oppositions between strong professional and institutional logics of action which might be sorted out through further meetings, especially the meetings of the function committees. Accordingly, at that stage of the process, key actors from the two initial coalitions recognised the need to collectively learn new games likely to support the growth of an integrated local network. This was a first step to be taken towards shifting the ecological and social configuration of the local system.

After this, the committees of function started to develop. Given the density of the ecological landscape corresponding to the FUL project, the development of the committees of function induced an intense process of actions/interactions involving many actors representing the residential, community and rehabilitation ecologies. They gave rise to multiple local orders inducing different kinds of questioning of the organisation of the local system for addressing personal problems. The meetings of the committees of function were places where conflicting relationships to personal problems had been simultaneously enacted by actors seeking to agree on a common definition of the problem they had to deal with: the operationalisation of one of the five care function. Depending on the composition of the committee (including its size, relative heterogeneity, and the relevance of knowledge and structural resources held by the members of the function) the local reframing of the functional model entailed more or less conflict. In some cases (particularly committee of function 2), this involved direct questioning of the traditional professional and institutional division of work by mental health professionals claiming logics of action close to the reformist network, and by representatives of services users groups. In other cases, for instance committees of function 1 and 3, the meetings rather involved a questioning of the limits of the system for addressing personal problems by actors from primary care and social help, who were seeking for means to improve their ability to cope with such problems.

On the whole, however, the successive meetings of the committees of function enabled front-line professionals and the network coordinator to enact local knowledge of the care functions they were to operationalise, and to learn about new methods and patterns of relationships consistent with that knowledge. As a result, by using those new methods and collating (part of) their enacted knowledge, they gradually moved toward the collective endorsement of new definitions of the care function and associated work procedures. Although those definitions and procedures had then to be sanctioned by the network committee (composed of leaders of the two initial coalitions) their creation by front-line professionals represented an important change in the local care system.

The creation of the FUL project, which implied relativising the strong professional projects inscribed in the two initial versions of the guide, allowed a progressive withdrawal of leaders of the two coalitions from the defining process. The merging of their projects also caused a sharp increase in the size of the committees of function, thus providing them with an increased level of representation in relation to the system as whole. Service representatives committed to take that opportunity to change the division of work prevailing in the local system thus attempted to influence the work of the committees using their knowledge of different relationships to personal problems. The collective endorsement of work instruments specific to the rehabilitation and community ecologies, especially the individual care plan, were the first signs of a gradual shift in the balance of power between the residential, community and residential ecologies. This also accounted for a significant change in the division of work between front-line professionals (who became responsible for initiating reflection and

planning the organisation of work in the system) and the top of mental health and psychiatric institutions (who were requested to sanction the decisions taken by the former).

Finally, as we have seen throughout the story of the FUL project, the meeting process involved in the creation of the committees of function prompted the development of various local orders. As highlighted by a service representative supporting the reform, the development of particular relationships to personal problems was not consistent with the overall philosophy of the global model inscribed in the guide. However, by asking front-line professionals with varying knowledge to conceive of new work procedures, federal authorities led them (whether intentionally or not) to negotiate the conditions of their collaboration through the reframing of every care function comprehended in the global model. That process caused more or less tacit agreement on the division of work prevailing in every committee, and the collective endorsement of a particular position in relation to the local system as a whole. Thus, it brought about the development of new groups of actors positioned both at the bottom of the institutional system and at the centre of the growing network.

5.2. **The Impact of the Ecological and Social Configuration of the System on Collective Action**

The story of the FUL project provided many opportunities to observe the enactment of logics of action alternatively deriving from the traditional coalition and the reformist network. It also allowed us witnessing the enactment of relationships to personal problems specific to the three ecologies identified in the first part of this work, and their relevance to collective action taking place in reference to the guide.

In that respect, the story of the FUL project first demonstrated that social actors (i.e. the traditional coalition and the reformist networks) were overlapping with ecological actors. As illustrated through the instance of the PUPH project, the residential ecology was not necessarily connected to the traditional coalition. Indeed, key actors of the PUPH project brought logics of action and networks of relationships closely aligned to the reformist network into the FUL project. Moreover, such connections to the reformist network did not involve a complete rejection of the specific relationship to personal problems involved by the residential ecology. Key actors of the PUPH project defended knowledge held by residential institutions, as well as championing the need for specialised care. Thus, although the overlapping of social and ecological configurations of actors rather complicated our account of the development of the Belgian system for addressing personal problems, it was necessary to understand how strategic actors behaved in relation to the reform.

Following this, the story of the FUL project helped us to demonstrate the importance of big ecologies(formalised through enduring institutions and involving several dozens of workers) and small ecologies (developed through flexible devices enacted by only few workers). Regarding big ecologies, we have seen that residential institutions developed very large networks of structures in the course of

the system's development, by taking the opportunities offered by successive reforms to create new facilities managed by different types of mental health professionals. However, we have also showed that regional policy initiatives, or initiatives taken by the NIHDI, enabled local actors to create other networks of community and rehabilitation structures, equally involving different types of mental health professionals. Those alternative networks came to be connected to big institutional networks through different policy initiatives, such as the therapeutic project and psychiatric home care. They involved particular relationships to personal problems, especially psychosocial and functional rehabilitation, which have been translated in very specific ways at the local level. The two alternative networks respectively developed by the Association and the Club provided very good instances of that process of local specialisation and its impact on collective action. Both the Club and the Association took every opportunity to create new structures to respond to local needs. They created CMHS, ISH and PNH, on the basis of which they took part in pilot projects such as the therapeutic projects. However, those two networks involved different ways of working and logics of action. The Association was at the origin of a very specific relationship to personal problems (deeply embedded in the community fabric, strongly linked to local powers, and significantly influenced by psychiatric rehabilitation theories) which clearly inspired the functional model inscribed in the guide (through the intermediary of the Federal Coordinator). In contrast, the Club developed a very specific relationship to personal problems, adequate to the social needs of the community of people living in a defined area of the Red city, and borrowing from both psychoanalytical theories and psychosocial approaches advocated by its members.

The story of the FUL project helped us in demonstrating the importance of such specialised relationships to personal problems to collective action. It became visible through the interventions of representatives of the Association and the Club, alternatively providing resources to conceive of the functional model and questioning dominant logics of action which hindered the local change process. The story also highlighted the importance of multiple relationships to personal problems developed through past pilot projects. It stressed, for instance, that the conceptual assemblage put forward through the therapeutic project (consultation, coordination, interprofessional networks etc.) was used by front-line professionals attempting to make sense of the functional models. Thus, on the whole, the story evidenced the need to consider the role of multiple and flexible ecologies in collective action, and to question their particular relationships to the reformist network and traditional coalition.

5.3. **The Role of Embodied Knowledge in Collective Action**

The development of the FUL project involved different kinds of embodied knowledge, including knowledge embodied by (among others): taking part in specific working groups; participating into the writing of a position paper by French-speaking psychiatrists; managing previous pilot projects; working in particular institutional environments; participating in de-institutionalisation processes in England and the United States; and working as a member of the Speed team.

That knowledge thus resulted from multiple individual and collective formal and informal experiences which all entail the active participation of actors. In fact, those experiences generally implied decisions taken by individual actors giving particular direction to their professional trajectory. For instance, the nurse in charge of the Speed team had not been obliged to leave her psychiatric wards. Instead, as a charge nurse in the PUPH hospital she had the opportunity to apply as charge nurse of the Speed team and she decided to do it. The head doctor of the PUPH also decided to conduct his psychiatric training in England and the United States. In contrast, the head doctor of the PRIPH preferred to continue his training in the local context.

In turn, that knowledge was very powerful in explaining how actors behaved in relation to the reform, that is: how they perceived the reform as a whole (see, for instance, the conceptions of the reform put forward by the head doctors of the PRIPH/PUPH); how they understood the role they had to play in the reform (see the conception of his role set out by the coordinator); how their perceived specific requests made by the federal authorities (for instance, the request to participate in the scientific evaluation); and the specific role they eventually endorsed in the committees of function (see, for instance, the role played by the psychiatrist in charge of the PRIPH mobile team and by service representatives of the Association).

Meanwhile, by relating the meetings of the committees of function, we highlighted that embodied knowledge included *know-how* (for instance, how to deal with psychiatric home care) and *know-that* (for instance, knowing that rehabilitation must be performed in community settings). Moreover, it involved strong convictions gradually conceived over the course of professional trajectories and strongly influencing the positions endorsed by service representatives. The instance of care accessibility, set out through the story of the committee of function 1, showed not only that such convictions were enacted again and again by service representatives holding them, but also that they were slightly adapted over time, as members of the committees enacted knowledge of the function they were dealing with.

Accordingly, the story of the FUL project first confirmed the importance of embodied knowledge in helping actors to make sense of particular situations. Second, it showed that embodied knowledge was, in fact, likely to change throughout successive sequences of actions/interactions. However, it seemed that those changes were small variations rather than radical shift. More precisely, they were variations intended to ensure that the conception in question became acceptable to all members of the committee, and was thus inscribed in documents resulting from the committee's meetings. Third, and consequently, the story of the FUL project emphasised the strategic aspect of embodied knowledge. On the one hand, in the context described by the guide, embodying particular knowledge of community care, mobile care, psychiatric rehabilitation, and so on, appeared to be the best means of gaining a leading position into the committees of function. On the other hand, by depending on enacted knowledge, embodied knowledge was likely to be slightly adapted to fit in with

collective definitions emerging from the meeting process, and thus to be inscribed in document intended to frame future actions/interactions.

5.4. **The Role of Inscribed Knowledge in Collective Action**

The story of the FUL project allowed us to highlight three aspects of the role of documents in collective action. First, provided that they were enacted through collective action, documents set a context in which particular resources appeared as more relevant than other kinds of resources. By referring to the guide at the beginning of the meeting process induced by the development of the committees of function, the coordinator presented it as the basis of the defining process that the committees must performed. Accordingly, service representatives continuously enacted the guide, by seeking to connect the definitions inscribed in that document to their knowledge of the local system for addressing personal problems. Service representatives embodying knowledge or holding inscribed knowledge (such as the individual care plan) that might help the group in translating abstract definitions into their concrete context of action had better resources - comparative to actors holding knowledge opposed to that inscribed in the guide - to promote them as key actors of the committee. It follows that these actors were in a position to exert significant influence on the definition of the problem the committee was dealing with, and thus on the local order emerging in relation to that problem. Therefore, the stories of the function committees illustrate that, by suggesting abstract definitions of the five functions, the guide set a particular context from which particular knowledge (and the actors holding it) was excluded, and in which other actors with other knowledge had, *a priori,* a dominant position. For that context to be realised it was necessary that actors with relevant knowledge participated in the project (as they did in the FUL project) and that those actors were willing to use that knowledge to engage in the reform, as service representatives of the Association did.

Second, the story of the FUL project seemed to corroborate the fact that not only people hold tacit knowledge: documents do too. We have stressed that the application document outlining the FUL project was more a political response than a document defining the substance of the project (i.e. by specifying a particular relationship to personal problems and the role of the involved actors, as in the case of the document outlining the REST project). Conversely, the FUL project only juxtaposed two contrasted professional projects as a direct response to a political demand, without taking care to resolve the oppositions resulting from that juxtaposition. Accordingly, it transferred the responsibility for resolving that conflict to front-line professionals in charge of enacting the document. Indeed, as we have seen through the story of committee of function 2, service representatives who had to cope with the most tricky aspects of the merged project (i.e. the development of the four mobile teams) had first to enact their conflicting logics of action, and *then* to seek for the basis of an agreement making their collaboration possible. Thus, to a certain extent, we can assert that the FUL project really grew from the interactions that took place in the function committees. Those interactions occurred in relation to

the guide, setting abstract definitions to be operationalised through the meeting process, and in relation to the FUL project, which had incorporated a wide range of care and social structures without proposing a shared basis for viewing their collaboration.

Third, the story of the FUL project allowed us to observe the synthesis of inscribed knowledge. In the last section of the FUL project case study we provided in-depth analyses of the synthesis of operational definitions of functions 1 and 2. In so doing, we emphasised the extent to which pieces of knowledge inscribed in documents were negotiated to fit in with the representations of the multiple actors involved in the committees. The painstaking work involved in the synthesis of those definitions showed the importance, for the actors involved in collective action, of refining their collective problems in a way that lent importance to the care structures they were representing. In effect, by refining the functions abstractly defined by the guide, service representatives were negotiating their jurisdiction, including the scope of their action, the way in which they wanted to relate to personal problems, and the corresponding local orders. Moreover, by stressing the many efforts devoted by service representatives and the coordinator to ensure that their definition was acceptable to key actors present in their specific and global context, we have highlighted the strategic aspect of that work. Thus, on the whole, we had the occasion to appreciate the extent to which representations of the reality inscribed in documents were mediated both by disposition effects (involving particular past experiences and situations of work), and position effects (involving a particular understanding of the context in which the document had to circulate). Situation effects (Boudon, 1989), jointly exerted by disposition and positions effects, resulted in making inscribed knowledge partial knowledge, intentionally avoiding the communication of some aspects of enacted knowledge to actors external to the function committee, and expressing other aspects in particular ways, with a view to improve their ability to circulate in the system.

Chapter VII – **DISCUSSION AND CONCLUSION**

This chapter discusses the main aspects of the sociological account of the development of the Belgian system for addressing personal problems proposed in this work. It involves: a brief reminder of the analytical and methodological decisions taken at the beginning of this work; a summary of key analytical findings following from the first and second parts of the thesis; a schematic definition of the comprehensive and processual approach to collective action endorsed in this work; and a summary of key learnings achieved through using the phenomenology of inscribed, embodied and enacted knowledge to analyse ongoing changes in the system.

Finally, a short conclusion highlights possible issues for further research, which have been raised by telling the story of past and ongoing changes in the system. Among those issues, it particularly highlights the idea of studying meetings as particular settings where collective action is made up, and that of exploring the conditions under which practice-based knowledge became a strategic resource in stimulating and envisioning change in professional and institutional systems.

1.   FROM PERSONAL PROBLEMS TO GLOBAL SYSTEMS

At the outset of this thesis, we suggested borrowing the expression "personal problems" from Abbott (1988), to designate human problems addressed by psychiatric and mental health professions and institutions. Personal problems were thus conceived as the *raison d'être* of the system; the kind of human problems in relation to which the system took shape. By taking personal problems as a starting point, we have been able to observe the gradual building of a wide-scale social system, whose successive developments went hand in hand with changes in their definition, from "madness" in the 19th century to "mental health" in the early 21st. Otherwise stated, that concept provided us with opportunities to stress the social, constructed and processual nature of institutions and professions devoted to addressing personal problems.

While personal problems were the *raison d'être* of the system, the global context represented its environment. This context includes human networks, social movements and knowledge systems in relation to which changes in the system made sense. By considering its national and international dimensions, we distinguished between two contrasting "knowledge regimes" (Mangez & Delvaux, 2008), representing different kinds of regulation relevant to the understanding of collective action in the system.

The knowledge regime specific to the national context was characterised by the progressive integration of knowledge-based regulations into a regime fundamentally based on interest. In that regime, collective action implied negotiations between intermediary actors representing the interests and the way of viewing the world of the Catholic, liberal and socialist pillars. The progressive integration of knowledge-based regulations induced new kinds of negotiations aimed to determine who should be responsible for knowledge production, and how to use it.

The second regime specific to the international context was based on knowledge. In that regime, collective action proceeded via the sharing of particular knowledge in particular ways. Knowledge involved in international regulation was initially limited to medical knowledge, before enlarging to include psychological and social knowledge, evidence and practice-based knowledge, and eventually political knowledge. We suggested considering those contrasting regimes as cardinal points likely to help us to make sense of collective action in the Belgian system for addressing personal problems.

Assuming that personal problems were the *raison d'être* of the system and the global context its environment, we conceived the Belgian system for addressing personal problems as an intermediary system. Its internal developments were viewed as mediating changes occurring in its environment to stimulate successive shifts in the subjective qualities (A. Abbott, 1988) of personal problems, and the associated professional and institutional responses. Thus, we elaborated a methodological framework enabling us to understand the internal developments of the system in relation to changes in its environment.

1.1. The Ecological System, Dominant Games and the Change Process

We proposed a methodological framework enabling us to account for the growth of a wide scale social system over a long period of time. That framework is based on the association between the interactionist and the strategic approach to collective action. By relying on that association, we derived a series of basic assumptions as to the composition of, and movement in, the system for addressing personal problems.

Those basic assumptions were: 1) the development of the Belgian system for addressing personal problems was composed of interrelated events; 2) events consist of series of actions/interactions; 3) actions/interactions involve human, empirical and strategic actors; 4) actions/interactions are situated; 5) they result from the perception of common problems; and 6) common problems have both subjective and objective qualities.

Alongside those basic assumptions, our methodological framework involves particular conceptions of professions, organisations and public action. Those conceptions entailed a relativisation of the associated sociological objects. First, professions were viewed as social movements claiming particular knowledge of human problems and relating to other various kinds of actors (particularly professional and occupational groups, public authorities and their clients) in collaborative or competitive ways, depending on their position in relation to the problem at hand. Second, organisations were viewed as mere contexts of actions defining a set of constraints and opportunities taken into account by strategic actors when negotiating the conditions of their concrete collaborations, or "local orders". Third, public policy making and implementation consisted in practical activities through which different kinds of actors attempted to address collective problems, by relying on: a) past policy learning; and b) incomplete knowledge of the problem in question and the environment in which their decisions had to be implemented on the other.

Relativised conceptions of professions, organisations and public action risked viewing the system as an undifferentiated and disintegrated social whole, a perspective in conflict with our empirical observations. Thus, seeking a means to reassemble the system growing in relation to personal problems, we suggested employing the concepts of *linked ecologies*, *systems of concrete action* and *social process* into a global methodological framework.

First, by borrowing the concept of linked ecologies from Abbott (2005), we meant to denote *differences* existing between actors of the system; that is, different relationships to personal problems, and their interdependence. Indeed, we assumed that these different relationships to personal problems grew in relation to one another.

Second, based on the concept of system of concrete action defined by Crozier and Friedberg (1980; 1997), we intended to account for social mechanisms ensuring the integration of multiple ecologies into an encompassing system and directing its concrete developments. The idea of interdependent games was particularly helpful to understand cross-regulations through which the social configuration of the system was maintained, in spite of regular changes in its ecological configuration.

Third, by mobilising the concept of social process, we accounted for the interrelation of different phases of the system's development. By assuming continuous enactments of contextual elements, or conditions, through interrelated sequences of action/interaction, this concept allowed us to understand that one sequence "reverberated" (R Freeman, 2012), to a certain extent, the preceding sequences. Consequently, it also enabled us to explain the existence of a continuing rhythm in the change process, in spite of the variations caused by strategic negotiations and sense-making activities induced by collective action. Finally, by accounting for the overall change process in terms of paradigm shift, we meant to situate successive sub-processes in relation to their various dimensions, including changes in public conception, policy objectives, policy means and social configuration.

1.2. Following Changes into Collective Action

Our endeavour to adapt our global framework to in-depth analyses of ongoing collective action, considered as involving several ecologies at once and occurring at different levels of action, led us to complement it with the phenomenology of embodied, inscribed, and enacted knowledge. Freeman and Sturdy (2014) intended that phenomenology to relate to the study of how knowledge was used and transformed through collective action. We argued that it provided adequate means to analyse ongoing changes in the system, in a way consistent with the basic assumptions involved in our global framework.

First, by considering different kinds of material supports (ranging for mental health services to instruments to documents) resulting from the inscribment of a particular knowledge of a particular problem, the concept of inscription allows us to recognise the role of both large- and small-scale inscription in orienting collective action. This concept insists on the role of inscriptions (whatever

their size, formalisation or origin) in providing actors with resources to think of and/or act on a particular problem. Consequently, it simultaneously draws attention to macro social process giving rise to big institutions and micro social process giving rise to small inscriptions. Incorporating both of these into the same sociological account highlights that macro-processes/big institutions and micro-processes/flexible devices went hand in hand to support collective action from the very beginning of the system development. Thus, it is helpful in overcoming theoretical oppositions between big institutions conceived as a typical product of bureaucratic systems, and flexible devices viewed as characteristic of post-bureaucratic systems (De Munck et al., 2003). Our empirical material showed that, while the degree of formalisation of flexible devices increased, in fact, in the course of the two last decades, they had supported shifts in the system organisations from the early 1960s.

Second, the concept of embodied knowledge draws attention to the importance of individual trajectories in explaining the respective resources of different kinds of actors in relation to collective action (a. Abbott, 2005). It invites us to consider the impact of past individual experiences on ongoing collective action, even if these experiences cannot be deduced from explicit memberships to a profession or organisation; for instance, the fact of being a psychiatrist or of representing psychiatric hospital. Moreover, by insisting on the indivisibility of embodied knowledge and human beings; this concept points to the strategic aspect of decisions relating to the inclusion/exclusion of particular actors in/from collective action. Consequently, it is appropriate to a processual and comprehensive understanding of the development of different sets of individual resources, representing different abilities to handle a particular situation.

Third, the concepts of inscribed and embodied knowledge involved the idea of movement. They include an invitation to follow them as they are changed through, or stimulate change in, collective action. The idea of circulation is particularly present in the definition of inscriptions, including documents. The assumption that documents are designed to circulate in multi-level systems implies a need to follow them from global to local systems, and to trace the system of action growing in relation to collective projects of which they are the material expression. Meanwhile, tracing that system of action affords opportunities to observe various kinds of enactments, or social expressions, of the initial inscription.

Fourth, the concept of enacted knowledge reminds us that inscribed and embodied knowledge are always mediated through strategic actors' perception of their situation. Indeed, the concept of enacted knowledge draws attention to the fact that even very effective inscriptions (i.e. inscriptions which proved their ability to stimulate change in different contexts over a certain period of time) might take on different meanings depending on the actors enacting them, and their context of action. Consequently, not only did the phenomenology provide a concrete means of viewing collective action as it unfolded through multi-level systems and change processes, but it also afforded the possibility of including the intervention of local orders in the analysis.

2.   Past and Ongoing Changes in the Belgian System for Addressing Personal Problems: from Medicalisation to Socialisation

By analysing past, recent and ongoing developments in the Belgian system for addressing personal problems, we have highlighted a progressive shift from a medical and residential paradigm to a community and social paradigm for personal problems.

The ecological, processual and strategic perspective used in framing this shift allowed us to highlight the social mechanisms enhancing or hindering it, and to understand its meaning in relation to the identity of the Belgian system for addressing personal problems. Indeed, our analysis showed that regulation specific to the Belgian public health system, which contributed to the development of medical psychiatry, were progressively replaced by regulations specific to the global context, which in turn supported the development of social psychiatry.

2.1.   Recounting Past Changes in the System: an Ecological, Strategic and Processual Perspective

By relating past and recent changes in the system, we emphasised: the gradual building of linked ecologies; the progressive stabilisation of interdependent games used by strategic actors to protect or support the growth of their respective ecologies; and the existence of two contrasting coalitions/networks of actors overlapping ecologies and characterised by different sociological properties. Overall, we demonstrated that the social integration of the residential, community and rehabilitation ecologies into the system was achieved through cross-regulation directing collective action in the system, and providing its overall change process with a regular rhythm.

First, we showed that the development of interrelated ecologies entailed the gradual building of particular relationships to personal problems. Actors of the system were likely to cite those relationships to account for particular actions/decisions influencing the course of collective action. We identified three main ecologies that we termed the residential, the community and the rehabilitation ecologies. At the end of the first part of this work, we argued that these ecologies resulted from situated claims to develop new relationships to personal problems. These claims preceded the development of social entities stabilising and giving concrete forms to those relationships. Such entities involved both micro-level systems, such as the therapeutic projects, and macro-level systems, such as the NACH. They can be understood as sites of differences, likely to be connected in different ways depending on the situation in which strategic actors found themselves.

Second, we highlighted the progressive stabilisation of dominant games and their associated strategies, employed by actors to protect or support the growth of their respective ecologies. Those strategies helped our understanding of how abstract ecological relationships were transformed into concrete practices, in a way that fit with idiosyncratic local orders and professional projects. We identified two dominant games, namely the protective and offensive games, and their associated

strategies: the disintegration and conversion strategies on the one hand, and the opportunistic and decoupling strategy on the other.

Third, we have suggested defining ideal-types encapsulating the sociological properties of two contrasting coalitions/networks of actors, both overlapping ecologies. We defined the traditional coalition as a homogeneous coalition composed of institutional actors, for instance the NACH and the NIHDI. The logic of action of that coalition was enacted through public discourses and actions legitimised through references to academic knowledge held by established professions, especially the profession of medicine. The coalition was strongly connected to the Catholic pillar, providing it with strategic, human and structural resources helpful to influence the change process. By stressing the willingness of members of the Catholic pillar to reach "unthinkable alliances" provided that these helped them in protecting their institutional interests, we argued that the "pragmatic culture" identified by Kuty (2006) summarised the attitude to change endorsed by the members of that coalition.

In contrast, the reformist network was defined as a heterogeneous network connected to international movements originating from outside the system. It was wider but less integrated than the tradition coalition. However, its weak integration was compensated for by values and beliefs shared by the actors connected to the network. Those values were closely aligned to those held by the WHO for several decades. Action and discourses held by members of the reformist network were based on practical and situated knowledge on the one hand, and on a-contextual and evidence-based knowledge on the other. These two kinds of knowledge were employed by the reformist network to conceive of ways to develop social psychiatry in the system, and to defend the associated change process against attempts by the traditional coalition to translate that process in a way suitable to its own interests.

Finally, we showed that the two coalitions enacted protective and offensive games in interdependent ways. Repeated enactments of interdependent games in the course of the system's development explained how it combined ecological fluidity and institutional stability. Institutional stability was ensured by protective games enacted by the traditional coalition; conversely, repeated attempts by the reformist network to create new vacancies in the system caused changes in the ecological configuration.

By allowing for the combining of interdependent games with independent development (once created, the residential, community and rehabilitation ecologies grew independently from one another) cross-regulation supported the continuing enlargement of the system's overall jurisdiction. Such enlargement induced the gradual definition of a very comprehensive paradigm, making the system increasingly vulnerable to paradigm shift. However, shifting policy objectives and instruments were not immediately followed by corresponding shifts in the social configuration.

2.2. **Looking at Ongoing Changes in Local Orders by Drawing on the Phenomenology of Inscribed, Embodied and Enacted Knowledge**

The three case studies proposed in the second part of this work illustrated the concrete impact of the ecological and social configurations of the system on collective action. In addition, by relating successive and interrelated sequences of interactions taking place at the institutional and local levels, it emphasised the gradual questioning of the division of work and power relations between the residential, community and rehabilitation ecologies. That questioning was first reflected by the involvement of new actors in collective action, and then by the collective endorsement of new documents and instruments stabilising alternative ways to relate to personal problems.

First, the case studies of the REST and FUL projects showed that different ecologies represented different kinds of embodied and inscribed knowledge likely to be enacted in collective action to give particular direction to the change process. In the context of action defined by the policy guide supporting Reform 107, knowledge held by the rehabilitation ecology was particularly relevant. In devising Reform 107, policy makers succeeded in creating an environment in which inscribed and embodied knowledge held by actors with experience in psychiatric rehabilitation and community care became helpful resources. By relying on those resources to make sense of the functional model inscribed in the guide, those actors were able to take leadership in its local translation. This situation sharply contrasted with that prevailing to the therapeutic project and horizontal consultation, where the medical logic inscribed in the federal framework tended toward the exclusion of the community and rehabilitation ecologies from participation in the change process.

Second, the three case studies presented in the second part of this thesis highlighted repeated attempts by the reformist network and traditional coalition to reframe collective action in a way consistent with their interests. The drafting of the guide first illustrated attempts of the reformist network to take control of the devising of the Reform 107. In so doing, they relied on resources and logics of action specific to the reformist network, especially their practical experience in reforming mental health care systems in Belgium and abroad. The use of such knowledge in devising the reform was reflected through the empowerment of front-line professionals, the use of strategic and communication plans, and the creation of training and immersion programmes. Local actors embodying the kinds of knowledge required to fully make sense of those techniques seized the opportunity to take leadership of the local implementation of the reform. In the meantime, the traditional ecology disagreed with aspects of the guide, which questioned the dominant position of its members. The stories of the REST and FUL projects stressed that local actors aligned with the traditional coalition questioned the validity of the guide. They attempted to disqualify the functional care model inscribed in the guide by referring to professional rights and obligations and to documents produced by traditional knowledge brokers, such as the NACH.

Third, the stories of the REST and FUL projects showed that a sustained process of negotiations involving actors from different ecologies stimulated progressive shifts in the balance of power at different levels of the system.

At the level of policy making, the case study relating the drafting of the guide highlighted the significant role played by the Federal Coordinator in the devising of Reform 107. It also proved the relevance of policy learnings achieved by key actors from the Federal Public Health Service by conducting previous policy initiatives in the system. It emphasised that the think tank achieved specific assemblages of knowledge of international regulations embodied by the former, and knowledge of social mechanisms specific to the Belgian system embodied by the later. Those assemblages helped the think tank to create a context which hindered the enactment of protective games. Combined with the ability of the proponents of Reform 107 to use past policy learnings in purposeful ways, the participation of actors embodying different kinds of knowledge in policy making enabled the creation of a policy device likely to protect the global philosophy of the reform from being enacted in contradiction to its original intent.

At the local level, the case studies of the REST and FUL projects showed a shift in decision making power, of which a part was gradually transferred from the top of mental health and psychiatric institutions (the steering committees) to front-line professionals (the committees of function). That transfer was followed by the progressive inclusion of actors from the residential, community and rehabilitation ecologies in committees responsible for the local operationalisation of the guide. For instance, the story of the REST project showed that, in spite of repeated attempts to limit the project to their traditional partners, its leaders did not succeeded in preventing actors from the community and residential ecologies from taking an active part in the steering committee. In a similar way, the leaders of the FUL projects failed in limiting the development of the project to existing networks, for instance that created by the Red platform. Moreover, as illustrated by the merger from which the FUL project originated, the new coalitions of actors supported through the reform overcame ideological divisions. Consequently, sequences of actions/interactions unfolding during the meetings of the committees of function enabled direct confrontations of multiple types of knowledge and contrasted logics of action. Those confrontations stimulated enacted knowledge of new conceptions of personal problems, and new divisions of work and professional relationships. Sometimes, they gave rise to the collective endorsement of new work procedures and the creation of new care structures.

In conclusion, the story of past and ongoing changes in the Belgian system for addressing personal problems indicated a gradual shift from a residential and medical paradigm to a community and social paradigm. That shift concerned policy objectives, policy means and the social configuration of the system. It did not consist in a teleological process starting with changing policy objectives, continuing with changing policy means, and ending with changes in the social configuration. Instead, it was a social learning process through which strategic actors continuously adapted policy objectives to changes in their specific and global context. Policy means were modified according to changes in

policy objectives as well as policy learning achieved through participation in reforms of mental health care systems, both in Belgium and elsewhere in the world. Repeated enactment of new policy objectives and instruments enabled gradual changes in the ecological and social configuration of the system.

Changes in the ecological configuration were reflected by change in the jurisdiction of each ecology. We noticed that the residential ecology had to forgo its exclusive relationship to personal problem, ultimately sharing its jurisdiction with the community and rehabilitation ecologies. Thanks to the importance of the resources held by the traditional coalition, changes in the social configuration proved more difficult to achieve. However, in 2010, the success of proponents of community psychiatry in leading the devising of the Reform 107 indicated a shift in the balance of power. That shift found concrete expression in the policy device inscribed in the policy guide. Indeed, this policy device set a context in which front-line professionals supporting community psychiatry were encouraged to take leadership of the change process.

Thus, at the end of our story, it is possible to postulate that the Belgian system for addressing personal problems is shifting from residential to community psychiatry at the time of writing. To characterise the context prevailing to past changes in the system and the context growing from ongoing changes, we propose to schematise the residential and community system as follows.

1) In the residential system, personal problems were conceived as medical problems. They were addressed through an institutional system regulated by pillar interests and deeply embedded in the Belgian public health system. That residential system drew its legitimacy from its alliance with the medical profession, and its stability was ensured by the inscription of the medical logic in administrative rules. As a professional system dominated by the profession of medicine, its ideal was quality of care.

2) In the community system, personal problems were conceived as social problems. They were addressed through networks of structures whose integration was ensured by shared ideas and practical knowledge. That network was strongly connected to the international organisations and social movement claiming knowledge and logics of action inspired by the WHO. It drew its legitimacy from international connections and community psychiatry success stories in OECD countries. As a public system shared by professional and occupational groups (particularly psychiatrists, psychologists, social workers, educational therapists and psychiatric nurses) its ideal is the accessibility of care.

3.   UNDERSTANDING COLLECTIVE ACTION IN THE BELGIAN SYSTEM FOR ADDRESSING PERSONAL PROBLEMS

This thesis proposes an approach to collective action that considers both local orders and the institutional system in which they are involved. This section stresses the four main aspects of the comprehensive and processual approach to collective action developed in the previous chapters, before summarising the main steps which had been taken to apply it to the Belgian system for addressing personal problems. In so doing, it intends to pave the ground for possible applications of that approach to the study of other social systems.

First, by identifying and defining linked ecologies, we intended to take into account the institutional and structural system in which collective action took place, without limiting that action to particular organisations, professions or institutions. While the linked ecologies argument allowed us to account for the development of what is generally considered to be an institutional system, it did not assume fixed entities, unchanged by social interactions through which they are enacted and exerting a stable constraint on collective action. Consequently, it provided an opportunity to take into account the *differences,* or boundaries, enacted through collective action, without bringing those boundaries back to organisational, institutional or professional boundaries. For this reason, we argued that the linked ecologies perspective enabled us to address the question of the differentiation/integration of social systems in a way consistent with relativised conceptions of professions, organisations and public action.

Based on that perspective, we were able to identify both macro (i.e. the residential, community and rehabilitation ecologies) and micro ecologies (e.g. the therapeutic projects). Those ecologies, including particular actors, locations and the relationships between them, created conditions relevant to collective actions. Indeed, they entailed particular knowledge of personal problems, the use specific instruments, the development of particular professional relationships, and so on. In a similar way to the formal structure defined by Friedberg (1997), those conditions could have turned into either opportunities or constraints, depending on the situation in which actors found themselves. For instance, we noticed that the collaborative relationships that developed between psychiatrists and GPs during the therapeutic project promoted by the Peter Brothers' Psychiatric Hospital proved to be constraining in the framework of the REST project.

Second, at the individual level, the concept of disposition effects enabled us to account for the importance of past individual experiences in orienting decisions and actions taken by strategic actors. By relating the concept of disposition effects to that of embodied knowledge, we intended to stress the extent to which particular past experiences (depending primarily on individual decisions rather than an overwhelming process of socialisation) explained the relative ability of individual actors to make sense of particular situations. For instance, we have stressed that knowledge embodied by participating in meeting processes held at the initiative of the NACH significantly impacted on the way in which

local actors made sense of the policy programme. Moreover, the concept of embodied knowledge led us to show that, just as with ecological links, embodied knowledge has the potential to manifest as constraints or opportunities depending on the situation. In the instance of knowledge embodied through participation in NACH meetings, we showed that it constituted a helpful resource in the framework of the therapeutic project, before turning into a constraint in the framework of Reform 107 by limiting the extent to which local coordinators were able to make sense of the associated policy programme.

On the whole, we suggested that different kinds of relationships to personal problems and different knowledge embodied by the actors of the system constituted individual and collective dispositions, on the basis of which actors made sense of their ongoing activities. The case study of the making of the guide provided a striking illustration of this point. It showed that the think tank devised the exploratory project by taking into account: 1) the complex ecological configuration of the system (collective dispositions resulting from past changes in the system); 2) knowledge embodied by key actors of the FPS PH by managing the implementing of past initiatives (individual dispositions); and 3) knowledge embodied by the Federal Coordinator through participation in European projects (individual dispositions).

Third, we insisted that individual and collective dispositions did not simply appear out of nowhere. They are not external constraints imposed on collective action from outside the system. Instead, collective dispositions were socially constructed in the course of past changes in the system, and individual dispositions resulted from decisions taken by strategic actors attempting to orient their professional careers according to their preference. By relating sub-processes through which multiple ecologies were formed, we showed that the particularities of those ecologies (for instance, the very local and specialised relationships to personal problems developed by the CMHS) were not comprehensible outside the context of the negotiations preceding their institutionalisation. Furthermore, by retracing the genealogy of embodied knowledge relevant to understanding the local perception of Reform 107, we demonstrated that such embodied knowledge grew from particular professional trajectories, defined by individual decisions taken by particular actors working in particular institutions (e.g. the decision of the charge nurse of the PUPH hospital to run the Speed team).

Fourth, we considered collective action unfolding in particular local orders at a particular time to be embedded in a larger social process. However, assuming the embeddedness of local orders in an overall change process did not mean acknowledging ongoing collective action to be entirely determined by the process in which it took place. Otherwise stated, collective and individual dispositions were not alone in explaining the directions taken by collective action. Instead, ongoing activities induced the negotiations of individual and collective dispositions in the light of current stakes. In turn, those negotiations took an active part in giving slightly different directions to the process in which they were embedded. By analysing past changes in the system, we have highlighted

that (to the extent that they supposed collective enactment of conditions settled by previous changes) successive sub-processes reverberated past changes in the system. Accordingly, we assumed that successive reforms belonged to the same long-term process of shifting the residential and medical paradigm for personal problems. In addition, by implying the renegotiation of those conditions in the light of current stakes (for instance, deliberate attempts by particular groups of actors to take over the system) successive sub-processes entailed slight moves in the overall change process. Those moves alternatively concerned policy objectives, policy means and local professional and organisational routines.

Thus, by reviewing different instances of collective action, we showed that neither disposition nor position effects were alone in explaining how collective action unfolded in the Belgian system for addressing personal problems. Rather, these factors were interdependent in influencing the course of collective action. While disposition effects mediated the way in which strategic actors made sense of particular situations, position effects induced changes in individual and collective dispositions. Individual and collective dispositions were essential to collective action but they were in process: on the one side, the ecological configuration of the system changed following successive sequences of collective action; on the other side embodied knowledge changed by being enacted in collective settings.

Finally, we propose a summary of the main steps taken to apply that approach to collective action to the study of the change process unfolding in the Belgian system for addressing personal problems over several decades. In so doing, we mean to prepare the way for its application to other social systems that developed following public recognition of the need for dealing collectively with some human problems. Instances of such systems are provided by: the study of the growth of social work suggested by Abbott (1988); the audit system by Troupin (2012); the judicial jurisdiction by Schoenaers (Schoenaers, 2014) and the profession of architects by Champy (Champy, 2009).

Our ecological, processual and strategic approach to collective action implied making sense of past changes in the system and analysing ongoing changes. With a view to make sense of past changes in the system, we first returned to the objective qualities of personal problems. This step was required in order to be able to perceive the gradual building of their subjective definition (as mental illness, mental health, etc.). Next, by identifying actors and groups of actors involved in successive redefinitions of the problem, we delineated the social system built up in relation to personal problems.

We committed ourselves to define both the environment of the system (by indicating the main kind of regulation existing in that environment) and the inside of the system (by defining its ecological configuration and the system of concrete action underpinning it). To define the ecological configuration, we identified different relationships between particular groups of actors and personal problems. To define the system of concrete action, including interdependent games and their associated strategies, we asked questions relating to: the kinds actors involved in devising and

implementing successive changes processes; the nature of their relationships; their respective roles; and the concrete activities involved in devising and implementing policy programmes.

Afterward, we described the trajectory of the system. To this end, we focused on movements in the system. We particularly concerned ourselves with the frequency of movements, the relative interconnection of successive moments, the global orientation, and specific objectives. The analysis of movement was intended to define the overall change process and its different moments, or sub-processes, in relation to the concept of paradigm shift. On that basis, we conceptualised the Belgium system for addressing personal problem by defining ideal-types summarising its ecological, social and processual dimensions. We then put that conceptualisation to the test of empirical reality through the study of ongoing changes in the system.

To study ongoing changes in the system, we first examined the conditions in which collective action took place. To do so, we sought to identify embodied and inscribed knowledge existing in the relevant local orders. Second, we focused on the enactment of embodied and inscribed knowledge through successive and interrelated sequences of actions/interactions. We distinguished between sequences of enactment according to their purpose and the kinds of actors they involved. We paid a particular attention to: 1) the kinds of knowledge enacted by multiple actors; 2) collective knowledge growing form their interactions; 3) negotiations relating to the pieces of knowledge to be inscribed in the documents; and 4) negotiations relating to the choice of the words through which that knowledge was properly expressed.

Then, by relating enacted and inscribed knowledge produced through ongoing collective action to conditions prevailing before the start of the ongoing change process, we identified shifts in the ecological and social configurations of local care systems. Finally, by relating local movements to the overall process of change in which they were embedded, we stressed their meaning in terms of paradigms shift.

4. LEARNING CONCERNING THE ROLES OF EMBODIED AND INSCRIBED KNOWLEDGE IN COLLECTIVE ACTION

In the three cases studies presented in the second part of this work, we conceived of embodied knowledge as consisting of experiences, conceptions, ideas and convictions acquired by individual actors in the course of their professional trajectories. We assumed that they embodied knowledge by taking an active part in different kinds of professional experiences, training, pilot projects, and meeting processes.

4.1. **Embodied Knowledge**

Our case studies highlighted two limitations of the ability of embodied knowledge to orient collective action. Embodied knowledge influenced the course of collective action to the extent that actors embodying it had the opportunity to participate in collective action. As emphasised by Freeman and Sturdy, embodied knowledge moved only to the extent that the actors themselves were moving.

The case study concerning the making of the guide illustrated that point: knowledge of community system embodied by the Federal Coordinator was only mobilised to impact on the devising of the reform only when he moved from the Association to the FPS PH. In a similar way, knowledge embodied by front-line professionals working in the Association and the Club were able to impact on the operationalisation of the FUL project only to the extent that those professionals took an active part in the committees of function. Consequently, attempts to exclude particular actors from the change process can be perceived as strategies intended to prevent alternative knowledge from challenging professional and institution routines.

In contrast, the enactment of embodied knowledge depended on how actors perceived the situations in which they found themselves. Since it was enacted by strategic actors, embodied knowledge was continuously process (i.e. likely to change in the course of successive enactments). Strategic actors enacted different kinds of knowledge in different ways according to their perception of the situation and the collective knowledge progressively emerging from their interactions. Our case studies showed that adaptations followed the production of enacted knowledge concerning the respective actors involved in collective action, their position in relation to the change process and the environment in which that process was unfolding. Otherwise stated, embodied knowledge changed as new conceptions of personal problems and the corresponding local orders emerged from collective action.

In spite of those limitations, the stories of the REST and FUL projects demonstrated that embodied knowledge was essential to collective action. They highlighted that actors needed embodied knowledge in order to make sense of both particular documents and the collective action taking place in relation to that document. The story of the REST project particularly emphasised that actors who did not embody knowledge which helped them to understand the intelligence of a document felt too uncertain to enact it properly.

Moreover, the stories of both the FUL and REST projects highlighted that embodied knowledge led actors to make sense of particular documents in particular ways. Local actors made sense of the reform by relying on knowledge embodied in the course of their professional life. Since they often attached value to those experiences, they experienced great difficulties in perceiving ongoing collective action through different lenses. Thus, in order to understand how actors behaved in relation to the reform, it appeared essential to know about their particular experience; for instance in devising

NACH documents, in leading a therapeutic project, in drafting policy documents, in participating in European projects, and so on.

4.2. **Inscribed Knowledge**

In the three case studies presented in the second part of this work, we particularly focused on documents, defined as a form of inscribed knowledge circulating in the system for addressing personal problems. The main kinds of documents analysed in the case studies were the policy guide, its local version, and minutes of the steering and function committees meetings.

We also evoked advisory and policy documents in the first part of this work. We noticed that, by being referred to through successive policy initiatives, those documents participated in reshaping the public conception of personal problems. By connecting different phases of the change process to each other (especially the devising of the concept of mental health care circuits and networks by the NACH in 1997; the 2002 and 2009 IMC; the therapeutic consultation; and Reform 107) those documents also instilled the change process with a sense of purpose and continuity.

The three case studies focusing on Reform 107 first highlighted that, to some extent, inscribed knowledge included tacit knowledge and ambiguities; inscribed knowledge was not necessary neat knowledge. By having a close look to the drafting of policy and local documents, we became aware that collective the decision to inscribe a particular piece of knowledge in a document, and to express it by using particular words, required substantial negotiations. The outcome of those negotiations was often to endorse vague expressions, enabling the juxtaposition of contrasting and sometimes conflicting conceptions of the issue at stake. In the case of the guide, we noticed that it came to embody conflicting conceptions of the policy process (top-down/bottom-up; domination/regulation) and policy objectives (implementing networks and care circuits/socialising psychiatry). When the guide was jointly enacted by public authorities and local actors, the juxtaposition of such conflicting conceptions caused misunderstandings and disagreements, which blocked collective action until spokespersons of the guide made their objective explicit by telling local actors they were not asked to consider the scientific validity of the guide, but simply to implement it.

Moreover, by avoiding making the existence of such conflicting conceptions explicit, the actors responsible for drafting the document transferred the responsibility for resolving the question to other actors. For instance, we noticed that the guide transferred the responsibility for resolving the opposition between the objective of implementing care networks and that of socialising psychiatry to local actors. In a similar way, the head of the PUPH and the PRIPH hospital made front-line professionals responsible for deciding between the traditional and reformist understandings of the guide which coexisted at a local level.

Second, the story of the REST and FUL projects led us to remark that documents achieved the framing of collective action in quite pervasive ways. They did this by setting a context in which particular actors holding particular resources were in a position to take a leading role. We emphasised

that resources specific to the residential ecology, which were particularly helpful in enacting the federal framework prevailing to the therapeutic projects, were almost entirely excluded from the context set by the policy guide framing Reform 107. However, the stories of the two projects equally illustrated that the enactment of documents in a way that realised such a context required the intervention of strategic relays.

Third, the ambiguity of documents made the intervention of skilful spokespersons particularly helpful. Concerning the role of spokespersons in supporting the accurate enactment of documents, our case studies emphasised that the intervention of faithful intermediaries, enacting the guide without translating it in the context where they found themselves, were not necessarily very effective in directing the change process. Instead, they often caused strong opposition from leading local actors, who either ignored or rejected the document in question. Thus, it appeared that strategic relays were much more effective in leading the change process. By drawing equivalencies between their knowledge of local orders and their understanding of the policy programme, they succeeded in conducting the change process in a way consistent with the global philosophy of the reform on the one hand, and the collective and personal trajectories of the actors involved on the other.

Finally, our case studies emphasised the relevance of conceiving the synthesis of documents as a process where actors negotiated the basis of new local orders. By negotiating a new definition of their common problems and by seeking for words to express that conception, local actors were, in fact, seeking to reach an agreement on a new division of work and new professional relationships. Those negotiations gave them the opportunity to position themselves in relation to the problem, and to inform their partners about the resources at their disposal to deal with that problem. Consequently, we stressed that interactions through which shared conceptions of personal problems were collectively synthesised and inscribed on material supports represented key moments in the change process.

5. CONCLUSION

This thesis related the growth of a large social system devoted to the treatment of personal problems; i.e. problems successively labelled as "madness", "mental illness" and "mental health problems", from the early 1950s to the present day. That system involved heterogeneous networks of actors, including scientific experts, established professions, social movements, policy makers, services users and international organisations. It also included instruments and knowledge ranging from psychoanalytical theories to models of governance. By studying past and ongoing reforms, considered as interrelated steps towards complete paradigm shift, we sought to explain how institutional change happened in that complex social system.

By relying on focused analyses of past reforms, the thesis conceptualised the system as composed of interrelated ecologies, corresponding to different kinds of knowledge of personal problems, whose development was directed by protective and offensive games enacted by two coalitions of actors, each holding different kinds of resources to influence the change process. The

traditional coalition was embedded in the Belgian institutional system; it referred to medical knowledge of personal problems, and held an important network of institutions delivering residential treatments. In contrast, the reformist coalition was connected to international professional and policy networks stimulating change in OECD-mental health systems; it referred to practical knowledge of social psychiatry and evidence produced by international organisations such as the World Health Organisation. It also contained non-profit associations delivering community treatments.

Cross-regulations exerted through joint participation of those coalitions in successive reforms caused rapid changes in the ecological configuration of the system, while hindering change in its social organisation. Thus, we suggested thinking of the issue of change in the system as consisting of setting conditions in which the reformist coalition might extensively use its resources in conducting the reform started in 2010, Reform 107.

Based on that assumption, we presented three case studies analysing the devising of that reform at the policy level and its implementation through local networks. Those case studies drew attention to the kinds of knowledge used by key actors, and to the way in which they used it in joint attempts to take leadership of the reform. Three main findings resulted from those case studies.

First, the designing of the policy guide framing the reform consisted of assembling different kinds of knowledge together. That knowledge included policy learning achieved through past changes in the system and knowledge of alternative care models implemented in OECD-countries. They were assembled in a way that encouraged sustained enactments of resources specific to the reformist coalition, while decreasing the relevance of resources specific to the traditional coalition.

Second, local projects designed to implement the reform led local actors representing different ecologies to jointly enact their respective logics of action and knowledge of local care systems. Repeated enactments of local knowledge induced adaptations of the care model inscribed in the policy guide to local particularities, but they also allowed for changes in the collective understanding of personal problems. Thus, local adaptations did not prevent the global philosophy of Reform 107, inspired by social psychiatry, from pervading local networks, through (among other means) being inscribed in operational documents resulting from the local projects.

Finally, by following the policy guide through local networks where it was translated into concrete practices, we were able to highlight social and learning processes supporting a shift from the paradigm of residential and medical psychiatry, to social and community psychiatry. We indicated that this paradigm shift went hand in hand with changes in the therapeutic ideal associated with the system (quality of care *versus* accessibility), in the nature of the system (professional *versus* public system), and in the kinds of regulation prevailing to its development (interest-based *versus* knowledge-based).

To conclude this work, we would like to propose three alternative perspectives which might be employed to continue or to complement the story told in this thesis. The first perspective would be to concentrate on the concrete work performed by mobile teams developed through different exploratory projects. By revealing how new work procedures defined by the committees of function were

translated in practice, that perspective might complement this work. It might also support a different approach to change in the system, focused on local orders at the exclusion of the global context in which they take place. That approach might also provide opportunities to study an increased number of projects, including projects unfolding in the Flemish and Brussels regions. Such longitudinal study might set the basis for a comparison, taking into account differences between linguistic and cultural communities.

The second perspective consists of considering the change process from the point of view of service user groups. This would involve in-depth analysis of the participation project, which started on the occasion of the therapeutic projects and continued in the framework of Reform 107. A recent conference on recovery in mental health (Lille, January 2015) gave us the opportunity to present a paper summarising the main steps of the development of the participation project. That paper emphasised some issues, especially the professionalisation of "experiential experts" and the development of an instrumental and conceptual apparatus by services user groups, which could provide the basis for interesting research. Such research might complement the account of the system development suggested in this work.

The third perspective consists of developing a particular approach to the study of change in social systems dealing with multi-sided problems. This approach would draw on the observation that, in the course of the development of the system for addressing personal problems, meetings between actors from different ecologies and representing different levels of decision making power constituted key sites in relation to collective action. Indeed, from the first developments of the system in the early 1960s to the ongoing exploratory projects, meetings were the places where new professional and organisational knowledge was collectively enacted, before being inscribed in documents designed to circulate in the system.

This approach would involve defining meetings as key sites in relation to change in public action; that is to say, sites whose specific organisation induced more or less effective collective decision making and problem solving, thus impacting on the relative effectiveness of change processes. Next, it would entail identifying key aspects of meetings.

By drawing from instances of meetings reviewed in this work, we suggest emphasising the three following aspects. First, the *location of meetings* in particular places, for instance social services instead of psychiatric hospitals, seemed to be meaningful to the involved actors. The issue of the location might be detailed to identify particular dimensions to be considered, including the characteristics of the meeting room, the care with which it had been prepared, the duration of the meeting, the organisation of a lunch in the course of or following the meeting, and so on. Second, meeting processes involving successive sequences of actions/interactions seemed to stimulate the development of a particular sharing of *role* systematically inhabited by the involved actors. The perspective of the theatrical performance (Goffman, 1959) might provide interesting insights to go deeper into that issue. Third, the different meetings reviewed in this work involved a shift in the kinds

of *position and knowledge* which constituted *strategic resources* in relation to collective action. Multiple and unstable positions seemed to provide actors with relevant knowledge, enhancing their ability to think of ways to work differently. This remark might encourage us to pay a particular attention to the issue of *movement*, by wondering about the number and the kinds of displacements providing actors with resources likely to be enacted during meeting processes. Meanwhile, increased interest in the issue of movement might lead us to devote attention to the growing importance of particular forms of knowledge, especially *practice-based knowledge* acquired through experiencing particular professional practices and organisational models. In the course of the system development, practice-based knowledge was continuously used to support change in dominant institutions and established professions. Its specific role, and the way in which it performs this role in supporting change in institutional systems, might be deepened through systematic analyses of meeting processes unfolding in various social systems.

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