

The Belgian mental health reform: When a combination of soft instruments hampers structural change

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Abstract

In Europe, the mental health field is undergoing a paradigm shift from a hospital-centered, institutionalized and segmented model toward a community-based, patient-centered and more integrated model. From 2010 onwards, Belgian policymakers availed themselves of new policy instruments to complete this shift, having been hampered by strong professional and cultural barriers over the four previous decades. However, the reform objectives have only partially been achieved. Assuming that an instrument perspective on policy implementation would illustrate why the reform does not achieve its priority objectives, the article questions the relationship between the types of instruments used and the type of change induced. Drawing on the analysis of three policy implementation processes, we argue that these “soft” instruments are by nature not suitable for initiating any type of change and may have limited effects when used in certain contexts and under certain conditions. The article ends with a discussion of the three limitations of these instruments.

1 | INTRODUCTION

For several years now researchers have observed a *paradigm shift* in the mental health field (Freeman et al., 2012), from a hospital-centered, strongly institutionalized and segmented model toward a community-based, patient-centered and more integrated model.

In Belgium, policymakers launched a major political endeavor to initiate this paradigm shift. This reform of mental health care draws on a set of policy instruments belonging to the category of “new regulatory tools” (Lascoumes & Simard, 2011), enabling a “softer” mode of regulation and providing the stakeholders with greater opportunities to negotiate the change locally. These instruments are expected to induce and support change within the sector by enrolling the actors through the development of local networks. However, as different scientific evaluations of the reform have shown (Mistiaen et al., 2019), the reform objectives have so far only partially been achieved. Despite high levels of activity within the new networks and a certain shift in professional cultures and local practices, the prevailing structure of the field seems quite resistant. Several scientific studies have deplored this situation (Grard et al., 2015; Marquis & Susswein, 2020; Mistiaen et al., 2019; Nicaise et al., 2020) but more than 10 years after the launch of the reform, none of them have attempted to understand how the structure has succeeded in resisting the strong political will displayed by the reform’s advocates.

In this article, we focus on the implementation process of three different but connected policy plans that are part of a general reform of mental health care. We suggest that an instrument perspective would allow us to understand why the reform has not achieved many of its priority objectives. We argue that this type of “soft” instrument is by nature not suitable for initiating change and may have limited effects when used in certain contexts and under certain conditions. Given its complex and highly institutionalized organizational structure, mental health in Belgium offers an ideal field of study for testing this hypothesis and understanding some of the limits of these new policy instruments. Adopting a view of instruments as prospective structures with a structuring capacity (Simons & Voß, 2018), we suggest looking at the logics of action these different instruments embody. Moreover, following the *practice turn* (Freeman et al., 2011) in policy studies, we assess the implementation of these logics by examining the action, interactions and negotiations used to enact them.

In the first part of this article, we introduce a theoretical conception of policy instruments as prospective structures (Simons & Voß, 2018). After briefly describing the methodology used to collect and analyze the data in the second part, the third part of the article will be devoted to the contextualization of our case study. In the fourth part of this article, we set out our empirical material by drawing attention to the main issues behind collective action within networks, as well as the role played by the different instruments. The article ends with a discussion on the structuring capacity of these “new regulatory instruments” and the type of change they induce.

2 | THEORETICAL FRAMEWORK

2.1 | Toward a regulatory state

Over the past decades researchers have observed a strong shift toward so-called “adaptive” modes of governance (Folke et al., 2005; Olsson et al., 2006). This type of governance promotes more collaborative, integrated and horizontal forms of working and decision making (Bryson et al., 2006; Exworthy & Hunter, 2011) intended to address the complexity of contemporary social problems. In this configuration the state is adopting a more “regulatory” role (Howlett, 2000; Lascoumes & Le Gales, 2007; Majone, 1997), shifting from *rowing* to *steering* the implementation of public policies (Eliadis et al., 2005; Lascoumes & Simard, 2011). The nature of these policies is also evolving, increasingly consisting in general axiological orientations rather than in clear and precise directives (Dubois & Orianne, 2012).

Furthermore, these policies tend to promote a more general approach to the problem they claim to address, bringing together a multitude of diverse actors while transcending sectoral boundaries. They are often characterized by strong dependence on local resources and realities, leading to extensive mobilization of actors in the field (Bureau & Sainsaulieu, 2012) along with their innovative or creative capacities. Calling for active commitment of local groups of stakeholders to public action, these policies indirectly confer political responsibility on these highly heterogeneous groups. Belgian contemporary public health policies have largely followed this trend, in particular through the establishment of diverse local stakeholder networks responsible for implementing them.

This change in governance has been accompanied by the emergence of new *governance mechanisms* or *regulatory instruments*, increasingly applied to contemporary health policies at the European level (Helderman et al., 2012; Hervey, 2008). These new instruments can be qualified as more procedural than substantive (Howlett, 2000): “they lack immediate, uniformly binding, direct effects, precision and clearly delineated monitoring, dispute settlement and enforcement authorities” (Shaffer and Pollack, 2009; cited by Koutalakis et al., 2010, p. 330). Lascoumes and Simard (2011) would define them as “Either ‘non self-executive’ instruments, where implementation is more uncertain and requires the continuous mobilization and commitment of the relevant actors, or ‘non-directional’ poorly defined instruments, based on the actors’ commitment and generating indirect dynamics” (p. 15, free translation). In this sense, these instruments are often referred to as “soft”.

Lascoumes and Le Galès (2005) identify five types of policy instruments: legislative and regulatory, economic and fiscal, agreement- and incentive-based, information- and communication-based, and standards and best practices. The last three types of instruments fall into this “new (soft) regulatory instruments” category. Their deployment thus encapsulates the idea that public action is no longer limited to the action of the state and its public authorities, but calls instead for a co-production of public policy through mobilizing the resources of both the actors and the beneficiaries (Hassenteufel, 2008).

2.2 | The steering role of instruments

For several decades many authors have pinpointed policy instruments as a gateway to understanding political phenomena. Calling for a move beyond the functionalist approach, Lascoumes and Le Gales (2007) define instruments as institutions that structure and influence public policy by conveying certain aspects of the political problem being addressed, as well as the solutions under discussion: they thus favor certain interests, actors and organizations. In this institutionalist approach, policy instruments are therefore not neutral, but act as cognitive frameworks structuring collective action: “they are bearers of values, fueled by one interpretation of the social and by precise notions of the mode of regulation envisaged” (Lascoumes & Le Gales, 2007, p. 4).

In line with the practice turn (Freeman et al., 2011), Arno Simons and Jan-Peter Voß went a step further and conceptualized the instrument as a “web of practices” rather than as a “set of rules” (Simons & Voß, 2018, p. 19). Both the *institutionalist* and *practice* approaches support the idea that instruments contain knowledge about how to govern and embody structuring power. However, Voß sheds light on the nature of the instrument, which is not fixed once and for all but is a *construct*. Instruments are both abstract models and implementation arrangements and

the interaction between the two generates what he calls the “innovation journey” (Voß, 2007) during which the instrument is produced and reproduced.

Simons and Voß (2018) define policy instruments as “working as prospective structures, which interest actors into aligning their agency towards the development, retention and expansion of the instrument” (p. 19). With their concept of “instrument constituencies” they highlight both the agency behind the instrument and its trans-local nature: “Constituencies form around instruments when expectations and promises attract and generate agency in support of the instrument.” (Simons & Voß, 2018, p. 22). The instrument thus derives a structuring force from the constituency it will aggregate, aligning the practices in its environment due to the functional and especially structural promises it holds.

With their understanding of instruments as “multi-faceted prospective structures,” Simons and Voß (2018) move the focus to the agency behind the instrument. In contrast to the institutionalist perspective, the structuring capacity of the instrument is not inherent to it but is produced by practice and interactions. In this configuration, the steering capacity of public authorities can be considered as something of an illusion: “Political action, even if well concerted, is shaped by dynamics more than it shapes them” (Voß, 2007, p.39). More generally, Simons and Voß break away from the linear approach to the policy process, in which the policy implementation consists of an application or a transfer without any evolution of the content of these policies. On the contrary, the moment of implementation should be understood as a translation (Freeman, 2009) where the meaning of the policy is reinvented through the practices required by its implementation (Freeman et al., 2011). From this perspective, it is necessary to look at what people *do* to understand the results of the policy implementation.

In the rest of this article we adopt this perspective to question the structuring capacity of these “new regulatory instruments” in the light of the type of change they both allow and impede in the Belgian mental health sector. We shall try to understand around which logics of action the actors’ practices and discourses are continually constructed and how the instruments are used in justifying those logics.

3 | METHODS

3.1 | Research field

This article focuses on one general mental health reform and, more specifically, on the implementation of three policy plans which are part of it in French-speaking Belgium. These plans are intended for specific target groups that partly overlap: (a) adults age 16 and above (b) forensic patients (c) children and adolescents up to 18 years of age. These three policy plans originate from and are managed by the federal state. They embody a common political vision and rely on the same public policy instruments.

3.2 | Collection of data

This approach is rooted in various research and action research projects¹ conducted since 2009, which have enabled us to maintain a continuous presence in the mental health field. The research approach is qualitative. It combines three data collection methods, allowing a comprehensive approach to the political process.

We first carried out a comprehensive analysis of the policy documents (policy plans, policy guides and manuals, contracts and cooperation agreements) in order to grasp the formal descriptions of the political vision, expectations, instruments and type of governance. Second, we conducted semi-structured interviews ($N = 85$) with the main stakeholders involved in the implementation processes: policymakers, coordinators and network members. These interviews allowed us to understand their discourse and perceptions of the policy vision and of the challenges associated with its implementation. The interviews were always recorded and transcribed before analysis. Finally, we conducted non-participant observations ($N = 77$) of different types of meetings—political as well as network meetings—where the implementation process was discussed. We were able to directly observe the actors' negotiations and discussions as well as their inherent ideas and logics. In addition to these methods, our quasi-continuous presence in the mental health field has enabled us to follow the implementation process over the long term and to comprehend its main developments.

We conducted a content analysis (Paillé & Mucchielli, 2012) of the different types of data to establish the categories of analysis underpinning the argument set out in this article.

4 | CONTEXTUALIZATION

Given its complex and highly institutionalized organizational structure, the Belgian mental health system offers an ideal field of study for questioning the structuring capacity of these “new regulatory instruments”.

The Belgian mental health sector currently involves seven ministerial teams, each with its own level of intervention, who come together at *Public Health Interministerial Conferences*, which began to meet in the 2000s with the purpose of coordinating public health-related policy initiatives. In addition, public health management in Belgium also involves other non-governmental entities, such as the National Institute for Health and Disability Insurance, mutual insurance companies, professional associations and so on. These multiple entities largely manage their responsibilities independently, although they are by necessity strongly interdependent. The political reform addressed in this article directly challenges this complex organizational system by aiming at greater service integration.

In the following sub-section, we describe the context surrounding the advent of this political endeavor and the three political plans, which we studied: the first one is the *Mental Healthcare Reform*, also called “Psy107,” aimed at reorganizing care for adults from the age of 16. This plan established the general political vision and framework. The other two plans fully adopt this vision but as already stated, specifically target two other sub-groups: the *Forensic Policy* and the *New Mental Health Policy for Children and Adolescents*, also called “Psy0-18,” in reference to the target group.

4.1 | Toward a new organization of mental health care in Belgium

The Belgian mental health field as we know it today finds its roots in the middle of the 20th century, when psychiatry became a matter for public health rather than the court system. The sector then quickly professionalized and specialized (De Munck et al., 2003), shifting from psychiatry to mental health (Thunus, 2015). From 1975 onwards, the first Belgian policy initiatives aimed at deinstitutionalization appeared, resulting however in an expansion of services rather

than a decrease in psychiatric beds. Internationally, the shift from a psychiatric model to a community model (Freeman et al., 2012) emerged more clearly in the 2000s. When the World Health Organization (WHO) came out more strongly in favor of a more community-based management style, national mental health policies multiplied.

Given these international pressures, Belgian policymakers launched several political initiatives to reorganize the sector. Advocating inclusion, continuity of care, professional dialogue or networking, the political initiatives of the 2000s were fully in line with the international trend toward a community model. However, they failed once again to produce the desired effect: in 2008, according to results published by the WHO (2008), Belgium ranked as one of the worst in Europe in terms of sector management with its essentially hospital-based care system, high number of psychiatric beds per capita and an insufficient reintegration rate. Nevertheless these political initiatives laid the conceptual foundations of the future reform (Grard et al., 2015; Thunus et al., 2011).

In this context, the “Psy107” policy emerged as an attempt to broadly transform the sector. It was officially launched when the members of the *Public Health Interministerial Conference* decided to apply Article 107 of the Law on Hospitals and Healthcare Institutions. This article allowed for the reallocation of parts of the hospital budget in order to operationalize local networks and care circuits favoring psychiatric care, which was to be provided as close as possible to the patient's residence. The idea of the 107 policy initiative was therefore that community care increases care quality and reduces costs. The initial target group was young people over 16 and adults, but this policy initiated a broader reform of the sector. The policy guide “*Toward better mental healthcare through care circuits and networks*” (2010) was presented to the sector in 2010.

Simultaneously, the forensic sector also faced strong international pressure, since it had one of the poorest management² structures in Europe. Political initiatives were launched in the 2000s to resolve these issues, without satisfactory results. At the end of the decade more ambitious political initiatives emerged with an attempt to shift care for forensic patients from the courts to the mental health sector. Keen to implement specific forensic care pathways and reinforce community-based care, these policies rapidly adopted the political vision of “Psy107” and were formalized in 2016 through the *Forensic Masterplan*.

Several years after the launch of Psy107, the “Psy0-18” policy plan was set in motion, complementing the reform by specifically targeting children and adolescents. Policymakers presented the guide “*Toward a new mental healthcare policy for children and adolescents*” (2015) to the sector in 2015.

These three policies aim at improving deinstitutionalization of mental health care through the development of community support and better integration of mental health and social services. All three follow much the same conceptual model, based on an identical policy vision and harnessing similar policy instruments. In this sense, these policies are akin to the combination of ideas, discourse and instruments of most (mental) health-care reforms that aim to improve care integration.

The three policies also showed similarly moderate results. As an illustration, several studies (Grard et al., 2015; Marquis & Susswein, 2020; Mistiaen et al., 2019; Nicaise et al., 2020; Walker et al., 2019) made the same observation: although the policy reform led to certain noteworthy achievements, the intended results were only partially attained, both structurally and ideologically. Regarding the structural aspects, the studies highlighted the persistence of a hospital-centric approach as well as the fragmentation of care services and the exclusion of certain categories of patients. Ideologically, these findings show that collaboration within networks remains

severely hampered by the partners' own perceptions and values, for example, of what constitutes “good care,” the role of other professionals, the place of medical knowledge, professional secrecy.

In the following empirical section, we present our empirical material to illustrate the dynamics that drive the implementation processes, depending on the type of instrument employed.

5 | EMPIRICAL PART

This empirical section is divided into four parts. First we present, describe and qualify the policy vision, policy instruments and type of management. Second, we draw a portrait of the collective action taking shape within local networks. Third, we illustrate the issues raised by the implementation processes of the three policies in question over the past few years. Although variations between these different local networks exist, observation of the actors' practices and discourses within the various networks leads us to easily identify transversal issues. Fourthly we provide some concluding empirical elements.

5.1 | Vision, instruments and management: A malleable framework

5.1.1 | Which vision?

The plans of these policies promote a *vision* with specifications that are mostly organizational in nature (Marquis & Susswein, 2020). The organizational model is in line with the paradigm shift observed internationally: it is community-based, patient-centered and integrative (i.e., adopting an intersectoral approach to the management of mental health care). This represents a major break with the previous model in the sector (see Table 1 below).

Policymakers expect practices and work cultures to evolve by adopting the working principles of the policy vision.

TABLE 1 Characteristics of the traditional organizational model of the field and of the organizational model promoted by the policy

Traditional structure of the field (Hospital paradigm)	Policy vision (Community-based paradigm)
1. Hospital-centered	1. Community-based
2. Institutionalized	2. Patient-centered
3. Segmented	3. Integrated

5.1.2 | Which instruments?

In order to implement this vision, the public authorities use three types of instruments that fall under the “new regulatory instruments” category. We classified them according to the typology of Lascoumes and Le Galès (2005) (see Table 2 below).

TABLE 2 Classification of the instruments

Information-based and communication-based instruments	Agreement-based and incentive-based instruments	Standards and best practice instruments
<ul style="list-style-type: none"> • Policy guides • Exploratory projects • Network coordinators 	<ul style="list-style-type: none"> • Funding mechanisms • Cooperation agreements 	<ul style="list-style-type: none"> • The “Handbook of Innovative Practices”

First, these policies largely rely on information-based and communication-based instruments to communicate the reform as widely as possible, in order to clarify and disseminate the ideas of the policies to the field. To achieve this, policymakers use two key documents, the Psy107 and Psy0-18 policy guides (forensic policy has no guide of its own, referring instead to the Psy107), which explicitly outline both the vision and the foundations of the organizational model. To enact this vision, policymakers set up exploratory projects consisting of local networks (20 for Psy107, 12 for Psy0-18 and six for the forensic policy) bringing together signatories to a cooperation agreement as well as any institution or professional wishing to take part. Finally, political authorities set up a coordination function for each local network. These network coordinators are the spokespersons of this political vision, responsible for facilitating the creation of networks *in line* with the political vision. As inscribed in the policy plan, the network coordinators benefit from, *inter alia*, “*in-depth training in the overall concept and objectives of the mental healthcare reform*” (Psy107 policy guide, p. 16).

Second, these policies also employ agreement-based and incentive-based instruments to *involve* and *engage* field actors directly. Intended to induce more direct change and allow for control by the authorities, these are more robust instruments. On the one hand, policymakers use funding mechanisms to develop the networks and care circuits, by using Article 107 to reallocate parts of hospital budgets (which implies reducing hospital beds) as well as allocating new funding. On the other hand, this funding mechanism is organized through cooperation contracts, based on calls for projects. In practice, because of the distribution of powers³ between the Belgian federal and regional entities, the Federal Public Health authorities signed these cooperation agreements with different psychiatric hospitals.

Third, policymakers also use standards and best practice instruments such as the “Handbook of Innovative Practices” (2016), published 6 years after the reform was launched. This document summarizes “good” and “innovative” practices observed during the first years of policy implementation. The handbook is defined both as a “means of communication” with the professionals and beneficiaries affected by the policy and as a support tool for coordinators and network partners, for whom it is intended to be a “source of inspiration” for the formulation and implementation of similar practices within their networks (Handbook of Innovative Practices, 2016, p.6). By recording these local experiences, this evidence-based handbook both presents the achievements made and (re)affirms the direction to be taken within the local networks.

In political discourse, the importance given to the various instruments differs. Although instruments related to financing are important, they are not at the core of policy reform. When asked about them, public authorities say, “*it is pure technique*” (Interview with a Mental Healthcare Unit Member, 2016). According to the discourse of the political authorities, what constitutes the heart of the policies is the political vision, set out in the guides and promoted by the coordinators: “*The reform is far more ambitious than reducing hospital bed capacity and using full-time staff to provide new ambulatory care. The federal government could have done that*

without asking anyone...The important thing is to work within the vision; this is the model we apply” (Mental Healthcare Unit, 2020). We repeatedly hear the federal authorities say, “Psy107 is not just about mobile teams [i.e. funding], it is about the [policy] vision” (Interview with a Mental Healthcare Unit member, 2016). It is therefore the informational and communicational instruments that are expected to produce the intended result.

5.1.3 | Which management?

A mental health-care unit has been set up within the federal health-care administration to manage the implementation process of the policies. It brings together the various actors responsible for steering this process and instigating a general strategic approach. It includes a federal coordinator, who ensures the coordination of different policies, and deputy coordinators responsible for monitoring local networks (e.g., administrative follow-up, coaching of the network coordinators).

Regarding both the political vision and the instruments, the desire for a more “flexible” management is apparent. This is openly justified by the desire to implement a “bottom-up” vision, by adapting to the local realities of the field: “*The current organization of mental healthcare should gradually evolve [...] This implies an adaptation of each of the resources which, together, will develop their own model, based on both the creativity and originality of the actors and their location, with a view to complementarity.*” (Psy107 policy guide, p. 12).

The various instruments described reflect this desire for flexibility, providing a “general framework” within which field practices are expected to evolve. Beyond the instruments, the policy vision also offers flexibility through “soft concepts” (Marquis & Susswein, 2020) (e.g., “care trajectories” and “patient-centered organization”).

5.2 | A general picture of collective action

Before analyzing more precisely the tensions which are the focus of debate within the networks (see next sub-section), we provide general descriptive elements of the collective action unfolding within the networks since their creation.

The presentation of the first political plan initially aroused questions, concerns and curiosity within the sector, and even more broadly. The local networks rapidly attracted a multitude of organizations and professionals from different sectors (e.g., health care, education and the court system), rendering them rather fragmented from a functional, organizational and cultural point of view. These networks were responsible for discussing and deciding on how to implement the policies.

In the first years following their creation, each network went through a necessary phase of identity building and fostering mutual acquaintance. The partners exchanged information and got to know each other and their respective contexts by holding regular meetings, drafting strategic plans, charters and cooperation contracts, in order to build a framework and add substance to their network. Over the following years the coordinators all noticed an overall change in practices and perceptions, observing more exchanges and collaboration between certain institutions/sectors. However, it remains rather limited and is often linked to interpersonal relationships:

“Sometimes I’d like to see a change in mentalities because I can see that at the moment we’re still in something very... each service, sector or institution works on its own. And eventually move them on and bring them together... it’s happening;

I'm not saying it's not happening, but it's still limited. I think there's still work to be done." (Interview with a Network Partner, 2019)

Furthermore, this phase of acquaintance led to hardly any major partner involvement, collective decision making, new sharing of responsibilities or budget transfers between sectors. Currently, although variations exist between networks in some respects, a majority of them are still encountering difficulties in structuring themselves and defining a framework for action. An illustration of this is the fact that during their training sessions organized by the federal authorities and during our action research projects (organized 5–7 years after the networks were set up), most network coordinators chose to focus on structural issues (e.g., decision-making processes, roles and the distribution of responsibilities).

Networks thus remain places where discussion, debate and negotiation take up a lot of space and where *collective decision making* is difficult to achieve. Decision-making processes are often slow and chaotic, whether they are concerned with strategic or operational decisions. Even when a number of actors agree on a project idea, things seem to get stuck when it comes to taking the decision to develop it. Moreover, we commonly observe partners questioning matters they had already reached agreement on, slowing down the decision-making process. Many projects are therefore abandoned for recurring reasons, and some partners show signs of disengagement.

As a result, the networks have a rather low degree of collective achievement. What they produce remains generally limited to measures involving low levels of commitment from the organizations or which can only be qualified as "local" (i.e., depending on certain affinities between network partners). Our interviewees largely corroborated these observations and contrasted this "lack of action" or practical progress with their deep commitment.

The issues on which the meetings and debates focused seem to have remained the same since the networks were created and are still unresolved. In the following sub-section we illustrate what is still at stake as well as the role played by instruments.

5.3 | Transversal issues

The different issues that underpin collective action within the networks arise from the existing tensions between the political model promoted and the traditional model of the field (see Table 1). As we shall see, policy instruments play a major role in reinforcing these tensions, by embodying different logics of action.

5.3.1 | Hospitals as foundations

The place and role of hospitals in decision making is one of the central points of discussion in many of the networks. It is often a source of unspoken conflict, innuendo and stagnant debate.

The issue is rooted in the tension between the policy's *community-based model* and the existing *hospital-centered model* and thus sets the mental health outpatient partners against the psychiatric hospitals. More particularly, it arises from the funding method used by the federal authorities, who rely fully on hospital-type structures to deploy the networks, rather than outpatient services. This issue is even more significant within the Psy107 networks, since their very existence intrinsically depends on the reallocation procedure for hospital funds and new funding is almost non-existent. In this specific case, hospitals are sometimes symbolically called the "pillars" of the network.

“There is something a bit twisted about it. The only reason the network exists today is because hospitals have removed some of their beds [to reallocate funds to the network]. If they had not, we would not be here. [...] The political will to provide funding in this way is there. But if you look at the reform from the outside, it’s as if we’re being told, ‘Oh, we value the hospitals very much, but at the same time we’re asking them not to play a central role.’” (Interview with a Network Partner, 2019)

The fact that the network resources—whether financial or human—are contractually attached to hospitals reinforces the ambiguity surrounding the place and role of hospitals within these networks. This necessarily results in a gap in terms of responsibility and commitment between the hospitals who invest resources and the network partners who do not. The funding and contracting mechanisms thus legitimize the persistence of a certain hospital-centric attitude within the networks, by giving hospitals decision-making power:

“As a manager, I deplore the unfortunate label attached to hospitals under this reform.” On the funding mechanism: “The reaction of any hospital manager is to say: if I make staff available, it’s going to be my responsibility. What are people going to actually do? What are they going to be used for? So the tension’s been there since the beginning of the reform.” (Interview with a Network Partner, 2019)

This creates inequalities between the network partners, offering hospitals opportunities to engage in the reform without necessarily changing their way of functioning in any major way.

Outpatient services as well as the network coordinators are reacting to this by championing the political vision and principles of community-based care and horizontal management embodied in the policy guide and in the very idea of what a network is. Overall however, these instruments do not yet seem to legitimize a major shift of the organizational logics, which remains mainly hospital-centered: “*This is a negative point of this reform. They forgot outpatient care. It doesn’t show up anywhere.*” (Interview with a Network Coordinator, 2018).

We observe variations between networks, depending on their composition and the partners’ traditional connections. Whether hospitals are in a collaborative or competitive dynamic with other partners can vary the amount of leeway each has, leaving more or less room for negotiation. Although this issue seems less prominent within certain networks, it often remains an unaddressed underlying issue and frequently reappears when important decisions are on the agenda.

5.3.2 | The place for the intersectoral approach

The place for an intersectoral approach within the networks constitutes another important issue. It is rooted in the tension between the *policy model for more integration* and the existing *segmented model* and thus sets the mental health partners against the partners coming from other sectors.

Despite widely expressed willingness to “integrate” care based on the logics of collaboration between different sectors of society (e.g., social services, education and the courts), few mechanisms have been set up to achieve this. Although the different federal and regional entities co-signed the policy guides, the federal public health system remains the main “manager.” Indeed, the funding deployed for the creation of the networks has been earmarked for mental health care: “*As far as employers are concerned, with a few exceptions only mental health employers exist. So the entire financial system hinges on mental health stakeholders within large institutions. The*

rest of the network collaborates for free and does not participate in the decision-making process.” (Interview with a Network Partner, 2019)

This produces asymmetry within networks between the strategic decision-making level and the operational level in terms of intersectoral representation. While the predominance of mental health organizations in the decision-making spaces seems justified by the funding mechanisms, this situation generates a certain imbalance between partners in terms of responsibility within the networks and often influences the negotiations:

“It’s a source of tension. The megastructures that support the network financially are mental health structures but there is also the larger network that works on collective projects, which are much broader than just mental health. So there is a negotiation, a balance of power to be struck between these two levels, where the objectives are not always the same. [...] There are issues when it comes to recruitment, in terms of profile for example.” (Interview with a Network Partner, 2019)

Therefore non-mental health partners regularly experience a gap between the time they invest in the network and the responsibilities they can assume: they are invited to take part but not to take decisions. As a result it is once again the coordinators whose job it is to recall the vision and the underlying logic: “*Because this funding comes from public health, they [the mental health partners] feel they should have more say than the others. But that’s not the policy or the vision. [...] You have to constantly restate this: the vision, the intersectoral and horizontal approach.*” (Interview with a Coordinator, 2018). These aspects are therefore subject to more or less explicit negotiations between partners. The importance of this issue emerged when the network partners started drafting the charters and other documents, where the very identity of the network was to be negotiated: “*It’s not a ‘mental health’ network. It comes from the mental health sector but... it’s a network of help and care in the broadest sense.*” (Interview with a Network Partner, 2019).

In addition, there is to date little consultation between different government levels and sectors of activity at the political level. Apart from some agreements on the principle, no intersectoral funding or mechanisms exist to facilitate “intersectorality” and partnerships often face administrative and legal obstacles. The need for harmonization and collaboration between political and administrative levels is thus regularly stressed.

Once again, the agreement-based and incentive-based instruments seem to affect the actors’ local arrangements more than is the case with communicational/informational instruments: the model as currently negotiated does not yet legitimize a deeper incursion of intersectoral considerations within networks, especially within decision-making processes.

5.3.3 | Institutional logics

Going beyond institutional interests is also a central issue within the networks, one that has arisen as a result of the tension between the policy’s *patient-centered model* and the existing *institution-centered model*. It thus mainly sets the representatives of the policy vision who manage policy implementation (including network coordinators) against the network partners.

In the political discourse, it is expected that the network partners will “play the game”, that is, act within the “rules” of the policy vision. The idea is for the network members to set aside the interests of the organizations they represent and endorse a patient-centered logic: “*The most important barriers? For me these are the institutional ones. Some network partners play the game*

but others will not and always defend their own institutional interests” (Interview with a Mental Healthcare Unit member, 2017).

In reality however, the collective action unfolding within the networks remains deeply dependent on institutional logics, according to which certain partners place institutional survival before patient needs: *“This network is not consistent with people’s catchment areas. But the network was created that way because of agreements between the two institutions. [...] These are both institutional and financial issues as well as issues of collaboration between institutions, and as a result the loser is often the user.”* (Interview with a Mental Healthcare Unit member, 2017). These institutional logics can be more or less apparent, depending on the network partners’ profiles (i.e., front-line professionals rather than decision makers), environmental competitiveness or meeting agendas (i.e., decisions involving strategy or funding). Where no strong institutional stakes are apparent, the rationale within networks remains deeply rooted in single institutional realities. The needs of the services and institutions influence the partners’ discussions about the daily difficulties they encounter in caring for patients within their institution.

It is the network coordinators who have to deal with this persistent institutional logic, constantly recalling the policy objectives and the need for a patient-centered focus: *“Yesterday we were at a round table; we had to formulate recommendations at the political level, i.e. a general level. The recommendations concerned their institutions. But ... this is completely denying the general objective of the reform. It discourages me a bit sometimes.”* (Interview with a Coordinator, 2018). For the network coordinators, the challenge is to ensure professionals taking part in the meetings assume their role or “play the game” as network members, at least partially: *“When an important subject is put on the agenda, it’s the director who shows up. Well that’s good, but if it is that important I’d prefer to see people who have attended all the meetings and who can contribute constructively, rather than a director who shows up and speaks on behalf of his or her institution”* (Interview with a Coordinator, 2018).

The persistence of this institutional logic within networks is easily explained, given that networks do not own their specific funding, which is more often than not institutionalized, even when dedicated to the networks. This tends to reinforce the competitive logic between institutions: *“Every hospital in my jurisdiction has hospital facilities such as psychiatric care homes or sheltered housing initiatives and would like to see a mobile team too. They want the whole package and they want that package to be the first thing they work with. And that is how it was created; the funding is the underlying cause”* (Interview with a Coordinator, 2018).

This third observation also illustrates the limited weight of the “softest” instruments when associated with more robust instruments that legitimize the persisting logics of action, in this case an institutional logic.

5.4 | Empirical conclusions

These empirical elements highlight some of the key issues framing interactions during implementation processes. It shows that networks are the very place where opposing logics of action meet: the community-based logic comes up against a certain strengthening of the role of hospitals; the development of an integrative/general logic is challenged by the logic of segmentation that is still present, and the patient-centered logic collides with an institutional logic.

Policy instruments appear to play a particularly prominent role, as they legitimize both organizational models (see Table 3). While the *informational/communicational* as well as *standards/best practice* type of instruments (policy guides, coordinators and other documents) embody logics specific to the policy vision, the agreement-based/incentive-based instruments

TABLE 3 Classification of the instruments according to the organizational logics they embody

	Traditional structure of the field (Hospital paradigm)	Policy vision (Community-based paradigm)
Information-based and communication-based instruments		<ul style="list-style-type: none"> • Policy guides • Exploratory projects • Network coordinators
Agreement-based and incentive-based instruments	<ul style="list-style-type: none"> • Funding mechanisms • Cooperation agreements 	
Standards and best practice instruments		<ul style="list-style-type: none"> • The “Handbook of Innovative Practices”

(cooperation agreements/funding mechanisms) embody logics specific to the field's traditional structure.

The combination of these policy instruments as negotiated in the field thus reproduces these tensions: it underlines the need for change while reinforcing what exists. The nature of the network is therefore itself contradictory and ambiguous, giving rise to endless negotiations between the partners trying to make sense of it.

6 | DISCUSSION

6.1 | Performance expectations and structuring capacity

The three mental health policies we studied are largely based on new regulatory instruments: *information-based/communication-based*, *agreement-based/incentive-based* and *standards and best practices* (Lascoumes & Simard, 2011). Among them, the most apparent instruments in the political discourse are the softest ones, those that deal with ideas, while the “hardest” or “binding” instruments are considered less significant. This form of public action thus fundamentally rests on the hope of aligning the actors' practices, through a dissemination of ideas.

Policymakers seem to have fairly high expectations regarding the *performative* power of these instruments, aiming to implement an organizational and cultural change without directly altering the field structure—in other words, changing the actors' practices without changing the rules of the game. Naming local groups and defining their members as a network is intended to allow a process of identification and thus bring these networks into being: “Through the interactive processes that they set in motion, the *project* mechanisms aim to produce mechanisms of identification among the actors [...] and to develop relationships between them based, among other things, on reciprocity” (Pinson, 2005, p. 227; free translation).

However, as observed, the performative effect of these instruments is rather limited. While the functional and structural promise (Simons & Voß, 2018) of the soft instruments was encouraging at the policy launch and succeeded in bringing together many actors identifying themselves as a network, the practice alignment seems to be moderate. On the one hand, the reform allowed a certain shift in terms of professional cultures and local practices. On the other hand, this shift remains marginal and often local. Generally, the principles and logics guiding the actors in their negotiations and practices are mainly characteristic of the traditional structure of the mental health field and not of that of the political vision. As a result, the initial

structural promise of the “softer” instruments’ seems to gradually fade away, explaining why some partners disengage.

While the discourse of the political authorities fully relies on the “soft” instruments to initiate change, the “harder” instruments—those considered as “secondary technical means”—are most apparent when we examine the practices of the actors. They have more influence over what the actors agree to and greater importance during their negotiations. Because these harder instruments embody the traditional structure of the field, they create an opportunity for the most powerful actors to reenact the existing structure and secure their position in the field.

Perhaps more than the type of instrument, we argue that it is the combination of instruments—embodying different logics of action—which has not sufficiently allowed for *disruption*. It has not shifted the possibilities available to the stakeholders or legitimized other forms of action, nor has it significantly changed the game by bringing out new issues, redistributing power or creating strong new interdependencies. In conclusion, the instruments have not entrenched the new rules of the game, nor have the actors included them in their practices. Instead, a deep ambiguity surrounds the very nature of the rules, which are therefore subject to negotiation. To a certain extent they legitimize the continued presence of the prevailing logic in the field.

6.2 | Toward a paradigm shift?

The combination of instruments used in the reform results in a *two-speed implementation* of the policy plans: while ideas quickly and widely disseminate in the actors’ discourses and intentions, we observe a slower evolution of work practices, which remain partly rooted in the current organizational field model. The transformations are thus peripheral, incremental and path-dependent, taking place in a bottom-up manner through local initiatives that grow in the interstices of the varying constraints in the structure of the field. The policy implementation thus appears fragmented and variable, leading to a decoupling (Meyer & Rowan, 1977) of the level of policy and the level of practice, a gap between the general objective of reorganizing the field and the local and fragmented practices of the stakeholders.

While the political intention was to engineer a paradigm shift, that is, a third-order change as Peter Hall (1993) terms it, instead this reform currently consists in a “second-order change,” namely a variation of the instruments “without radically altering the hierarchy of goals behind policy” (Hall, 1993, p. 281). As Hall (1993) observed, a third-order change only occurs when there is a *change in terms of hierarchy of goals* and when the set of instruments employed also undergoes a radical shift.

We can therefore identify three limitations of this type of more flexible instrument. The first limitation lies in its very nature. As we have seen, these instruments show a weaker structuring capacity and therefore require the support of harder instruments to initiate structural change. Undeniably, the aforementioned case study illustrates that the *combination of soft instruments* did not create sufficient opportunity to renegotiate the structural conditions in which change takes place. We believe that overcoming the current situation and achieving the desired paradigm shift is almost inconceivable without the support of “harder” policy instruments which shift the balance of power between actors in the field. This is because the field is currently dominated by those who remain supportive of a change within the current model and not of a change to the model itself. It is therefore necessary for policymakers to consider “harder” instruments as essential to change: “hard and soft regulations reinforce rather than substitute

for each other” (Koutalakis et al., 2010, p. 340). As for soft instruments, they would need to embody the logic underlying the community-based paradigm in order to create greater consistency between instruments and less ambiguity regarding the nature of local networks. Recommendations in this regard have already been made (Thunus et al., 2019).

Second, these soft instruments, when employed in this fashion, do not seem appropriate for initiating change in such a complex, rigid and closed field. They do not identify the places and modalities of decision making or the background knowledge needed to inform decisions and action. On the contrary, the way they are currently used leaves considerable room for interpretation and the agencies and organizations involved must therefore first reach detailed agreements. The political authorities thus currently rely on the field actors’ willingness and need to collaborate, on their ability to understand and agree with each other (i.e., on the existence of common cognitive frameworks) and on pre-existing relationships based on trust. However, as numerous works on health-care systems have shown, one can rarely postulate the presence of these characteristics (trust, common knowledge...); most of the time these systems are actually characterized by considerable decentralization, a high degree of specialization, organizational fragmentation and strong professional cultures. Furthermore, given the varying local contexts, these characteristics vary in time and space.

We thus argue that the structuring power of these soft instruments can be variable and highly context-dependent, resulting in fragmented or partial implementation. However, we believe that these “softer” instruments could still initiate some change in complex fields such as these, if modulated to promote the alignment of ideas and practices. This could be achieved, *inter alia*, by proposing a well-defined cognitive framework together with clearer governance modalities (e.g., roles, responsibilities of actors within networks, decision-making frameworks, etc.)

A third limitation of this type of soft instrument is that it also requires special management and monitoring. Indeed, this case study supports the idea that policy implementation draws heavily on the deployment of middle managers with both the legitimacy and the skills to do the job. As already illustrated, the network coordinators attempt to compensate for the weakness of these instruments and their inconsistencies by trying to influence the actors’ local arrangements. The attempts by the coordinators to dismantle the structure of the field at its base are a form of “institutional work” (Lawrence and Suddaby, 2006; cited by Bergeron & Castel, 2016). They are emerging as new intermediaries or reforms leaders (Denis et al., 2015) or even as entrepreneurs of change (Bergeron & Castel, 2016) to whom a political role is delegated (Darcis & Thunus, 2020). Like institutional entrepreneurs, boundary spanners (Morse, 2010; Williams, 2002), knowledge brokers (Currie & White, 2012; Meyer, 2010) or translators (Callon, 1986), coordinators avail themselves of specific knowledge and skills that we need to better comprehend. We argue that looking more closely at what coordinators do could help us to understand contemporary forms of public action.

The results provide an understanding of the limits encountered in the implementation of these new mental health-care policies in Belgium. More broadly, they facilitate an understanding of the difficulties arising from this move toward integrated care. Although these are not explicitly “integration” policies, the mental health policies under examination are nevertheless fully in line with this movement. The results demonstrate the need to move beyond the type of magical thinking that suggests that merely proposing these integrative ideals will profoundly change professional practice. Instead they emphasize the importance of considering the context in which the change is intended and the mechanisms and instruments that will eventually lead

to it, as well as the political courage required, type of funding mechanisms, monitoring and implementation time.

7 | CONCLUSION AND LIMITS

Our aim was to understand the process of implementation of three Belgian mental health policy plans through the prism of the instruments they employ. We showed that by embodying different logics of action, the proposed combination of policy instruments induced ambiguity and reproduced the traditional structure of the field. However, to a certain extent these instruments did facilitate changes in ideas.

This research revealed three limits of these soft regulation instruments. When aiming for structural change they require: (a) the support of harder instruments (b) a favorable implementation environment and (c) close management. We argue that there is a pressing need to examine how these different variables affect the local deployment of instruments and more specifically, to analyze the practice of the coordinators. This will facilitate a greater understanding of the dynamics involved in the formation of the instruments' constituencies.

The main limitation of our argument lies in the fact the study was restricted to Belgium. Nevertheless, we believe it provides interesting food for thought regarding these new forms of governance and regulatory instruments which are now being deployed globally as part of health and social policies.

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CONFLICT OF INTEREST

The authors declare no potential conflict of interest.

DATA AVAILABILITY STATEMENT

As this data is partly the result of commissioned research, we are bound by a moral commitment not to make it public. Furthermore, the qualitative nature of the data does not easily allow for free sharing because of its density and for reasons of confidentiality and anonymity, but also because data interpretation methods are specific to each research team. If there are any questions about the data do not hesitate to contact the authors.

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ENDNOTES

- ¹ (a) “*Knowledge and Policy in the Health and Education Sectors.*” Funded by the European Commission under the Sixth Framework Programme (2006–2011); (b) “*The System for Addressing Personal Problems. From Medicalisation to Socialisation: Shifts in Belgian Mental Health and Psychiatric Institutions.*” S. Thunus (2015) PhD Dissertation; (c) “*For-Care: A ‘realist evaluation’ of the Belgian Policy Reform Programme for Mentally Ill Offenders.*” Funded by the Federal Public Health Service (2016–2020, In press); (d) Action research project with Psy107 and Psy0-18 networks (2018–ongoing); (e) Intervention in the framework of the training of network coordinators (2018–ongoing).
- ² Belgium has been condemned on several occasions for poor treatment of forensic patients, a significant number of whom are staying long-term in the psychiatric annexes of Belgian prisons where they do not receive appropriate care.
- ³ In Belgium, political powers are divided between the federal state and the regional entities. For health matters the federal state is responsible for hospital financing, while the regional entities are responsible for financing the outpatient sector.

REFERENCES

- Bergeron, H., & Castel, P. (2016). Les Habits Neufs Du Néo-Institutionnalisme ? La Redécouverte de l'ordre Méso-ologique et de l'agency. *L'Année Sociologique*, 66(1), 31–72.
- Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of cross-sector collaboration: Propositions from the literature. *Public Administration Review*, 66, 44–55. <https://www.jstor.org/stable/4096569>.
- Bureau, M.-C., & Sainsaulieu, Y. (2012). *Reconfigurations de l'Etat Social En Pratique*. Villeneuve d'Ascq: Presses universitaires du septentrion. <https://doi.org/10.4000/books.septentrion.9524>.
- Callon, M. (1986). Eléments Pour Une Sociologie de La Traduction. La domestication des coquilles Saint-Jacques et des marins-pêcheurs dans la baie de Saint-Brieuc. *L'Année Sociologique*, 36, 169–208. <https://www.jstor.org/stable/27889913>.
- Currie, G., & White, L. (2012). Inter-professional barriers and knowledge brokering in an organizational context: The case of healthcare. *Organization Studies*, 33(10), 1333–1361.
- Darcis, C., & Thunus, S. (2020). What do coordinators do? Mental health policy implementation as translation. *Administrative Sciences*, 10(1), 9.
- De Munck J., Genard, J.-L., Kutry, O., Vrancken, D., Delgoffe, D., Donnay, J.-Y., Moucheron, M., & Macquet, C. (2003). *Santé Mentale et Citoyenneté. Les Mutations d'un Champ de l'action Publique*. Gent: Academia Press et Politique scientifique fédérale. <https://dial.uclouvain.be/pr/boreal/object/boreal:79499>.
- Denis, J. L., Ferlie, E., & Van Gestel, N. (2015). Understanding hybridity in public organizations. *Public Administration*, 93(2), 273–289. <https://doi.org/10.1111/padm.12175>.
- Dubois, C., & Orienne, J.-F. (2012). Les politiques publiques comme partitions à construire: L'introduction de la justice réparatrice dans les prisons belges. *Gouvernement et Action Publique*, 2(2), 117–139. <https://doi.org/10.3917/gap.122.0117>.
- Eliadis, P., Hill, M. M., & Howlett, M. (2005). *Designing government. From instruments to governance*. McGill-Queen's University Press. <http://www.jstor.org/stable/j.cttq938d>.
- Exworthy, M., & Hunter, D. J. (2011). The challenge of joined-up government in tackling health inequalities. *International Journal of Public Administration*, 34(4), 201–212.
- Federal Service for Public Health Food Chain Safety and Environment (2010). *Guide Vers de Meilleurs Soins En Santé Mentale Par La Réalisation de Circuits et de Réseaux de Soins*. Brussels: Federal Service for Public Health Food Chain Safety and Environment. <http://www.psy107.be/index.php/fr/doc>.
- Federal Service for Public Health Food Chain Safety and Environment (2015). *Guide Vers Une Nouvelle Politique de Santé Mentale Pour Enfants et Adolescents*. Brussels: Federal Service for Public Health Food Chain Safety and Environment. <https://www.psy0-18.be/index.php/fr/>.
- Federal Service for Public Health Food Chain Safety and Environment (2016). *Handbook of innovative practices in mental healthcare*. Brussels: Federal Service for Public Health Food Chain Safety and Environment. <http://www.psy107.be/index.php/fr/doc>.

- Folke, C., Hahn, T., Olsson, P., & Norberg, J. (2005). Adaptive governance of social-ecological systems. *Annual Review of Environment and Resources*, 30(1), 441–473.
- Freeman, R. (2009). What is ‘Translation’? *Evidence & Policy: A Journal of Research, Debate and Practice*, 5(4), 429–447.
- Freeman, R., Griggs, S., & Boaz, A. (2011). The practice of policy making. *Evidence and Policy*, 7(2), 127–136. <https://doi.org/10.1332/174426411X579180>.
- Freeman, R., Smith-Merry, J., & Sturdy, S. (2012). Rhizomic regulation: Mobilising knowledge for mental health in Europe. In *Knowledge and regulatory processes in health and education policies*. (13–50). Lisbon: Educa - Instituto de Educação da Universidade de Lisboa.
- Grard, A., Nicaise, P., & Lorant, V. (2015). Evaluation de La Réforme « Vers de Meilleurs Soins En Santé Mentale » — Résultats 2014. *Acta Psychiatrica Belgica*, 115(1), 40–49. <https://core.ac.uk/download/pdf/34091797.pdf>.
- Hall, P. A. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25(3), 275–296. <http://www.jstor.org/stable/422246>.
- Hassenteufel, P. (2008). In A. Collin (Ed.), *Sociologie Politique: L'action Publique*. Paris: Armand Colin. <https://doi.org/10.3917/arco.hasse.2011.01>.
- Helderman, J. K., Bevan, G., & France, G. (2012). The rise of the regulatory state in health care: A comparative analysis of The Netherlands, England and Italy. *Health Economics, Policy and Law*, 7(1), 103–124.
- Hervey, T. K. (2008). The European Union's governance of health care and the welfare modernization agenda. *Regulation & Governance*, 2(1), 103–120.
- Howlett, M. (2000). Managing the ‘Hollow State’: Procedural policy instruments and modern governance. *Canadian Public Administration*, 43(4), 412–431. <https://doi.org/10.1111/j.1754-7121.2000.tb01152.x>.
- Koutalakis, C., Buzogany, A., & Börzel, T. A. (2010). When soft regulation is not enough: The integrated pollution prevention and control directive of the European Union. *Regulation and Governance*, 4(3), 329–344. <https://doi.org/10.1111/j.1748-5991.2010.01084.x>.
- Lascoumes, P., & Le Galès, P. (2005). In P. Lascoumes & P. Le Galès (Eds.), *Gouverner Par Les Instruments*. Presses de Sciences Po.
- Lascoumes P., & Le Galès P. (2007). Introduction: understanding public policy through its instruments. From the Nature of Instruments to the sociology of public policy Instrumentation. *Governance*, 20(1), 1–21. <http://dx.doi.org/10.1111/j.1468-0491.2007.00342.x>.
- Lascoumes, P., & Simard, L. (2011). L'action Publique Au Prisme de Ses Instruments. *Revue Française de Science Politique*, 61(1), 5.
- Majone, G. (1997). From the positive to the regulatory state: Causes and consequences of changes in the mode of governance. *Journal of Public Policy*, 17(2), 139–167.
- Marquis, N., & Susswein, R. (2020). « Rétablir Par Le Réseau ». Enjeux et Tensions Issus de La Réforme Des Soins de Santé Mentale « Psy107 » (Belgique). *SociologieS*. [En Ligne], Dossiers, mis en ligne le 20 mai 2020. <http://journals.openedition.org/sociologies/13711>.
- Meyer, J. W., & Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. *The American Journal of Sociology*, 83(2), 340–363. <https://www.jstor.org/stable/2778293>.
- Meyer, M. (2010). The rise of the knowledge broker. *Sage Publications*, 32(1), 118–127. <http://dx.doi.org/10.1177/1075547009359797>.
- Mistiaen, P., Cornelis, J., Detollenaere, J., Devriese, S., Farfan, M. I., & Ricour, C. (2019). *Organisation of mental health Care for Adults in Belgium*. Health Services Research (HSR) Belgian Health Care Knowledge Centre (KCE). <https://kce.fgov.be/en/organisation-of-mental-health-care-for-adults-in-belgium>.
- Morse Ricardo, S. (2010). Integrative public leadership: Catalyzing collaboration to create public value. *The Leadership Quarterly*, 21(2), 231–245. <http://dx.doi.org/10.1016/j.leaqua.2010.01.004>.
- Nicaise, P., Grard, A., Leys, M., Van Audenhove, C., & Lorant, V. (2021). Key dimensions of collaboration quality in mental health care service networks. *Journal of Interprofessional Care*, 35(1), 28–36. <https://doi.org/10.1080/13561820.2019.1709425>.
- Olsson, P., Gunderson, L. H., Carpenter, S. R., Ryan, P., Lebel, L., Folke, C. & Holling, C. S. (2006). Shooting the rapids: navigating transitions to adaptive governance of social-ecological systems. *Ecology and Society*, 11(1). <http://dx.doi.org/10.5751/es-01595-110118>.
- Paillé, P., & Mucchielli, A. (2012). *L'analyse Qualitative En Sciences Humaines et Sociales*. Paris: Armand Colin. <https://doi.org/10.3917/arco.paill.2012.01>.

- Pinson, G. (2005). Chapitre 5: Le Projet Urbain Comme Instrument d'action Publique. In P. Lascoumes & P. Le Galès (Eds.), *Gouverner par les instruments* (pp. 199–233). Paris: Presses de Sciences Po. <https://doi.org/10.3917/scpo.lasco.2005.01.0199>.
- Simons, A., & Voß, J. P. (2018). The concept of instrument constituencies: Accounting for dynamics and practices of knowing governance. *Policy and Society*, 37(1), 14–35.
- Thunus, S. (2015). *The system for addressing personal problems—From medicalisation to socialisation: Shifts in Belgian psychiatric and mental health institutions*. University of Liège.
- Thunus, S., Cerfontaine, G., & Schoenaers, F. (2011). Evolution Du Champ de La Santé Mentale En Belgique: De l'Asile Vers Les Réseaux et Circuits de Soins. *L'observatoire*, 72, 5–11.
- Thunus, S., Neyens, I., Walker, C., Hermans, K., Smith, P., Nicaise, P., Van Audenhove, C., & Lorant, V. (2019). Strengths, weaknesses, gaps, and overlaps in the current mental health care supply: A focus group study. In *Organisation of mental health care for adults in Belgium* (pp. 166–206). Belgian Health Care Knowledge Centre (KCE). <https://kce.fgov.be/en/organisation-of-mental-health-care-for-adults-in-belgium>.
- Voß, Jan-Peter. 2007. “Designs on governance. Development of policy instruments and dynamics in governance.” University of Twente.
- Walker, C., Nicaise, P., & Thunus, S. (2019). *Parcours. Bruxelles. Évaluation Qualitative Du Système de La Santé Mentale et Des Parcours Des Usagers Dans Le Cadre de La Réforme Psy 107 En Région de Bruxelles-Capitale*. Région de Bruxelles Capitale. https://www.ccc-ggc.brussels/sites/default/files/documents/graphics/rapports-externes/parcours.bruxellesfr_def.pdf.
- Williams, P. (2002). The competent boundary spanner. *Public Administration*, 80(1), 103–124.
- World Health Organization. 2008. *Policies and practices for mental health in Europe: Meeting the challenges*. World Health Organization. <https://www.euro.who.int/en/publications/abstracts/policies-and-practices-for-mental-health-in-europe.-meeting-the-challenges>.

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