Title: Stakeholder coalitions and priorities around the policy goals of a nation-wide mental health care reform

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Abstract

Purpose: The difficulty of implementing mental healthcare reforms owes much to the influence of stakeholders. So far, the endorsement of mental health policy reforms by stakeholder coalitions has received little attention. This study describes stakeholder coalitions formed around common mental health policy goals and highlights their central goals and oppositions.

Methods: Data were collected on the policy priorities of 469 stakeholders (policymakers, service managers, clinicians, and user representatives) involved in the Belgian mental healthcare reform. Four coalitions of stakeholders endorsing different mental health policy goals were identified using a hierarchical cluster analysis on stakeholders' policy priorities. A belief network analysis was performed to identify the central and peripheral policy goals within coalitions.

Results: Coalitions brought together stakeholders with similar professional functions. Disagreements were observed between service managers and policymakers around policy goals. The two coalitions composed of policymakers supported a comprehensive approach that combines the different goals and also supported the shortening of hospital stays, whereas the two coalitions composed of service managers emphasised the personal recovery of users and continuity of care. Regardless of the coalitions' differing policy priorities, strengthening community care was a central goal while patient-centred goals were peripheral.

Conclusions: The competing policy positions of the coalitions identified may explain the slow and inconsistent pace of the Belgian mental healthcare reform. Strengthening community care may be an essential part of reaching consensus across coalitions. Finally, special care must be taken to ensure that patient-centred policy goals, such as social integration, are not set aside in favour of other goals.

Keywords: Mental health, Stakeholders, Advocacy coalitions, Health policy, Health care reform

Background

In recent decades, mental health care systems in Western countries have undergone provision, coordination, and funding reforms (Anthony, 1993; Bergmark, Bejerholm, & Markstrom, 2017; G. N. Grob, 1991; Knapp, McDaid, Mossialos, & Thornicroft, 2007). The historical roots of mental health care and its evolution over time have led to numerous reforms with multiple policy goals (Rochefort, 1988). Two important policy goals have been the deinstitutionalisation of mentally ill people, which started in the second half of the twentieth century (Goodwin, 1997; Novella, 2008), and priority being given to the personal recovery of people living with mental illness, which has been a guiding principle of mental health care reforms since the early 2000s (Anthony, 1993; Everett, 1994; Jacobson & Curtis, 2000).

Mental health care reforms and policies have been driven by multiple demands that have emerged from the health and social sectors and also from society more generally (Hannigan & Coffey, 2011; Meyer & Scott, 1983; Scheid, 2008). For example, in the 1980s, the deinstitutionalisation of people who live with mental illness in Italy was rooted in a "democratic psychiatry" movement with a progressive view of the human capacity for resilience (de Girolamo & Cozza, 2000; Pergami, Gonevi, & Guerrini, 1997). In the UK, however, deinstitutionalisation has been driven by a neoliberal vision that has sought to reduce the costs related to the number of psychiatric beds in public hospitals (Cummins, 2010; Ramon, 2008). Demands have often been contradictory and mental health reforms and policies have continuously been subject to recurring tensions, ambiguities, and inconsistencies (Rochefort, 1988, 1999). Indeed, mental health policies, like other policies, are an attempt to balance technical demands (such as efficiency, cost control) and normative ones (such as human rights, quality of care) (Scheid, 2008). In addition, there may also be tensions between contradictory normative demands (Abravanel, 1983; Scheid, 2008). An example of this is the tension between users' movements calling for more social inclusion and safety concerns raised by wider society, the former aiming to support the autonomy and inclusion of people living with mental illness in the community while the latter aims to separate individuals who are stigmatised as potentially dangerous (e.g. people living with severe mental illness) from the community.

Amid multiple, contradictory demands, the implementation of mental health care reforms is often slow and inconsistent, leaving policy goals unachieved. Thus, although national and international authorities have advocated deinstitutionalisation and the provision of effective community-based care over the last few decades (Cylus et al., 2015; WHO, 2001), an international comparison of the progress of deinstitutionalisation policies found that hospital closure was still in an early stage in 21 out of 30

European countries in 2016 (Taylor Salisbury, Killaspy, & King, 2016). Another study also drew attention to forms of reinstitutionalisation in some countries, i.e. an increase in the number of involuntary hospital admissions and places in forensic institutions and supported housing, to replace the beds that were closed in psychiatric hospitals (Priebe et al., 2005). In terms of recovery-oriented policy goals, four systematic reviews have shown that recovery outcomes of people who live with severe mental illness have not improved over recent decades, despite reforms and major changes in mental health care (Hegarty, Baldessarini, Tohen, Waternaux, & Oepen, 1994; Jaaskelainen et al., 2013; Menezes, Arenovich, & Zipursky, 2006; Warner, 2004). For example, employment is an important dimension of personal recovery and the integration of people with mental illnesses into the labour market has been on the political agenda of many OECD countries since the early 2000s, but the pace of policies and reforms to achieve it has been slow (OECD, 2015). In 2010, in OECD countries, the risk of being unemployed was two to three times higher for people living with mental illness than for people without mental illness (Hewlett & Moran, 2014). Furthermore, some studies have suggested that periods of economic hardship have intensified the economic exclusion of people living with mental illness and caused a progressive decline in their employment rate (Evans-Lacko, Knapp, McCrone, Thornicroft, & Mojtabai, 2013; Marwaha & Johnson, 2004).

Another key reason for the slow and inconsistent pace of reforms is that they can be thwarted or reshaped by inconsistencies between stakeholder and policy priorities (Lorant, Grard, Nicaise, & Title 107 Study, 2016; Mancini et al., 2009; Slade et al., 2014; Whitley, Gingerich, Lutz, & Mueser, 2009). In policy implementation research, disagreements within the policy community and between the policy community and other stakeholders have frequently been identified as a factor explaining failures in the implementation of public policies (Fixsen, Naoom, Blase, & Friedman, 2005; Schofield, 2001). Furthermore, recurrent tensions and ambiguities in mental health reforms have enabled the most powerful stakeholders to protect their particular interests (Scheid, 2008), so that the effectiveness of a reform's implementation is also related to the stakeholders' endorsement of its goals and programme (Cunningham, Barwick, Rimas, Mielko, & Barac, 2018; Hudson & Lowe, 2004). For example, it has been suggested that the difference in effectiveness between evidence-based supported employment interventions in the USA, Canada, and Europe result from their differing implementation strategies and low fidelity to the intervention programmes due to stakeholder resistance (Bond et al., 2001).

Although reform programmes are often devised by policymakers, their implementation is largely shaped by mid-level managers, who have the most influence in practice (Oliver, de Vocht, Money, & Everett, 2013). This is described by Lipsky (Lipsky, 1980) in policy implementation research as "street-level bureaucracy", emphasising the central role of frontline staff in putting policy into action.

However, mid-level managers may have different priorities and interests to policymakers (Peters & Pierre, 2003; Rice, 2012). The influence of service managers and other providers on the implementation of public policies is even greater in health care systems that are based on corporatist decision-making processes, with a weaker state authority and in which providers (e.g. private hospitals or private practitioners) have extensive autonomy. (Atkinson & Coleman, 1989; Burau & Blank, 2006; Moran, 2000; Wendt, Frisina, & Rothgang, 2009).

Finally, the mental health sector is characterised by a multitude of stakeholders with different professional profiles and there is little consensus among them on the etiology of mental illnesses, the definition of recovery, treatment approaches, and appropriate quality of mental health care (Cook & Wright, 1995). This situation facilitates appropriation of and opposition to reform programmes and goals (Mechanic, 1994). The reform process, therefore, requires gaining the support of these multiple stakeholders from different statutory frameworks and professional backgrounds, who form coalitions around common interests and priorities (G. N. Grob, 1994). Coalitions may have a greater influence on policy-making and implementation than fragmented groups of stakeholders (Ansell, Reckhow, & Kelly, 2009; Swigger & Heinmiller, 2014). The Advocacy Coalition Framework developed by Sabatier (Sabatier, 1987) analyses, among other things, the influence of coalitions whose beliefs differ about what constitutes good evidence and about what the priorities should be, and on the adoption and implementation of public policies (Sabatier, 2007). Although research has started to address the influence of coalitions on health policy agenda setting and implementation (Heaney, 2006; Meister & Guernsey de Zapien, 2005; Swigger & Heinmiller, 2014), there has not been much research looking at coalitions of stakeholders in mental health policies. This is unfortunate given the heterogeneity of mental health policy goals and the diversity of the actors involved.

Identifying stakeholder coalitions and understanding the complex relationships between policy goals and stakeholders' priorities would be useful in understanding why reforms are lagging behind and would help to coordinate policy implementation more effectively. In the context of an ongoing nation-wide mental health care reform in Belgium, we (1) identified coalitions of stakeholders around the policy goals of the reform, (2) highlighted the central policy goals of those coalitions, and (3) identified the most influential stakeholders in the organisation of mental health care.

Methods

Setting

The Belgian health care system is a regulated-market, social insurance-based system characterised by a substantial level of corporatism in policy decision-making. Although the provision, coordination, and funding of care are the responsibility of the political authorities, these responsibilities tend to be delegated to semi-public institutions in which stakeholders, such as sickness funds and representatives of professionals, have a high level of bargaining power and defend their particular interests (Gerkens & Merkur, 2010).

In Belgium, the process of deinstitutionalisation started around 1975 with the establishment of community mental health services, followed in the 1990s by other alternatives to psychiatric hospitalisation (e.g. residential rehabilitation units, sheltered housing, and psychiatric nursing homes). That process of deinstitutionalisation is, however, still far from complete and long-term psychiatric hospitalisation remains an important part of the care supply for adults with mental health problems (Nicaise, Dubois, & Lorant, 2014). In 2008, the rate of psychiatric beds per 100,000 inhabitants was 153, one of the highest in OECD countries (WHO, 2008).

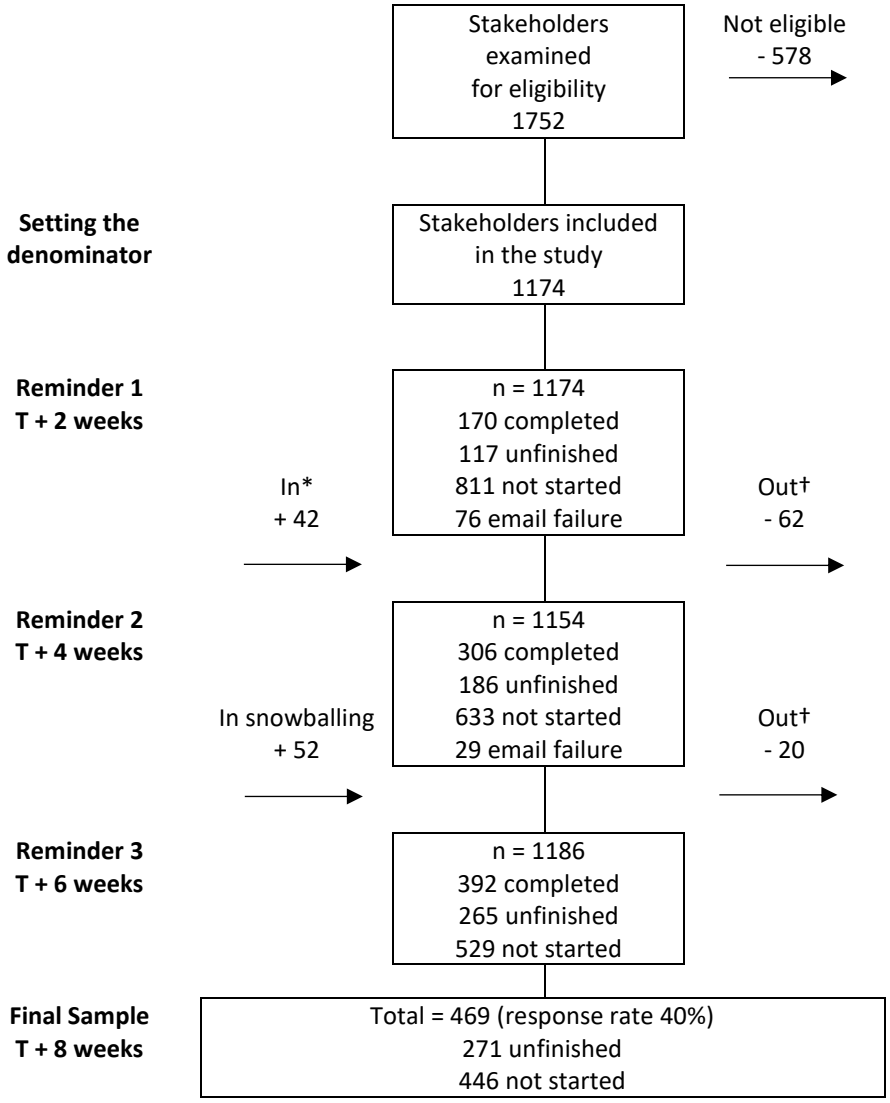
Belgium has been implementing a reform of its mental health care system since 2010. The policy underpinning the reform had various objectives, such as the personal recovery and social integration of people with mental health care needs, the improvement of continuity of care between the social and health care sectors, shorter and less frequent hospital stays, and the strengthening of the community-based care system. The reform mainly focuses on the establishment of networks of services that must cover all mental health care needs in a defined area and provide five care functions: (i) prevention and early detection, (ii) outreach, (iii) personal recovery and social integration, (iv) intensive inpatient treatment, and (v) specific housing and long-term facilities. The reform was implemented from the bottom up, leaving extensive autonomy to local care stakeholders in the development of their own networks of services and resulting in diversified projects (Lorant, Nazroo, Nicaise, & Title107 Study, 2017). The programme theory of the Belgian mental health care reform has been analysed in detail elsewhere (Nicaise et al., 2014).

All in all, these successive waves of reforms have pursued a wide range of international mental health policy goals, such as the deinstitutionalisation and personal recovery of people with mental health problems.

Design

A national stakeholder survey was conducted online in 2018 as part of a broader evaluation of the Belgian mental health care reform. A stakeholder is a person or an organisation that has an important stake in or influence on the solutions being considered (Brugha & Varvasovszky, 2000). In this study, stakeholders include policymakers, public authorities, sickness funds, experts (i.e. people working in academic or public mental health research centres and mental health expert committees from different ministries), professional associations, service managers and network coordinators, clinicians, and representatives of users and family associations. The stakeholders were selected from the databases of the Belgian Health Care Knowledge Centre (KCE) and from two academic mental health research institutes. The survey questionnaire was delivered via Qualtrics and the anonymity of respondents was ensured throughout the survey procedure. The survey was open for two months, during which participants received three reminders. The flowchart of the sampling process is presented in Table 1. After examination of their eligibility, 1174 stakeholders were contacted. Snowball sampling was used to improve the initial contact list of stakeholders. Initial respondents were asked to nominate up to five people whom they considered important in the organisation of mental health care to contact for the survey. We received 643 nominations regarding 391 different individuals. Of these, 75% were already on the initial contact list. For the remaining 96 people, eligibility was assessed, a contact email was sought, and 52 people were added to the list. In total, 469 stakeholders replied (response rate = 40%). The comparison of the characteristics of respondents and non-respondents is presented in Additional Table 1. The respondent group did not differ from the non-respondent group in terms of professional function ($\chi 2 = 2.03$, $p = 0.31$) and differed slightly in terms of language spoken ($\chi 2 = 4.25$, $p < 0.05$), with an overrepresentation of the Dutch-speaking stakeholders in the respondent group.

Table 1: Flowchart of the sampling process



* New contact persons (job change, resignation, or retired)
† Job change, resignation, retired, or email failure

Measures

Six generic mental health policy goals were presented to respondents: (1) to ensure continuity between the social and care sectors, (2) to treat users in their community, (3) to provide short hospitalisations and three patient-centred goals: (4) to support users with their life goals, (5) to support users to connect with their community, and (6) to involve users in developing and offering new services. These different goals were based on those of the reform programme (Guide, 2010). The goal of continuity of care, referred to as "de-categorisation" in the reform programme, is to provide integrated care across the multiple care and welfare sectors. The goal of treating users in their community is derived from the "deinstitutionalisation" goal; it refers to providing care in the community and avoiding residential care as much as possible. The goal of shortening hospital stays is

derived from the “intensification of care in hospitals” goal in the reform programme; the aim is to limit hospitalisations to acute, short care episodes. Finally, the "inclusion" goal refers to the social integration and personal recovery of users. We subdivided this broadly defined goal into three patient-oriented goals (i.e. to support users with their life goals, to support them to connect with their community, and to involve them in developing and offering new services), which were derived from previous analyses of the reform programme (Nicaise et al., 2014; Smith et al., 2019). A Budget Reduction Decision method was used to identify the respondents' explicit policy priorities (Doyle, Green, & Bottomley, 1997; Yoon & Hwang, 1995). Each respondent was asked to indicate the level of priority they gave to the six goals presented by distributing 100 points across the goals. Respondents could give as many points as they wanted between 0 and 100 to one or more of the six goals according to the goal’s priority until they had given a total of 100 points. The order in which the six policy goals was presented in the online survey was randomised in order to avoid a possible design bias. The Budget Reduction Decision method was used instead of ranking or scoring to identify trade-offs between the different goals (Swenson & McCahon, 1991; Yoon & Hwang, 1995). Indeed, in the real world, stakeholders face choices that involve a trade-off between the different goals of health policies (Powell et al., 2017). For example, stakeholders may acknowledge the need to improve care coordination but, at the same time, want to preserve the autonomy of providers (Nicaise, Lorant, & Dubois, 2013). There is, therefore, “*a need for methods that study the implementation decision in the context of the tradeoffs that influence real-world planning”* (Cunningham et al., 2018). Information was also collected on respondents’ language, professional function, seniority, and self-perceived influence on the organisation of mental health care. The stakeholders’ self-perceived influence on the organisation of mental health care was measured using four criteria with 5-point Likert scales, returning a total score ranging between 0 (no influence) and 20 (strong influence). The four criteria were: influence of the institution on the organisation of mental health care, participation in recruitment or promotion of employees within the institution, participation in budget decisions within the institution, and participation in decisions on the adoption and implementation of new activities, policies, and programmes within the institution. This score of influence has been used in previous studies (Aiken & Hage, 1968; Spaeth, 1985). It measured both the influence of the respondent’s institution and the respondent’s influence within the institution.

Data analysis

The different statistical analyses that were carried out complemented each other and aimed to (1) identify the stakeholders' priority policy goals, (2) identify coalitions of stakeholders around those policy priorities, and (3) identify the central and peripheral policy goals of those coalitions.

First, descriptive statistics were computed for stakeholders' characteristics and priority scores of the six mental health policy goals. One-way analyses of variance (ANOVA) were performed to assess the significance of differences in stakeholders' self-perceived influence on mental health care organisation across professional functions and language groups.

Second, a cluster analysis was used to group those stakeholders who gave similar priority scores to the six policy goals of the reform. This method identifies potential advocacy coalitions and has been applied in other studies (Costantini, Crescenzi, De Filippis, & Salvatici, 2007; Diaz-Bonilla, Thomas, Robinson, & Cattaneo, 2000; Jenkins-Smith, Clair, & Woods, 1991). Indeed, the Advocacy Coalition Framework suggests that policy subsystems are structured around competing coalitions that bring together stakeholders sharing similar policy viewpoints and priorities (Sabatier, 1988; Wildavsky, 1962). We performed a hierarchical cluster analysis on the priority scores of the six policy goals using the Ward minimum variance method. The dendogram of the cluster analysis (see Additional Figure 1) was used to determine the optimal cut-off point for the number of clusters. We decided to proceed with four clusters that accounted for 34% of the variance. The four-cluster solution was chosen because the fifth cluster was a small subgroup of the first cluster (n = 26) and this small sample size reduced the value of additional subdivision. In addition, a limited number of clusters of comparable sizes also makes for better interpretability. Chi-square and ANOVA tests were performed to describe the composition of these clusters.

Finally, several theories suggest that policy preferences are structured as networks of interrelated policy positions, in which some are central and others are peripheral, the former making the backbone for the latter (Boutyline & Vaisey, 2017; Feldman, 1988; Jost, Federico, & Napier, 2009). In the context of advocacy coalitions, some studies have supported the hypothesis that members of a coalition adhere to hierarchically structured policy positions in which a central policy priority constrains the peripheral ones and is related to political decision-making (Converse, 1964; Heintz, 1988; Sabatier, 1987). A policy goal may, therefore, be considered the lowest priority, but nonetheless be central. The priority and centrality of policy goals, therefore, constitute complementary information. For that reason, a belief network analysis was used to identify the central and peripheral policy goals of the

different clusters of stakeholders (Boutyline & Vaisey, 2017). This method uses weighted networks constructed from squared correlation between pairs of variables (e.g. a priority score of policy goals) to analyse the relationship between them and to identify central and peripheral variables (Boutyline & Vaisey, 2017). A policy goal is considered central when it is strongly correlated, positively or negatively, with all the other policy goals. In this study, the method was applied to the priority scores of the six mental health policy goals. Since the priority scores were continuous, we performed squared Pearson's correlation for each pair of policy goals in order to construct the network of policy priorities of stakeholders for the four clusters and for the whole sample ($T = \sum \rho^2$). We also used a Quadratic Assignment Procedure (QAP) to test whether the network of policy priorities differed between the four clusters of stakeholders. QAP tests the correlation between pairs of networks. The Belief Network Analysis was performed using UCINET 6. Other statistical analyses were performed using SAS 9.3.

Results

Stakeholders' characteristics, priority policy goals, and self-perceived influence on the organisation of mental health care

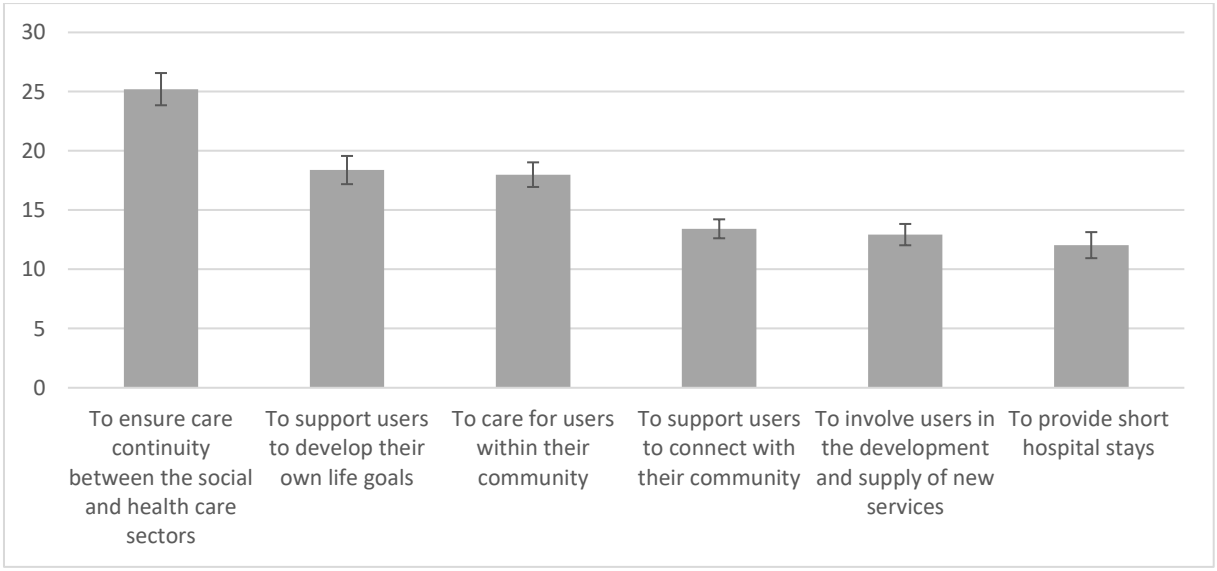
Stakeholders' characteristics and self-perceived influence on the organisation of mental health care are presented in Table 2. The sample was well balanced between clinicians and non-clinicians and representative of the language groups in the Belgian population. The mean score of self-perceived influence on the organisation of mental health care was 14.1 on a maximum of 20 (SD = 3.6). Self-perceived influence differed significantly depending on stakeholders' professional function ($F = 25.6$, $p < 0.0001$). Service managers perceived themselves as more influential in the organisation of mental health care (16.3/20, SD = 2.5) than policymakers and experts (14.2/20, SD = 3.1) and clinicians (12.9/20, SD = 3.7). User representatives had the lowest self-perceived influence (12.6/20, SD = 4.1).

Table 2: Stakeholders' characteristics and self-perceived influence on the organisation of mental health care

Stakeholders' characteristics and priority policy goals		**Score of self-perceived influence on the organisation of mental health care (1 = weak, 20 = strong)**	
		Mean score (SD)	F (p-value)
Professional function, n (%)			
- Policymakers and experts	131 (27.8)	14.2 (3.1)	
- Service managers	108 (23.1)	16.3 (2.5)	25.6
- Clinicians	193 (41.2)	12.9 (3.7)	(<0.0001)
- User representatives	37 (7.9)	12.6 (4.1)	
Language, n (%)			
- French-speaking	195 (41.6)	14.2 (3.6)	0.27
- Dutch-speaking	274 (58.4)	14.0 (3.6)	(0.60)
Self-perceived influence, mean (SD)	14.1 (3.6)	/	/
Seniority, year, mean (SD)	19.1 (11.5)	/	/

Stakeholders' priority goals are presented in Figure 1. Ensuring care continuity between the social and health care sectors was the highest priority (25.1/100, SD = 14.6). Next in terms of priority were the goals of supporting users to develop their life goals (18.4/100, SD = 13.2) and treating them within their community (18/100, SD = 11.1). Finally, the lowest priority goal was the provision of short hospital stays (12.1/100, SD = 12.1).

Figure 1: Stakeholders' priority policy goals in relation to the mental health care reform (0 = low priority, 100 = high priority)



Note: mean 95% CI displayed on each bar

Stakeholder coalitions around policy goals

Table 3 presents the clusters of stakeholders who share similar mental health policy priorities and the characteristics of those who form the four coalitions identified.

The four coalitions were significantly different in terms of stakeholders' professional function ($\chi 2$ = 43.9, $p < 0.001$). The first coalition was the largest and included 161 stakeholders. In this coalition, stakeholders gave relatively equal priority to the different policy goals, so we labelled this coalition "everything is important". Compared to the other coalitions, there were more user representatives and policymakers or experts and fewer service managers in this coalition. Stakeholders in the second coalition (n = 101) favoured the policy goal of supporting users to develop their own life goals (32.7/100, SD = 14.8). We labelled this coalition "personal recovery". This coalition was composed of more clinicians and service managers and fewer policymakers or experts than the other coalitions. The third coalition (n = 97) favoured shortening hospital stays (28.6/100, SD = 13.5), so we labelled this coalition "deinstitutionalisation". The coalition was composed of more policymakers or experts and fewer service managers than the other coalitions. The second and third coalitions had opposing priority goals. The goal of shortening hospital stays was of the lowest priority (6.4 / 100, SD = 5.5) for stakeholders in the "personal recovery" coalition and the goal of supporting users to develop their own life goals was not a priority (11.4 / 100, SD = 9.4) for stakeholders in the "deinstitutionalisation" coalition. Finally, stakeholders in the fourth coalition (n = 94) favoured care continuity between the social and health care sectors (45.2/100, SD = 15.0). Compared to the other coalitions, there were more service managers and fewer policymakers and user representatives in this coalition. We labelled this coalition "continuity of care".

The two policy goals on which coalitions differed the most were ensuring continuity of care ($F = 169.3$, $p < 0.0001$) and shortening hospital stays ($F = 156.9$, $p < 0.0001$). Conversely, the two policy goals on which coalitions differed the least were supporting users to connect with their community ($F = 15.4$, $p < 0.001$) and caring for users within their community ($F = 6.1$, $p < 0.01$).

Table 3: Composition of stakeholder clusters and priority policy goals

	Clusters*				
	"Everything is important" (n = 161)	"Personal recovery" (n = 101)	"Deinstituti-onalisation" (n = 97)	"Continuity of care" (n = 97)	
Policy goals	Priority score (0-100), mean (SD)				F, (p-value)
Ensure continuity between the social and care sectors	19.1 (6.7)	17.4 (8.8)	23.6 (9.6)	45.2 (15.0)	169.3 (<0.0001)
Provide short hospitalisations	9.1 (6.5)	6.4 (5.5)	28.6 (13.5)	6.4 (7.6)	156.9 (<0.0001)
Support users to develop life goals	16.9 (7.3)	32.7 (14.8)	11.4 (9.4)	12.9 (10.9)	85.8 (<0.0001)
Involve users in developing and offering new services	19.1 (9.6)	9.1 (6.0)	10.4 (8.1)	9.3 (9.2)	44.1 (<0.001)
Support users to connect with their community	15.1 (7.6)	16.4 (9.5)	10.1 (7.6)	10.8 (8.3)	15.4 (<0.001)
Treat users in their community	20.7 (11.1)	17.9 (10.1)	15.9 (9.9)	15.5 (12.4)	6.1 (<0.01)
Stakeholders' characteristics					F / χ^2 (p-value)
Professional function, n (%)					
- Policymakers and experts	47 (29.2)	18 (17.8)	42 (43.2)	20 (20.6)	43.9 (<0.001)
- Service managers	30 (18.6)	26 (25.7)	12 (12.4)	37 (38.1)	
- Clinicians	62 (38.5)	51 (50.5)	37 (38.1)	38 (39.2)	
- User representatives	22 (13.7)	6 (5.9)	6 (6.2)	2 (2.0)	
Language, n (%)					
- French-speaking	69 (42.8)	34 (33.6)	43 (44.3)	45 (46.4)	3.9 (0.27)
- Dutch-speaking	92 (57.2)	67 (66.4)	54 (55.7)	52 (53.6)	
Self-perceived influence, mean (SD)	14.2 (3.5)	13.5 (3.4)	14.4 (3.7)	14.6 (3.7)	1.27 (0.28)
Seniority, year, mean (SD)	17.3 (10.9)	20.1 (11.5)	21.1 (12.1)	18.7 (11.5)	2.7 (0.09)

***** Hierarchical cluster analysis with the Ward minimum variance method on the priority scores of the six policy goals with a cut-off point of four clusters accounting for 34% of the variance

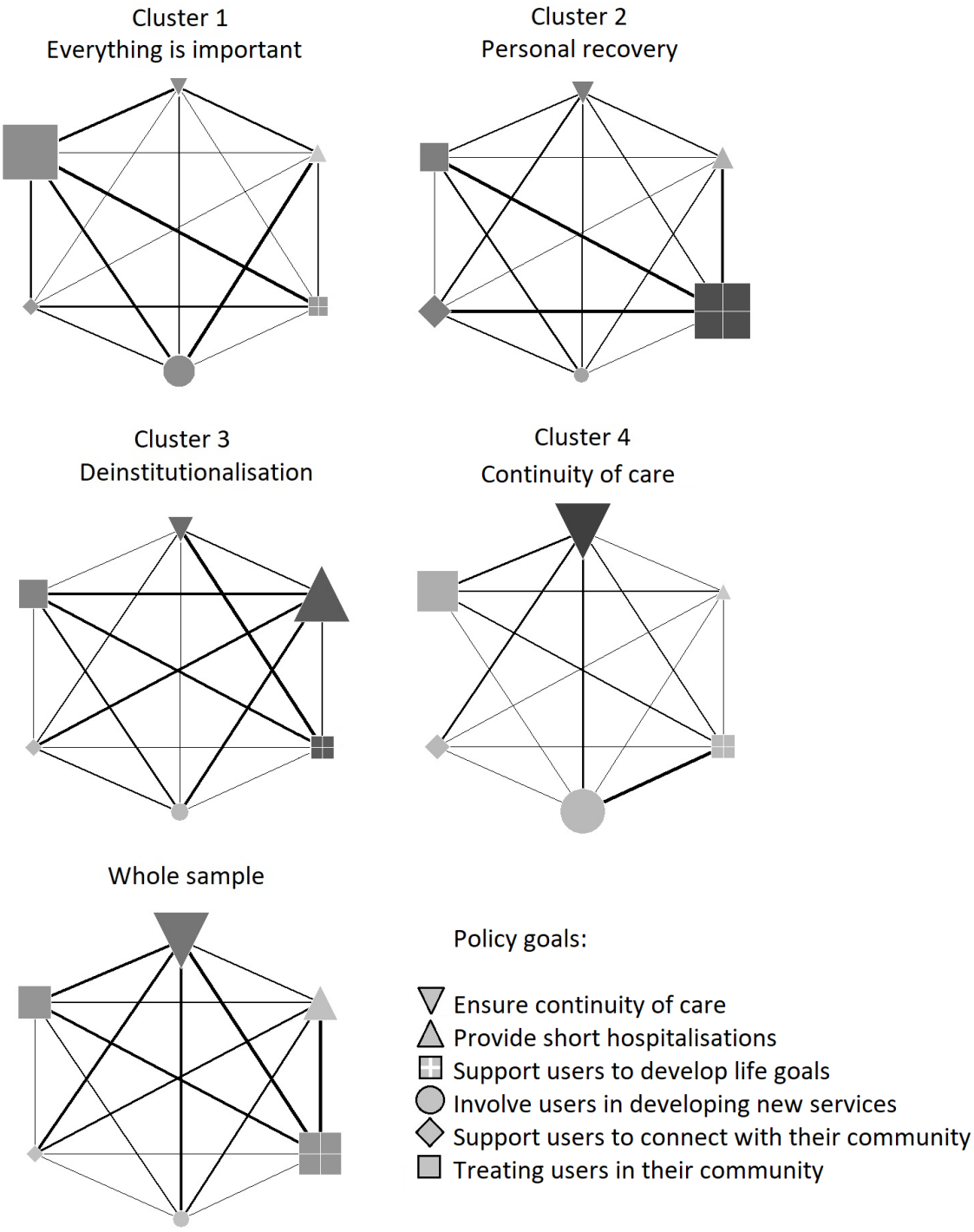
Central and peripheral policy goals within the four coalitions of stakeholders

The networks of policy priorities of stakeholders are illustrated in Figure 2 for the whole sample and for each coalition.

For the whole sample, the two policy goals that were considered priorities were also central, i.e. ensuring continuity of care and supporting users to develop their life goals. Providing short hospital stays, however, was also central, though it was the lowest priority. The peripheral goals for the whole sample were supporting users to connect with their community and involving them in developing new services. This pattern differed between coalitions. In the "everything is important" coalition, the different policy goals were all considered priorities, but we observed that the central goal was treating users in their community while the most peripheral goals were supporting users to connect with their community and providing short hospital stays. In the "personal recovery" coalition, the priority policy goal was supporting users in the development of their life goals, which was also the most central goal. The most peripheral goal in this coalition was involving users in developing new services. In the "deinstitutionalisation" coalition, providing short hospital stays was both the highest priority and the most central goal. The peripheral goals in this coalition were supporting users to connect with their community and involving them in developing new services. In the "continuity of care" coalition, three policy goals were central: ensuring continuity of care and treating users in their community, which were also the priority goals, and involving users in the development of new services, which was not, however, a priority goal. The peripheral goals in this coalition were providing short hospital stays and helping users to connect with their community.

Finally, across the four coalitions, we observed that the goal of treating users in their community was often central, while the goals of supporting users to connect with their community and of involving them in the development of new services were often peripheral.

Figure 2: Networks of policy priorities of the four coalitions of stakeholders



Legend:
Tie strength | Tij | = cor2 (xi, xj) is represented by the edge thickness
The size of the symbol = ∑ cor2 is proportional to policy goal centrality
The boldness of the symbol = xi is proportional to policy goal priority

Table 4 presents the correlation (quadratic assignment procedure) between the networks of policy priorities of the four coalitions. Overall, there was no significant correlation across the four coalition's networks. The highest convergence was observed between the "personal recovery" and "everything is important" coalitions (r = 0.258, p = 0.15). The largest difference between networks was observed between the "deinstitutionalisation" coalition and two other coalitions, the "continuity of care" coalition (r = -0.260, p = 0.17) and the "personal recovery" coalition (r = -0.251, p = 0.18). The central goal in the "deinstitutionalisation" coalition, shortening hospital stays, was peripheral in the "continuity of care" and "personal recovery" coalitions. The central goals of the "continuity of care" and "personal recovery" coalitions respectively, ensuring continuity of care and supporting users in the development of their life goals, were peripheral in the "deinstitutionalisation" coalition.

Table 4: Correlation between networks of policy priorities

	Quadratic assignment procedure, r (p-value)			
	Cluster 1	Cluster 2	Cluster 3	Cluster 4
Cluster 1: Everything is important	1			
Cluster 2: Personal recovery	0.258 (0.15)	1		
Cluster 3: Deinstitutionalisation	-0.052 (0.42)	-0.251 (0.18)	1	
Cluster 4: Continuity of care	-0.235 (0.21)	-0.116 (0.40)	-0.260 (0.17)	1

Discussion

Main findings

This study found that mapping mental health policy goals enables us to identify different stakeholder coalitions that shared different policy priorities. This study highlighted four main stakeholder coalitions bringing together stakeholders with similar professional functions in the mental health care system, and revealed a divergence in priority policy goals between service managers and policymakers. The largest coalition was made up of a majority of policymakers and fewer service managers and supported all the policy goals with equal priority. The other three coalitions were each formed around one specific (and different) policy goal. One of those three coalitions prioritised deinstitutionalisation and was also made up of a majority of policymakers and fewer service managers. The other two coalitions were made up of a majority of service managers and fewer policymakers. One prioritised the personal recovery of users and the other prioritised continuity of care. Across coalitions, service managers considered themselves more influential in the organisation of mental health care than other stakeholders. As for the representatives of users and families, they considered themselves to be the least influential stakeholders in the organisation of mental health care and were mainly represented in the "everything is important" coalition, in which all the policy goals were considered priorities, and were poorly represented in the "continuity of care" coalition.

As well as each having a different priority goal, our results also showed that the structure of the network of policy priorities of each coalition was different. The largest difference was observed between the "deinstitutionalisation" coalition, on the one hand, and the "continuity of care" and "personal recovery" coalitions, on the other. Indeed, providing short hospitalisations was a central goal of the coalition in favour of "deinstitutionalisation", but it was peripheral in the "continuity of care" and "personal recovery" coalitions. The central goals of the latter two coalitions (ensuring continuity of care and supporting users in the development of their life goals, respectively) were peripheral in the "deinstitutionalisation" coalition.

Finally, while the policy goal with the highest priority tends to be the most central of each coalition, the goal of treating users in their community was highly central across all coalitions, while two patient-centred policy goals, i.e. supporting users to connect with their community and involving them in the development of new services, were peripheral across all coalitions.

Interpretation of findings

So far, coalitions of stakeholders formed around mental health policy goals have received little attention. This study revealed four stakeholder coalitions, bringing together stakeholders with common professional functions in the organisation of mental health care that have significantly different policy priorities. This result indicates that there is a strong link between the professional functions of individuals and their policy priorities, and reveals differences in policy priorities between policymakers and service managers. The two coalitions mostly composed of policymakers supported a comprehensive approach to the different policy goals and the provision of short hospital stays while the two coalitions composed mainly of service managers emphasised the personal recovery of users and continuity of care. In addition, the "deinstitutionalisation" coalition (i.e. in favour of short hospital stays), which was mainly composed of policymakers, and the two coalitions mainly composed of managers were in opposition regarding the overall structure of their policy priorities, i.e. the central policy goals of the former were peripheral in the latter and vice versa. If these different policy goals aim at general interest, which can be shared by all stakeholders, i.e. to provide effective, equitable, and affordable mental health care, the specific functions of stakeholders may involve individual interests that influence their priorities. These cleavages and oppositions may, therefore, reflect the different relationships and interests that stakeholders have in relation to policy goals, depending on their function and position in the mental health care system. For instance, policymakers may support the shortening and intensification of hospital stays because of pressure from international organisations, e.g. the WHO (WHO, 2009, 2013, 2014), or to reduce public expenditure, whereas service managers are not so concerned by such demands. The WHO European Mental Health Action Plan 2013-2020 reinforced the focus on shortening and intensifying psychiatric hospital stays by stating that *"the commitment to deinstitutionalization and the development of community-based mental health services have continued, although progress is uneven across the Region. The consensus is that care and treatment should be provided in local settings, since large mental hospitals often lead to neglect and institutionalization"* (WHO, 2013). By contrast, in Belgium, as in other regulated-market systems, hospitals are partly funded on a fee-for-service basis and, therefore, the reduction of the length of stay in hospitals may also reduce the hospital's income, which is a concern of hospital managers. Conversely, the interests of service managers probably have more to do with the organisation of their services and care, e.g. ensuring continuity of care, and with patients, e.g. supporting users to develop their life goals. Some studies have shown that mid-level managers weigh the implementation of policies against their local management agenda (i.e. funding of their institution, staff management, organisation of activities, and performance) (May & Winter, 2007; Riccucci, Marcia, Irene, & Jun, 2004; Wells, 1997). In other respects, while the goal of supporting users to develop their

life goals was central in one of the two coalitions mostly made up of service managers, the goal of involving users in the supply and development of new services was the most peripheral. It is likely that, for service managers, involving users in the supply and development of services may induce organisational and management constraints, so that these considerations run counter to their central goal of patient personal recovery.

This study also found that service managers perceived themselves as the most influential stakeholders in the organisation of mental health care, particularly compared to policymakers. This supports the results of a previous study that found that the most influential stakeholders in the public health policy-making process in the UK were mid-level managers (Oliver et al., 2013). Although it has been observed in other countries, this result is probably reinforced by the Belgian context. As previously explained, the Belgian health care system is characterised by a substantial level of corporatism in policy decision-making and the mental health care reforms of recent decades have mainly been developed using a bottom-up approach (Gerkens & Merkur, 2010; Lorant et al., 2017; Nicaise et al., 2020), thus leaving extensive autonomy, bargaining power, and influence to stakeholders such as service managers (Atkinson & Coleman, 1989). This finding is important for policy development and implementation. Indeed, the frameworks and main goals of policies and reforms are often set by policymakers, but our results highlighted that the implementation of these frameworks and the achievement of initial goals relies heavily on mid-level managers and on the degree of convergence with their priorities and interests. This divergence in relation to policy priorities between policymakers and managers and the latter's perceived high level of influence could, therefore, explain the difficulty of implementing some policy goals of the reform, such as the deinstitutionalisation and personal recovery of people living with mental illness. In Belgium, the process of deinstitutionalisation began around 1975 but was far from being complete in the 2000s; in 2008, the per capita psychiatric bed rate per 100,000 population was the second highest in Europe (153/100,000) (WHO, 2008). Since 2010, one of the goals of the reform has once again been the deinstitutionalisation and intensification of psychiatric hospitalisations (i.e. reduction of the number of beds, resort, and length of stay in psychiatric wards). Recent figures have shown, however, that this goal has not been achieved (OECD, 2020). According to a report on the performance of the Belgian health system published in 2019, the number of days of psychiatric hospitalisation per inhabitant even increased between 2000 and 2016 (from 305 per 1000 inhabitants in 2000 to 351 in 2016) (Devos et al., 2019). The employment rate of people living with mental illness as an indicator of their personal recovery. Compared to other OECD countries, Belgium has one of the lowest rates of employment and one of the highest rates of unemployment among people living with mental illness (OECD, 2013). Furthermore, the employment rate among Belgians living with mental

illness declined between 1997 and 2008, widening the employment gap between them and people without mental illness (OECD, 2013).

In the context of a bottom-up reform, these results highlighted the importance of mobilising and bringing together policymakers, service managers, and other stakeholders in the different stages of policy development and implementation. For example, in Canada, Ontario's 2011 Mental Health and Addictions Strategy placed more emphasis on stakeholder engagement and established policy networks which brought together people from government ministries and stakeholders representing different individual and collective interests, such as researchers, service managers, professional associations, and consumer groups (Bullock & Abelson, 2019). These policy networks were mobilised during the policy formulation phase (to provide overall direction and priorities for the strategy) and during the implementation phase. A policy analysis of this process has shown that *"continuing to mobilize policy network actors into the implementation stage significantly increases the prospects for reform by embedding changes across systems and developing shared ownership at the implementation level."* (Bullock & Abelson, 2019).

Despite the competing policy positions of the coalitions, some policy goals could be a lever for consensus within and between coalitions. As previously explained, several theories suggest that policy priorities are structured as networks of interrelated policy positions, in which some are central and others are peripheral, central policy positions structuring the more peripheral and being strongly related to political decisions (Bem, 1970; Feldman, 1988; Rokeach, 1973). On the one hand, the political support and decisions of stakeholders in a specific coalition can therefore be fostered by identifying and then supporting the central goals of that coalition. On the other hand, identifying and supporting a policy goal that is central in all coalitions, such as the policy goal of treating users in their community, could be a lever for consensus between the coalitions.

Finally, representatives of users and families were mainly represented in the coalition that gave equal priority to all the policy goals, which may indicate their desire to have a comprehensive mental health policy and to prevent certain policy goals from taking precedence over others. This study, however, made it clear that, regardless of the goals around which the coalitions were formed and the structure of policy priorities of each coalition, two patient-centred policy goals were often peripheral policy goals, i.e. supporting users to connect with their community and involving them in the development of services. In addition, the descriptive results also showed that user and family representatives perceived themselves as the least influential stakeholders in the organisation of mental health care.

Although the participation of user and family representatives in policy and health care decision-making is on the political agenda in many countries (Crawford et al., 2002; van de Bovenkamp, Trappenburg,

& Grit, 2010), several studies have shown that their full participation remains a challenge and that there is little consensus on their role, on the extent of their participation or even on the aims of such participation and the process for achieving it (Fischer & Van de Bovenkamp, 2019; Fredriksson & Tritter, 2020; Tritter, 2009). These results can be interpreted in two ways. First, they can be linked to the literature suggesting that Western health care systems tend to prioritise the needs of providers and society rather than those of patients (Drake & Whitley, 2014) and that, as a result, policy goals oriented towards professionals and services, such as continuity of care or intensive psychiatric hospitalisation, can override patient-centred goals. Second, this result could be interpreted in relation to two notions of health economics: uncertainty and opportunity cost. On the one hand, there is more certainty about the return on an investment in policy goals such as the intensification of hospital stays than about patient-centred goals such as involving patients in the development of services. On the other hand, "to choose is to renounce". Since health care systems have limited resources, it is necessary to choose one alternative (e.g. if there is more certainty about the return on investment) and forgo others (e.g. if the return on investment is less certain).

Strengths and limitations

The main strength of this stakeholder survey is the representativity of the sample. We started with a database of 1752 people. Their eligibility as stakeholders in the organisation of mental health care in Belgium was evaluated to arrive at a contact sample of 1174 stakeholders. This contact sample was representative of the diversity of the different services involved in the provision, organisation, and funding of mental health care, the different stakeholder profiles, and the different regions. As previously explained, stakeholders had the opportunity to nominate up to five people to contact to complete the survey and the analysis of the nominees showed that 75% were already in our starting sample. This result confirms the quality of our initial sample. The remaining 25% were contacted after their eligibility had been checked. Another strength of this online survey is the 40% response rate obtained. A response rate of 30% was expected, based on the literature (Nulty, 2008; Sheehan, 2006). Finally, the Budget Reduction Decision method used to identify the policy priorities of stakeholders allowed us to replicate the trade-offs that stakeholders face in real life (e.g. if I choose to invest time and funds to achieve one policy goal, I will not invest that time and those funds to achieve another) and to identify central and peripheral policy objectives (Powell et al., 2017; Swenson & McCahon, 1991). This study also has some limitations. One limitation is that, although the 40% response rate is satisfactory for an online survey, we cannot rule out a selection bias. To control for this potential bias, we compared the main characteristics of respondents and non-respondents. The final sample of respondents did not differ from the non-respondents in terms of the stakeholders' professional

function. There was a slight oversampling of Dutch-speaking stakeholders among the respondents. Another limitation of this study is that the belief network analysis was developed on the assumption that the relationships between policy positions are linear and can be captured by correlations. It is possible, however, that the relationships between policy positions are more complex (e.g. non-linear functional form or unobserved heterogeneity) (Boutyline & Vaisey, 2017). Another limitation is that stakeholder coalitions and their policy priorities are context-dependent, even if the policy goals are international. These results are therefore linked to the Belgian context and are not intended to be extrapolated to other contexts. However, the question raised and the method used to answer it can be applied to other contexts, since the difficulty of implementing policies and reforms and the presence of competing advocacy coalitions is a feature of all health systems. Finally, although the cluster analysis provides a credible and realistic representation of the formation of potential advocacy coalitions, we cannot confirm the existence of these coalitions in real life. Indeed, we were able to identify potential advocacy coalitions based on the policy positions and priorities of stakeholders but we cannot prove that there was an interaction between the members of a coalition.

Conclusion

The first step in solving a problem is to identify it and ascertain its nature. Working with the different coalitions of stakeholders is essential in the context of mental health care reform as they have a strong influence on policy-making and implementation. This study showed that stakeholder coalitions favour different and conflicting mental health care policy priorities. These competing interests between coalitions may explain the slow and inconsistent pace of the Belgian mental health care reform and the difficulty of achieving some initial goals. Mapping policy priorities and identifying areas of agreement and disagreement may, therefore, be one of the first steps towards improving the implementation of health care policies and reforms. This is particularly true in a corporatist health care system in which some stakeholders, such as service managers, have a big say in the decision-making process.

This study found a divergence in relation to policy priorities between policymakers, i.e. those who often set policy programmes and goals, and service managers, i.e. those who have a strong influence on policy development and implementation. Since these different priorities can reflect the different relationships and interests that the stakeholders have in relation to the different policy goals, it seems important to find common interests and objectives. The results of this study showed that the policy goal of treating users in their community was a relatively central policy goal in the different coalitions. Since central goals are strongly related to political decision-making, this goal could, accordingly, be

emphasised in order to reach consensus between coalitions. Finally, special care must be taken to prevent policy goals that are oriented towards professionals and services, such as improving continuity of care or intensifying psychiatric hospitalisations, from overriding patient-centred goals, such as their social integration and personal recovery.

Further research might study stakeholder coalitions and policy priorities in other countries. In this study, the mental health policy goals were international (e.g. recovery, continuity of care, or community care) but the influence of stakeholders and their explicit policy priorities were specific to the Belgian context. A common feature in all countries and contexts is the difficulty of implementing policies and reforms and the presence of competing advocacy coalitions. The methodology used in this study could, therefore, be replicated and improved in other contexts to achieve a better understanding of stakeholder policy priorities and coordinate policy implementation more effectively.

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Compliance with Ethical Standards

Conflict of interest: The authors declare they have no conflict of interests.

Ethical Approval: This study was in accordance with the ethical standards of the institutional and national research committee.

Informed Consent: Informed consent was obtained from all individual participants included in the study.

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